

# Results of a Prospective Study on Multidisciplinary Care of Head and Neck Cancer

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## Abstract

**Objectives:** Head and neck cancers, have been the object, within the frame of multidisciplinary support, of some work and publications notably European and American ones. A prospective study of the multidisciplinary approach to these cancers, in our country (Algeria), seemed original and interesting to realize in order to determine the impact of the multidisciplinary on quality-care of patients and on professional practice.

**Material and methods:** Our multidisciplinary structure ensured patients recruitment (predatasheet-based), organized and saw to it that multidisciplinary consultation meetings (MCM) were run properly, and made patients benefit from the quality of multidisciplinary care. Evaluation and discussion of the results will be of interest to, the functioning of multidisciplinary consultation meetings and their impact on professional practices on a one hand, and the quality of the multidisciplinary support of patients in its epidemiologically, diagnosis and therapy, on the other hand.

**Results:** The patients took charge rate multidisciplinary mode of 52.80%. The cancers care period of our patients is proving quite efficient (12 to 21 days). Epidemiologically, our study provides accurate data especially concerning new cases of cancer and recurrence, locations and sub locations according to the International Classification of head and neck cancers. Diagnostically, the MCM improves the accuracy of diagnosis and rectifies potential errors. Therapeutically, the MCM is supposed to improve the treatment and survival of patients and the costs of various therapeutic.

**Conclusions:** The mode of multidisciplinary care for cancer is necessary for qualitative care for patients, to improve professional practice, for training and for different studies.

**Keywords:** *Head and Neck Cancer; Multidisciplinary care; Skills assessment; Resources; Process-quality*

## 1. Introduction

For a long time, it appeared that collaboration between different specialties of health professionals was one of the foundations of medical practice in oncology. It recognizes REGAUD Claudius (1870-1940) have stated in 1926 the foundations for multidisciplinary oncology, saying, that there can now be a serious organization of cancer therapy without concentration of resources and without coordination skills, hence the concept of multidisciplinary it is integral to the organization of care for better care for cancer patients, it is also one of the main axes of different plans against cancer.

Across the world, in different countries, especially since the 90s of the past century, there has been the emergence of multidisciplinary (MD) structures under various names: Multidisciplinary management of cancer patients, Multidisciplinary Care Teams, Multidisciplinary (Interdisciplinary) clinical meeting and tumor boards in the USA [1,2]. In Europe, for France and Francophone countries include the terms of committees, units of multidisciplinary centers [3]; Great Britain, Germany, Switzerland, Holland and some Arab countries are mainly known Anglo-Saxon words.

These MD structures located in approved centers for the care of cancers are specialized by organ, organize Multidisciplinary consultation meetings (MCM) by involving specialists and experts involved in the diagnosis and treatment decisions for patients cancer, they allow to have a result of a considerable database that can be exploited by various studies, institutions or bodies [3,4]. MD structures called transdisciplinary or interdisciplinary international or national order for shooting in very specific load such as clinical trials, rare cancer therapy, have also emerged. Legislative support, to accompany and sustain multidisciplinary and structures, proved indispensable. In France for example, since 2005, the MCM became mandatory by presidential decree [5]; although considerable progress has been made in this country, there are still issues calls for research proposals on the organization of care and quality management, built around the cancer patients.

Head and neck cancer, or cancers of the upper aerodigestive tract (UAT) represent 10% of all cancers are ranked fifth among cancers their incidence and sixth in mortality from cancer [6]. These cancers have been in the context of multidisciplinary care (MDC) of some European works and publications [3,7] and American [1,8].

A study of the multidisciplinary approach to head and neck cancers, within our specialty, seemed to us to conduct original and interesting. This is a prospective study, population interesting territory or hospital catchment area of the university hospital center (UHC) of Batna (Algeria).

The issue raises on one hand, the issue of MD structure and its network with determining the conditions of its operation and its sustainability and, secondly, the question of the potential impact of the shooting mode multidisciplinary management of head and neck cancers, professional practices and quality of care for patients.

The main objective of our work is to benefit to a maximum of patients with cancer of the upper aerodigestive tract, from the UHC Basin Batna, the mode MD care and the evaluation and promotion of this type of cancers care. A secondary objective, as important, is that of having a bank or computer database for tracking patients, which constitute, moreover, a source of important information for epidemiological, clinical, therapeutic, socioeconomic, for cancer registries, as well as scientific research.

