SFORL Guidelines

Guidelines (short version) of the French Otorhinolaryngology – Head and Neck Surgery Society (SFORL) on patient pathway organization in ENT: The therapeutic decision-making process


a Service d’ORL, CHU, avenue de la Côte-de-Nacre, 14000 Caen, France
b Service d’ORL, hôpital Tenon, 4, rue de la Chine, 75018 Paris, France
c Service d’oncologie et de radiothérapie, centre de Haute Énergie, 10, boulevard Pasteur, 06000 Nice, France
d Service d’ORL, institut universitaire de la face et du cou, 31, avenue Valombrose, 06100 Nice, France
e Service d’ORL, hôpital Claude-Huriez, rue Michel Polonovski, 59037 Lille cedex, France
f Service d’ORL, hôpital Charles-Nicole, 1, rue de Germont, 76000 Rouen, France
g Département de chirurgie oncotologique, centre de lutte contre le cancer Léon-Bérard, 28, rue Laennec, 69008 Lyon, France
h Service d’ORL et de chirurgie cervico-faciale, hôpital de la Conception, CHU, 147, boulevard Balard, 13005 Marseille, France
i Service d’oncologie médicale, institut universitaire de la face et du cou, 31, avenue Valombrose, 06100 Nice, France
j Service d’ORL, hôpital Robert-Debré, avenue du Général-Koenig, 51100 Reims, France
k Service d’oncologie médicale, CHU, 38043 Grenoble, France
l Service social, CHU, 14000 Caen, France
m Service d’ORL, hôpital Nord Michalon, BP 217, 38043 Grenoble cedex, France
n Service social, hôpital Tenon, 4, rue de la Chine, 75018 Paris, France
o Service social, C.C.E.C. François-Badosse, 3, avenue du Général-Harris, 14000 Caen, France
p Service d’ORL, hôpital Larrey, 24, chemin de Pouvoirville, TSA 30030, 31059 Toulouse cedex 9, France

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ABSTRACT

Objectives: The authors present the guidelines of the French Otorhinolaryngology – Head and Neck Surgery Society (SFORL) for patient pathway organization in head and neck cancer, and in particular for multidisciplinary team meetings. The present article concerns the therapeutic decision-making process.

Methods: A multidisciplinary work group was entrusted with a review of the scientific literature on the above topic. Guidelines were drawn up, based on the articles retrieved and the group members’ individual experience. They were then read over by an editorial group independent of the work group. The final version was established in a coordination meeting. The guidelines were graded as A, B, C or expert opinion, by decreasing level of evidence.

Results: It is recommended that: an organ specialist should contribute to all multidisciplinary meetings on head and neck cancer; all members of the multidisciplinary meeting should have specific knowledge in head and neck cancer; any referring physician who does not follow the multidisciplinary meeting’s advice should justify that decision; there should be sufficient time to prepare, discuss and sum up the cases dealt with in the multidisciplinary team meeting.

1. Introduction

The therapeutic decision-making process comprises the various stages, following discovery of tumor, leading to a coherent treatment proposal by the medical and paramedical team to the patient and family, who should at least partly adhere to the proposal.
Multidisciplinary team meetings (MDTM) were made mandatory in France under a Circular from the Health Ministry dated February 22nd, 2005 [1], to bring together the patient’s file and propose treatment. At least 3 physicians of different specialties are required under the terms of the Circular, although it is often desirable that a larger number of specialties should be represented. The MDTM is a therapeutic decision-making tool. A number of benefits have been reported:

- positive impact on tumor staging [2] (level of evidence: 4);
- impact on decision-making and treatment modification [3] (level of evidence: 4): treatment as recommended by the MDTM tends to be curative and more aggressive [4] (level of evidence: 4);

A nationwide multidisciplinary work group was entrusted with drawing up guidelines for the therapeutic decision-making process in head and neck cancer. The French Health Authority (HAS)’s methodology of formalized expert consensus for good practice guidelines (http://www.has-sante.fr) was followed. A pilot group organized the consensus conference logistics, choice of editorial group members, and analysis of the literature based on a PubMed search. Articles were graded A, B, C or expert opinion according decreasing level of evidence, in line with the National Agency for Evaluation and Accreditation in Healthcare (ANAES)’s literature analysis and guidelines grading guide. A preliminary series of guidelines was drawn up, based on a position paper, then assessed by the editorial group, and recast by the work group following feedback.

