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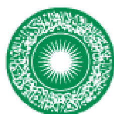

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Ahmed Nadeem Abbasi

Sehrish Abrar

Bilal Mazhar Qureshi

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EDITORIAL

Site-specific multi disciplinary tumour board is an important milestone in cancer patient's treatment journey

Ahmed Nadeem Abbasi, Sehrish Abrar, Bilal Mazhar Qureshi

Site-specific multi-disciplinary tumour boards are being conducted in order to achieve a consensus recommendation before commencing the first treatment modality of management. They are proven to be an essential milestone in high quality cancer management pathway. Review of contemporary literature showed a positive relationship in the form of better treatment outcomes in terms of survival and local control of malignancies for patients who were discussed and deliberated in site-specific multidisciplinary tumour boards.[1,2]

In developing countries, we consider these tumour boards as lifeline for our cancer patients.[3] These tumour boards provide us with an opportunity to review the quality of preliminary workup, investigations and in certain cases we do necessary changes in the tumour staging and sub-staging. In this way, we ensure an accurate recommendation for every case discussed in the board. In developing countries, due to a variety of reasons, we have observed that it is not possible to discuss every case in a site-specific Tumour Board at every institute. A practical solution to this problem in Pakistan lead to the formation of City Tumuor Board which is being attended by experts from all concerned specialities. This is an independent, non-institutional and non-territorial board which is being conducted on Sunday mornings at a neutral venue. This city Tumour Board serves to all those cancer cases who have no access to an institutional tumour board and a thorough multi-disciplinary discussion is sought. In 2013, a clinical audit of this non-institutional tumour board was published in the Journal of the Pakistan Medical Association.[4]

In the absence of a national cancer registry and a national cancer plan, we can only focus on patient-centred approaches, like the ones which improve our clinical decision making geared towards an improvement in our clinical outcomes. Establishment of high quality site-specific multi-disciplinary tumour boards is one of the examples of such patient centred, focused and practical endeavour. Cancer care providers serving in the developing countries rarely have direct involvement in the national healthcare policy-making corridors of the country. Therefore, we take the route of addressing the problems faced by our patients with a head on problem solving approach. Establishment of a city Tumour Board in 2010 is an example of this thematic plan which is only addressing a portion of the wider problem.[5]

Cancer clinical practice guidelines which are published regularly in developed countries are also over emphasizing on the fact that we shall form properly represented and mandated expert committees in the form of site-specific multi-disciplinary forums which oversee and monitor the site-specific Tumour Board in institutions where cancer patients are managed.[6]

Clinical quality indicators will monitor the performance of these Tumour Boards via looking into the quality of recommendations made after thorough deliberations in these meetings. With time, our learning curve is improving and we are addressing quality of these professional activities.[7]

The more we get to involve ourselves in a multi-disciplinary culture, the better will be our patient centred approach. A site-specific surgical team who is conducting complex oncological operative procedures cannot function without expert radiation and medical oncology teams as most malignancies are being managed by more than one modality of treatment. There are certain malignancies, like locally advanced breast and rectal cancers, in which neo-adjuvant oncological treatment is recommended before the surgical removal of the tumour.[8] Extensive surgical procedures like whole limb amputation, total laryngectomies and abdominoperineal resections can be avoided, if all cancer cases are discussed in multi-disciplinary site-specific Tumour Boards. Tumour staging work up and biopsy of lesions is conducted by surgical teams, as patients seek the first consultation in surgical consulting clinics. Therefore, in most diagnosed cases, it becomes the responsibility of the surgical team to bring all such cases in respective site-specific boards for a thorough discussion before embarking on the surgical procedure. Bringing cases to the Tumour Board after the

Department of Oncology, Aga Khan University, Karachi,Pakistan.
Correspondence: Ahmed Nadeem Abbasi. Email: nadeem135@gmail.com

completion of surgery destroys the whole purpose of these endeavours. The frequency of these boards also plays a major role in the reluctance of bringing cases. We recommend weekly boards to ensure swift decision making and faster start of the first modality of the management plan. Leaving cases in pending does not serve the purpose and destroys the theme to establish these multi-disciplinary teams.

Postgraduate training programmes in academic institutes can take an extra benefit from the establishment of these site-specific Tumour Boards. The cases can be prepared and presented by the postgraduate trainee students and during the process of preparation and presentation, their clinical acumen will improve.[9] Also, working in a multi-disciplinary culture, we are expecting to develop future specialists who will know their limitations and will be eager to establish these boards in the hospitals where they will get specialist appointments. The same dictum applies to faculty professional growth and development. The institutes can incorporate the participation of concerned faculty in this activity in annual appraisal as an integral entry under clinical services heading. We would recommend the establishment of site-specific multi-disciplinary Tumour Boards in all institutions where cancer patients are managed.[10]

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