We report the results of our study, a series of 141 cases of cancer of the upper aerodigestive tract, by MD care, collected by our multidisciplinary structure at the cancer center of Batna two years. Analysis of the results is discussed through a review of the international literature.

## **2. Patients and Methods**

### **2.1 Patients**

The geographical coverage of the population to be studied is determined by the flow of patients with cancer of the UAT (prospective study), corresponding territory UHC in Batna (department of the city of Batna: 1,108,000 in habitants) this is an unselected population. These are patients with head and neck cancer, whose locations and localizations correspond to the International Classification of Diseases ICD 10: tumors of the oral cavity, pharynx comprising: nasopharynx, oropharynx and hypopharynx (C00 - C14); tumors of the cervical esophagus (C15); tumors of the nasal cavity and paranasal sinuses (C30 - C31); laryngeal tumors (C32); salivary gland tumors (C07 - C08); the stage of these locations corresponds to the international classification of malignant tumors TNM.

Patients included in the study are patients with head and neck cancer at all stages of the disease, of all ages (children and adults), affecting both sexes and from the catchment area of the University Hospital of Batna: Patients cancer of the head and neck for the first time patients with a second location in the same sphere of UAT, patients with recurrent or suspected cancer recurrence, patients in evolutionary continuation of the disease, patients with a diagnosis of the problem and patients requiring palliative care. Patients who were excluded from the study were patients with skin cancer of the face and neck and thyroid cancer, patients above all therapy and patients who refuse the MCM.

### **2.2 Methods**

This is a prospective descriptive study. The duration of the study is two years from 1 January 2013 to 31 December 2014. Our multidisciplinary structure called multidisciplinary consultation unit in oncology (MCUO) of head and neck cancer , located at the Cancer center of Batna, includes mainly an oncologist, a radiation oncologist, a specialist organ (head and neck surgery), a pathologist, a radiologist and a Coordinator. The unit will eventually appeal to other specialists if needed. For the recruitment of patients, an information campaign on the MCUO and MCM patients is done at the network level of this structure consisting of the ENT clinic and head and neck surgery (public hospital),cancer center of Batna (oncology and radiotherapy department) and the ENT liberal sector of the hospital territory UHC Batna, with delivery to the medical technical-patient record (MT-PR), comprising the (MT-PR) number, date of MCM and the quorum, the name of gatekeeper, marital status and the patient's details, the MCM application pattern (diagnostic or therapeutic decision), treatment history and history (which may influence the management), discovery of the circumstances, the office of the primary tumor, the report endoscopy, imaging and pathological, the ICD code 10, TNM stage and tumor, decision or therapeutic proposal. The (MT-PR) is recovered during passage of the patient's record in MCM and used for the collection and analysis of data.

### **2.3 Organization and operation of MCM**

Unit organized a MCM twice a month, and if extra MCM, it is called extraordinary MCM. The appointment of the registration file / patient MCM is given by the coordinator. Prior to the MCM, MCM applications with patient charts and records entrusted to the Coordinator (Secretariat). The minimum number of doctors present at the MCM said quorum, the

quorum for cancers of the nasopharynx is 2 doctors (because the management of nasopharyngeal carcinoma is quite well codified) by cons it is 3 for other types of head and neck cancers. The number of files / cases or patients spent MCM is recognized by month, year and the two years of the study. The MCM past patients rate is the rate of recruitment of patients by the MCUO, it is the total number of past cases in MCM Coming from the ENT clinic, cancer center of Batna and liberal sector to the total number of patients (past MCM and not spent MCM) of the ENT clinic, cancer center of Batna and liberal ENT sector.

At MCM, the patient record is presented with its (MT-PR) (pre-filled by the referring physician) is discussed from a diagnostic and / or therapeutic to formulate a collegial and collaborative proposal, diagnostic or therapeutic, relying heavily on a framework established by the learned societies (guidelines), SOR (standards, options and recommendations), evidence based medicine (EBV) and experience of physicians participating in MCM. The guidelines we chose, is that of the ENT surgery of the face and neck society of the Nord Pas de Calais - France [9] (moderately modified) in the absence of a local Algerian repository or guidelines. The therapeutic decision following the guidelines or not be notified. The proposal also called therapeutic individualized care plan (TICP), be forwarded to the referring doctor who has the free choice to follow or not to follow it further up to him to inform the patient. Patient care will be made later in the appropriate service (for ENT head and neck surgery, oncology and / or radiotherapy). The management of time, which is the number of days between the date of MCM and early treatment is raised.