2. Results

**Guideline 1**
An organ specialist (head and neck or maxillofacial surgeon) should attend all head and neck cancer MDTMs. Expert opinion.

**Guideline 2**
All MDTM members should have specific knowledge in head and neck cancer. Expert opinion.

The following factors are mandatory in MDTMs [6] (HAS guideline):

- statement detailing organization and functioning;
- minutes of each meeting, with list of those present;

All MDTM members should have specific knowledge of head and neck cancer and general oncology [8] (European guideline). The presence of a specialist organ surgeon is desirable [9–11] (level of evidence: 3).

Each patient file is presented by a physician, whether or not usually an MDTM member: a physician not regularly present may come to present a case or delegate an MDTM member, but it is preferable that the physician in charge of treatment or treatment coordination should be present. The person presenting the file should be familiar with the case and able to discuss it and answer the questions and arguments of those present.

Files for patients with new primary or recurrence should be systematically presented, either for discussion or for treatment validation [8] (European guideline). Each key step of treatment should be dealt with in MDTM. Possible inclusion in clinical trials is also dealt with (interest of presence of a clinical research associate or clinician).

**Guideline 3**
The MDTM should have sufficient time to prepare, discuss and sum up the cases presented. Expert opinion.

Ahead of the meeting, a standarized medical data form should be filled out by the physician referring the case to the MDTM [7] (HAS–INCA [National Cancer Institute] guideline). The medical proposal must take account of the following factors, requisite to decision-making:

- TNM classification, essential before considering treatment: classification as local, regional or generalized;
- pathology data not included in TNM classification. Certain pathology results are of recognized interest in tumoral assessment: thickness, certain histologic forms, expression of certain antigens, etc;
- imaging file: usually, all examination results available will be looked at during the meeting, as a final check, which may reveal a suspect element: metastasis, doubtful image, suspicion of second tumor, etc;
- general health status and assessment of capacity to withstand treatment: analysis of all complementary examinations performed at initial assessment;
- opinion of patient’s usual physician, provided directly or reported to a MDTM member. The patient’s own physician is aware of the patient’s socioeconomic situation, capacities and support;
- epidemiological and social data: private and family life, support, friends and relatives;
- the possible interest of the patient being present at the MDTM is a matter of debate [12,13] (level of evidence: 4).

**Guideline 4**
If the advice of the MDTM is not followed by the referring physician, the latter should justify that position. Expert opinion.

After examination of the various elements:

- either the file is sufficient for therapeutic decision-making, and discussion leads to a team opinion;
- or further examinations and/or consultations are needed and the file is held over for consideration in a subsequent MDTM.

After free discussion in which each team member gives his or her opinion, a consensus should emerge [14] (level of evidence: 4). The MDTM report should include the date, treatment proposal and names and qualifications of those present [6] (HAS guideline) and be kept in the patient’s file [15] (HAS–INCA guideline: charge book for oncology communication files). The treatment proposal is to be based on the guidelines used by the MDTM.

Once the MDTM has come to a decision, implementation is to be considered: referral to specialist consultations in oncology, radiology, surgery, support cells and supporting care (physiotherapy, nutrition, pain, psychology, social work). This enables the disease to be considered globally, without adding to the anxiety inevitably experienced by the patient and family, who often come up against practical problems.
If the treatment implemented differs from the MDTM’s recommendation, the reasons should be put forward in writing by the patient’s physician and included in the file [6] (HAS guideline).

The MDTM is intended to offer the patient the best adapted treatment [8] (level of evidence: 4). This form of organization is particularly useful in rare tumors. To meet INCA requirements for expert center organization [10] (INCA guideline), a national bi-monthly back-up MDTM is held to deal with complex decision-making in rare head and neck tumors: the French Expert Network for Rare Head and Neck Cancers (REFCOR) [17,18] (level of evidence: 4).

The patient may also wish to have other opinions on treatment, and this should be facilitated by providing the patient with all relevant information.

3. Conclusion

The MDTM is intended to offer the patient the best adapted treatment, and should apply to all cases of new primary or recurrence and to each key step in treatment, either for discussion or for validation.

References