ABSTRACT • Objectives: The objective of this study was to examine the impact of multidisciplinary team meetings on the management decisions for urological cancers. A prospective study was conducted. Methods: The study population is cases presented to multidisciplinary teams at Notre-Dame de Secours University Medical Center between July 2012 and July 2014. Data was collected by a standard pro forma. Results: 189 cases were presented in multidisciplinary meetings during the study period. Results of this study showed that multidisciplinary team meetings change management decisions in 40.7% of cases. Change in management decisions was mainly significant in testicular cancer (57.1%), prostate cancer (42.7%) and bladder cancer (38.2%), with less important changes in renal cancer (33.3%). Prostate cancer cases with Gleason score 7 (51.7%) and bladder tumors with TNM ≥ T2 (85.7%) were the most modified in their respective groups. Conclusion: Multidisciplinary team meetings have a major impact in therapeutic decisions taken by urologists for newly diagnosed urological cancers.

Keywords: MDT, MDM, multidisciplinary, cancer, prostate, testicle, kidney, bladder

INTRODUCTION

Cancers figure among the leading causes of death worldwide: 8.2 million of people died in 2012 because of cancer. Expectations are alarming, speculating a rise of cancer deaths from 14 million in 2012 to 22 million within the next two decades [1]. Globally, the management of cancer is increasing in complexity and necessitates the intervention of a variety of health professionals, specialized in different disciplines for prevention, diagnosis and treatment. Urological cancers account for 16.5% of all cancer incidence, and 11.7% of cancer mortality. Prostate cancer is well known for being the second most common cancer worldwide occurring in men. Testicular cancer is the most common tumor found in younger men under 45 years of age.

According to the National Cancer Registry (NCR), 1808 new cases (19.1% of all new cancer cases) were declared in 2008: 10 penile cancer cases (0.6%), 761 for prostate cancer (42.1%), 65 for testicular cancer (3.6%), 147 for kidney cancer (8.1%), and 825 bladder tumors with other urinary tumors (45.6%) [2].

In order to promote the patient-centered care, Multidisciplinary Team Meetings were established to build an environment of exchange among specialists of different backgrounds, to discuss diagnostic and therapeutic strategies, especially in cancerology. Nevertheless, those meetings, adopted by different teams in many countries and centers, have a fluctuating influence on the initial decision of the physician or the medical team, according to the diagnostic criteria and national treatment and monitoring recommendations.

Breast cancer and lung cancer have been widely studied by tumor boards, as well as other tumors, but very rarely has the group of urological cancers been managed by multidisciplinary teams hence assessed.

Multidisciplinary teams (MDT), or Multidisciplinary team meetings (MDM) in the United Kingdom, Tumor boards in the United States, "Réunions de concertation pluridisciplinaire" (RCP) in France, are "a group of people
of different health-care disciplines, who meet together at a given time (whether physically in one place, or by video or tele-conferencing) to discuss a given patient and who are each able to contribute independently to the diagnostic and treatment decisions about the patient. MDTs deal specifically with one type of cancer or group of cancers, and bring together the relevant health-care professionals” [3,4]. The importance of MDMs is in their focus on collaborative decision-making and planning, where different team members share their knowledge and experience and give evidence-based recommendations for the management of the involved patient [4]. Tumor boards date back to early as 1975 and were being evaluated for the past five decades, but proliferated in the 1980s when their influence on cancer care in community hospitals emerged [5-7].

In a systematic review conducted on 37 articles published about multidisciplinary teams for different cancers, Lamb et al. found that among six studies showing evidence that MDTs changed management decisions in 2 to 52%, only one study assessed how changes improved management; MDTs were also shown to improve accuracy of clinical diagnosis [8].

Moreover, Fleissig et al., in the review written about the efficiency of MDTs in cancer care in the UK, state that several studies have shown changes in treatment decisions, basically improving decisions by closing the knowledge gap between the treating physician and the team, without necessarily improving the overall quality of decision-making [2]. Aizer et al. also note that MDTs improve physicians’ adherence to guidelines, especially for the National Comprehensive Cancer Network (NCCN) guidelines [3,9].