Criteria for judgment and evaluation of results: evaluation of results focus, firstly the functioning of MCM (on quantitative and qualitative assessment criteria) and their impact on professional practice and secondly the quality of decision multidisciplinary care of patients.

### **3. Results**

#### **3.1 Operation of the Multidisciplinary Consultation Meetings (MCM)**

It concerns the conditions of conduct of MCM in their quantitative and qualitative aspect.

##### **3.1.1 Quantitative aspect of the MCM (Quantitative Assessment Criteria):**

- The frequency of MCM: The MCUO organized periodically 2 MCM per month, it organized more extraordinary MCM on demand to reduce the support period (5 in 2013 and 8 in 2014 thus totalling 13 extraordinary MCM over two years).
- The number of MCM per year: 29 MCM for 2013 and 32 for 2014, so a total of 61 MCM.
- The number of files / cases or patients treated with MCM ranged from 1 to 4. The number of cases in MCM per month, per year is reported on TABLE 1.
- Patients rate Spent MCM (recruitment rate of patients by the MCUO) is: 52.80%.
- The catchment area or territory UHC of Batna: the study of the provenance (origin or department) of patients allowed us to identify the hospital territory UHC Batna for CMC of these patients with head and neck cancer and includes several departments in the neighboring provinces of Batna.

TABLE 1. Number of cases per month per year in MCM.

Month	Year		Total
	2013	2014	
January	8	6	14
February	10	3	13
March	6	7	13
April	4	9	13
May	5	10	15
June	6	3	9
July	6	4	10
August	4	9	13
September	8	6	14
October	4	4	8
November	3	8	11
December	6	2	8
<b>Total</b>	<b>70</b>	<b>71</b>	<b>141</b>

### 3.1.2 Qualitative aspect of the MCM (Qualitative Assessment Criteria):

- The regularity was observed at a rate of 2 MCM month.
- The quorum was always obtained (minimum presence of doctors in the MCM).
- The referring doctor, was always mentioned in the data sheet (100%).
- The detail, was always presented with the / patient and quite busy.
- Application of the guidelines, was 95.7% (135 patients) in 4.3% of cases (6 patients) therapeutic decision was based on the SOR and physician experience.
- The processing time for files / patients by MCM ranged from 02 to 06 days.
- The transmission of therapeutic decision to the referring physician after MCM, referring physicians had been systematically therapeutic proposal (the patient treatment plan).
- Monitoring of the treatment plan: The treatment plan was followed in 86.5% of cases and 13.5% in non-tracking of cases.
- The management of time after MCM ranged between 10 and 15 days, with delivery to meet the patient's referring doctor with the doctor and the management structure.
- There has been no denial of the gatekeeper for the realization of the proposed treatment plan.

### 3.2 Multidisciplinary care of patients

This is a series of 141 cases of patients (years 2013-2014). The results concern the parameters and criteria of judgment in their epidemiological aspects, diagnosis and therapy.

#### 3.2.1 The epidemiological aspect:

- For age, there are an average age of 55.75 years, with extremes ranging from 06 years to 92 years.
- For sex, there is a male 71.6%, female gender is 28.4% and sex ratio was 2.5.
- On the grounds of the MCM include the therapeutic decision in 100% of cases, including: 77.3% of new cases (109 patients) and 22.7% recurrence (32 patients).

- For Headquarters of the tumor or its location, there are first nasopharyngeal cancer 48.9% (69 patients) then comes laryngeal cancer 28.4% (40 patients). The nasal cancers (maxillary and ethmoid) as well as cancers of the oral cavity are each 5.7% (8 patients for each location). That oropharynx represents 4.3% (6 patients), those of the hypopharynx represent 2.8% (4 patients), esophageal cancer represents 2.8% (4 patients) and the salivary gland 1.4% (2 patients).

**3.2.2 The aspect diagnosis:**

- For the classification of the tumor in ICD 10, an accurate description of the endoscopic and radiological tumor lesion allows the match to ICD 10 and to have the details of the locations below (TABLE 2). In our study, we note that 20% of these endoscopic reports are imprecise and 25% of radiological interpretations are inaccurate.
- For the distribution of cases according to the results pathological, found in the majority of cases, squamous cell carcinoma (SCC) with a total of 131 cases (differentiated SCC was found in 66 cases, the SCC undifferentiated said UCNT in 65 cases); 5 cases of lymphoma in nasopharyngeal and tonsil location; 2 cases of adenocarcinoma (salivary glands); 1 Case cylindroma maxillary sinus; 1 case of Esthesioneuroblastoma (ethmoid) and 1 case of embryonalrhabdomyosarcoma (nasopharynx).
- For the distribution of cases according to the TNM classification, this applies only to carcinomas, she finds her interest in the therapeutic indication and prognosis. Tumors type of lymphoma, and sarcomas blastomas belong to other classifications. The T1T2 tumors represent 32.0% while the T3T4 represent 68.0%.
- The distribution of cases by grouping stage (S) include: SI (9.9%), SII (7.1%), SIII (39.7%), SIV (30.5%) and other classifications (12.8); the diagnosis remains relatively late (70.2% of stage III and IV).

**TABLE 2. Distribution ICD 10 (location and location under).**

<b>Location ICD 10</b>	<b>Location in ICD 10</b>	<b>Real</b>
Tumors of the oral cavity	C00.4/C03.1	1
	C02.0	2
	C02.0/C04	1
	C02.2/C04	1
	C03.1/C04	2
	C04	1
Salivary gland tumors	C07.9	1
	C08.0	1
Tumors of the nasopharynx	C11	12
	C11.0	5
	C11.0 / C11.2	2
	C11.0/C11.1	1
	C11.0/C11.2	16
	C11.2	3
	C11.9	30

Oropharynx tumors	C01	1
	C09.9	5
Hypopharynx tumors	C13.9	2
	C13.9	2
Tumors of the cervical esophagus	C15.0	4
Tumors of the nasal cavity and the paranasal sinuses	C30.0/C31.0	1
	C31	1
	C31.0	2
	C31.1	4
Tumors of the Larynx	C32.0	6
	C32.0/C32.1	1
	C32.1	1
	C32.9	32
<b>Total</b>		<b>141</b>

**3.2.3 The therapeutic aspect:**

The distribution of cases according to the site of the tumor and treatment to achieve helps to account for the specific type of therapeutic indication (TABLE 3).

**TABLE 3. Cross tabulation seat primary tumor and treatment performed.**

	Treatment to be carried out								Total
	Surgery	Radio Therapy	Surgey + Radio therapy	Neoadjuvant Chemotherapy	Adjuvant Chemotherapy	Palliative Chemotherapy	Concomitant Chemotherapy & Radio therapy	Look-out	
Nasopharyngeal	0	5	0	43	5	1	3	12	<b>69</b>
Oropharynx	0	1	0	5	0	0	0	0	<b>6</b>
Hypopharynx	0	0	0	0	0	4	0	0	<b>4</b>
Larynx	1	4	10	14	0	7	4	0	<b>40</b>
Oral Cavity	0	0	1	3	0	3	0	1	<b>8</b>
Salivary Glands	0	0	1	0	0	1	0	0	<b>2</b>
Ethmoid Sinus	1	0	2	0	0	0	0	1	<b>4</b>
Maxillary Sinus	0	0	3	1	0	0	0	0	<b>4</b>
Esophagus	0	0	1	1	0	1	1	0	<b>4</b>
<b>Total</b>	<b>2</b>	<b>10</b>	<b>18</b>	<b>67</b>	<b>5</b>	<b>17</b>	<b>8</b>	<b>14</b>	<b>141</b>

#### 4. Discussion

**For head and neck cancers:** There is not a common name throughout the world, for the Anglo-Saxon term most used is that of tumors or cancers of the head and neck called Head and Neck Cancer, for the NCI (National Cancer Institute) based on the definition of the American Association of Cancer, cancer of the head and neck include: oral cavity, pharynx (nasopharynx, oropharynx and hypopharynx), larynx, nasal cavity, paranasal sinuses and salivary glands. In France, the most used term cancers of the upper aero-digestive tract (UAT), but we find other denominations such as ENT and UAT cancers, UAT and salivary glands cancers, cancers of the head and neck. Most authors exclude cancers of the thyroid gland. ICD and TNM classification together this type of cancer to as cancer of the head and neck. We chose the terms of head and neck cancer because they understand, first raised the different locations and secondly, they are well used terms.

**The Current management of patients with head and neck cancers:** It should be a multidisciplinary therapeutic consultation, for many authors [1,4,7,8,10,11]. Studies have focused on the multidisciplinary management of cancers of the head and neck are rare and particularly prospective studies [8]. Most studies have evaluated the impact of MCC (Multidisciplinary Cancer Conference) on the therapeutic decision rather than on treatment outcomes, there is evidence that the MCC significantly influence the therapeutic decision and that in contrast, there is little evidence that the MCC improve therapeutic outcomes of patients [1].

**For multidisciplinary structures:** Their existence or establishment was necessary for structuring and Performing multidisciplinary [2]. Although the term of interdisciplinarity is the most used, that interdisciplinarity should be preferred to better reflect the need for interdisciplinary dialogue and not mere juxtaposition of skills [12]. The MD structure must be located (address, phone number, website), an authorized [5]. It consists of members and shall have a secretariat to manage files, records of patients and appointments [13]. She must have a status and a budget [13]. In the terminology of these structures found large disparities [1,5]. We called our MUCO structure (Multidisciplinary consulting unit in oncology) composed of permanent members, considered as consultants in oncology where specificity (treatment unit). The composition of the MD structure is variable, it essentially comprises a body specialist, an oncologist, a radiation oncologist, a radiologist and a pathologist, it can extend to other specializations may demand [4,5]. The membership of this structure is similar to what is described in the literature. It is recommended that the structure has a coordinator.

#### 5. Evaluation and Discussion of Results

They concern on the one hand the functioning of MCM and their impact on professional practice and secondly the quality of multidisciplinary care of patients.

##### 5.1 Operation MCM and their Impact on Professional Practices

For the operation of MCM, assessment and discussion focus on the criteria of judgment both quantitative and qualitative.

##### 5.1.1 The quantitative criteria are:

**The frequency of MCM:** Most authors [4,5,8,14] reported the pace of MCM once a week. The high French Health Authority (HAS) recommends a minimum rate of twice a month [15]. Our structure has organized MCM at the rate of twice a month. But it turned out that the time between MCM was long enough and it was against the reduction of support possible,



we had to therefore use additional MCM (05 for 1st year and 08 for the second year of the study). The pace of MCM weekly with fixed day and time seems very reasonable [4].

**The number of cases handled by MCM:** The number of cases handled by MCM is variable [3,4,16], this also depends on the volume of the structure (rate of recruitment of patients). The number of cases handled by MCM in our structure proves quite small (1 to 4). The number of cases processed per month and per year is also important to know for activity and evaluation reports [17,18].

**The rate of past patients MCM:** The rate of patients is very important to determine; it should be 100% according to the measure of 31 French Cancer Plan 2003-2007 [14]. This is quite logical for countries made mandatory MCM and putting too many resources [5]. In France, the rate of past patients given MCM by HAS in the 2008 evaluation campaign is in the order of 80%, now it is almost 100% [14]. Our rate of patients in past MCM (entire study, two years) is 52.80%. Note that the conditions are totally different (MCM passage of obligation to the rate in France and not mandatory MCM for our rates). The rate of patients is a reflection of the success or failure of MCM for multidisciplinary management. In the report of the General Inspectorate of Health Affairs (IGAS) 2009, the MCM in France had more success than expected [14].

#### 5.1.2 Qualitative criteria are:

**Technical / patient record:** This is a qualitative criterion of great importance; it is a true database-patient. It can be more or less developed according to different multidisciplinary structures [5]. The discussion MCM is done on the basis of this survey's (MT-PR) assessment on indicators of MCM the 2010 campaign of the HAS on the presence of in (MT-PR), found a rate of 70% [17]. In our study, the rate is 100%.

**The referring doctor:** It is mentioned in the data sheet, its place is very important, it is he who prepares the case and patient and (MT-PR) entrusts them to the MCM [5,17].

**The quorum (minimum of 03 physicians):** The minimum number of doctors to validate MCM, the one given by Circular 22 (France) is three physicians [5]. If one refers to this definition, our minimum attendance rate by three doctors ROE is 70%. The rate given by the survey "Assessment on the 2010 campaign of the MCM indicators" of HAS is 38%. Physician involvement in MCM can be extended to other specialties [4] according to the need of these opinions such as anesthetist to discuss the feasibility of a heavy and compromising surgery for some patients and nutritionist for the often-malnourished patients requiring intensive nutritious and quick scheme. The presence of the referring physician is desirable but not essential. Some authors evoke the interest of video conferences for the presentation of the patient file by the referring physician [17]. Some authors suggest the presence of the patient [6].

**Therapeutic decision:** The use of repositories, SOR and levels is evidence of systematic in MCM [3,19], they support the therapeutic decision. SOR and levels of evidence are developed internationally. [19] The standards are developed at national and regional level. We note for example in France there are as many repositories' regions (approximately 24), should there not plenty of references! especially since most standards meet the essential indications, and that n is not as specific for as many repositories. In Algeria, n is not yet repositories, including head and neck cancers and face and neck. Which led us to

choose a French reference for our study [9]. The application repositories MCM is considered a qualitative criterion of the latter [3,17].

**The cases for discussion** in MCM Some authors [4] all cases are discussed for other [5] cases where the indication is codified and given by the repository, are saved and others will be discussed. At our MCM, all cases were discussed.

**The therapeutic proposal:** It is made by the MCM doctor referent without obligation applies. The referring doctor and the patient have the choice whether to follow this indication [3]. In our study, we note that the indication was followed in 86.5% of cases.

**The terms of conduct of MCM:** Some authors emphasize the material conditions and MCM course comfort (local conditions, ease of use, time to MCM release, availability and records management and files....) [14].

**The impact of the MCM on professional practice:** A multidisciplinary approach requires training and therefore training [2]. The MCM is the place of high-level exchange to improve the level of knowledge and improving performance of the multidisciplinary team [2,3]. Throughout our study, we actually found these impacts on our practices and the need for the presence of skills to MCM. The presence of physicians, residents, interns would add value to training and university education of these MCM [4]. The multidisciplinary structure and its network accordingly require human and material resources to ensure proper operation and durability.

**The medico-legal aspect:** All physicians who contributed to the process of decision making, would be personally responsible for this decision on their area of expertise [20]; physicians should be aware of the legal implications of their participation in these meetings [20] and can it be considered a legal responsibility of the MCM, each member or care institution [16]?

The evaluation and discussion of the multidisciplinary care of patients It determines the impact of the multidisciplinary on quality-care of patients. The desired criteria are firstly the quality of care and secondly the support period.

**-For the period of care for patients:** according to French study by the Francim network, the Institute of Health Surveillance (VS) and the National Cancer Institute (INCA) on time management of cancers, care period of cancer patients is currently a concern of health authorities and the reduction of inequalities that period cancers care is a priority of the 2009-2013 cancer Plan, as described in the measure 19. One objective of this measure is to "Getting to know the MCM possible to reduce inequalities in access to care are any delays." Originally the mechanisms of these inequalities are multiple and can occur at all stages of the cancers care [21].

The most mentioned period is the period (date of diagnosis - date of start of treatment) [21]. The study on time cancers care (cancers colon and rectum) entre 1999 and 2008 include: a period of care for colon cancer from 17.5 to 20.7 days and that of rectal cancer by 27 to 30 days. In our study this period of cancers care is 12 to 21 days (processing time for files / patients from 2 to 6 days and time after MCM 10 to 15 days). The MD care reduces the period of cancers care [3,8].

For the quality of multidisciplinary care of patients, it is discussed in its epidemiological, diagnostic and therapeutic.

**The epidemiological aspect:** MCUO provides a rich database epidemiologically, patients Regarding the origin of patients, age, sex, new cases and recurrences, the distribution according to tumor location that determines the cancer more frequent, we noted that the nasopharyngeal cancer occupies the 1st place 69 cases (48.9%). Laryngeal cancer is in second position with 40 cases (28.4%). For France, for comparison, we find for the distribution by the location oropharyngeal cancer and hypopharynx first with 35 to 45% of cases, then comes laryngeal cancer with 30 to 35% case and in third position the cancer of the oral cavity with 20 to 25% of cases. Nasopharyngeal carcinoma accounts for only 1% of cases. The provenance of patients allows a health map of head and neck cancers by population center or hospital territory.

**The diagnosis aspect:** Evaluation of the terms of cancers care, including multidisciplinary and impact of this type of care on the quality of cancers care patients was the subject of some publications. A prospective study of the clinical impact of MD cancers care for tumors of the head and neck, which compared the decision of care patients before and after the MCM, published in 2010; This study found that about 24% of patients had a change in diagnosis, stage and plan the treatment of tumors of the head and neck. The authors conclude that the CMC has a positive and effective impact on the therapeutic decision for a significant number of patients and it would be entitled to the care tumors of the head and neck [8].

The elements for a qualitative cancers care are the elements of diagnosis and should be the most accurate, it is mainly the record (R) endoscopic, radiological and histological. Endoscopic.R with radiological.R, should report an accurate description of injuries to correspond to ICD 10 and the TNM classification. The indication for surgery is extremely linked. In our study, we note that 20% of endoscopic. Rare imprecise, not found statistics in the literature. For radiological.R include 25% inaccurate interpretations, some authors found 23% [22]. For the pathological.R, in our study, we had to resort to precision applications in 2 cases; some studies report pathology errors [23]. The presence, therefore, a radiologist (a body) MCM would be indispensable.

For the TNM stage and tumor classification, cited above factors determining a TNM classification and a fairly accurate tumor stage and to consider early and advanced stages necessary for the most adequate possible therapeutic indications [10]. In our series include: to the TNM classification (68% of T3T4) and for the stage (70.22% stage III and IV). The diagnosis is, therefore, quite late. In France, despite the resources and information campaigns on this type of cancer, the diagnosis remains as late [10].

**The therapeutic aspect:** The patient's general condition, comorbidities, patient WHO status and nutritional status should be well evaluated MCM to guide therapeutic indications. The therapeutic indication should also take into account the patient's age, it is often the patient's physiological age that is retained [10], therapeutic features (including chemotherapy and radiation) in children and some types of rare tumors [24]. The indication is based primarily on the location, type and tumor stage [10]. The discussion is high-level and may involve some type of surgery and its feasibility on recent protocols of chemotherapy, radiotherapy and the inclusion of some patients in therapeutic trials [3,10].

**The therapeutic indication and skill:** The therapeutic indication is dependent on multidisciplinary and the competence of the participating physicians [3,24]. The quality of decisions is not only based on the collective nature of the discussions but also depends on individual skills and specific [24].

The use of standards is recommended and is a reference to the therapeutic decision [3,9,10,17]. For our study we used the repository in 95.7% of cases.

**The impact of the multidisciplinary management on treatment outcomes:** MD cancers care is supposed to improve the outcome and cost-effectiveness, but the evaluation of the functioning and results of the multidisciplinary team is necessary for their treatments become a base in the provision of care [2,3].

**The impact of the multidisciplinary management on survival:** An Australian study on the impact of MD cancers care patients with cancer of the head and neck compared the two series, the first MCM and 2nd without MCM [25]. The authors report one hand that the MD cancers care is best for the management of patients and diagnostic care unidisciplinary (without MCM) and on the other hand, survival is improved by the MD cancers care, especially for patients with cancer of the head and neck of stage IV. Treatment protocols (chemotherapy and chemoradiation) evidence confirming levels are discussed at the MCM and adapted to the case of patients. The competence related to the specialization of participating doctors seem to help much [25]. Some authors [12], MD cancers care allows access to the best treatment.

## 6. Conclusion

The multidisciplinary oncology clinical interests the medical field and the field of healthcare organization (Clinical Governance of Anglo-Saxon system) which considers both the medical aspect and the organizational aspect of the health system. As a result, all reflections, all development projects or action plans are taking into account these two aspects and their players. The evaluation of results based on a comprehensive and accurate database, enables significant improvements in the system.

The mode of multidisciplinary care for cancer is necessary for qualitative care for patients, to improve professional practice, for training and for different studies, epidemiological, clinical, therapeutic, socioeconomic, for cancer registries, as well as for scientific research.

Thus, to sustain this type of structure and management mode, should accompany the training, resources and legislation.

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