The National Institute for Clinical Excellence, in its Guidance on Cancer Network in 2002, found that there is little evidence for the effectiveness of MDTs in treating urological cancers. However, some evidence in prostate cancer shows that there is unclarity about the choice of one treatment modality over others, whereas specialists tend to choose their own treatment modalities over conservative options like monitoring [10]. However, Taylor et al. reported that patients received more conservative treatments than previously decided because the teams had not taken comorbidities and the patient’s preferences into consideration [11].

Leonard Gomella recognizes the challenge in evaluating the impact of multidisciplinary teams on decision-making in prostate cancer, because of the different definitions, recommendations and standards in establishing MDTs [12], though prostate cancer units have shown survival improvement over fifteen years [13] and increase in the rate of active surveillance for low-risk prostate cancer [14] and overtreatment in patients with low life expectancy [9]. Furthermore, Sternberg et al. suggest that a strong partnership among different specialists will be the cornerstone of using new developments in prostate cancer treatment [4].

The first paper treating evaluation of MDMs was written by Acher et al. and has been a reference for the following studies. They analyzed 124 cases of urological cancer presented to regular MDMs over a period of six months, among which only two cases had a change in clinical management, with the addition of four histological report changes and a single radiological report change, with no influence on clinical decisions. Acher et al. concluded that the vast majority of urological cancer cases do not require multidisciplinary meetings, and the unselective discussion of all cases is useless [6].

Five years later, another study published by Kurpad et al. was done over the course of one year, about 269 patients with a positive diagnosis of a urological cancer. Cases were divided into four groups according to the modification of management as follows: no change either in diagnosis or treatment, no change in diagnosis and change in treatment, change in diagnosis and no change in treatment, and change in both diagnosis and treatment. 34.6% of patients had no modification of diagnosis or treatment decision: 50% of prostate cancer cases, 37.1% for bladder cancer; 22.1% for renal cancer, 0% for testicular cancer and 50% for other tumors (penis, scrotum and other urothelial). Overall, there was a change in management decisions in 43% of bladder cancer cases, 36% of renal tumors, 29% of testicular cancers and 22% of prostate cancers. Other tumors had 33.3% of modification of management. The authors concluded that MDMs have an important impact on clinical decision-making unlike Acher et al., whose study design did not take the board members’ influence on decisions into consideration. Changes reached 14% in diagnosis and 32% in treatment [7].

METHODS

Study design

The objective of this prospective study is to investigate the relationship between newly diagnosed urological cancers (cancers of the kidney, bladder, prostate, testicles and penis) presented to multidisciplinary team meetings and change in management decisions.

Study population

The study population is cases presented to the uro-oncology MDTs at Notre-Dame de Secours University Medical Centre (NDS-UMC). All newly diagnosed urological cancer cases with positive pathology reports were presented in MDMs.

A total of 189 cases were presented to the MDTs between July 2012 and July 2014, over a period of twenty-four months, with a total of 20 meetings, gathering at least two urological surgeons, two medical oncologists, and one radiation oncology specialist, as well as radiologists, pathologists, residents and nurses. Cases were mainly presented by the urologists; some were for patients diagnosed and treated in other hospitals or centers, whether referred or not to NDS-UMC. Only two patients were present in MDMs, but others were informed about
the discussions and the decision. MDMs were organized by the Division of Urology. The meetings’ structure was modified according to the recommendations of the French National Authority for Health [15].

The reference used by the team was the NCCN Guidelines for all urological cancers [16-20]. All decisions taken were conform to the national guidelines published by the Lebanese Ministry of Public Health [21]. Subjects excluded from the study were cases with secondary urological tumors or negative pathology reports.

Data collection
The instrument used to collect the data in this study is a standard document that contains basic information about the patient, the history with the primary diagnosis as well as the staging, the management decision of the treating physician, his question to the MDT and the decision taken by the team.

This document was prepared by the Division of Urology according to the shared oncology record (“Dossier Communicant en Cancérologie”) recommendations given by the French National Institute of Cancer [22]. It was modified three months after implementation of MDTs, with addition of details to fill such as the initial decision of the treating physician and the application of guidelines.

The document was to be filled by the treating physician before the MDM, and to be continued after the decision of the team was taken.

Instrumentation

Dependent variable
In our study, the dependent variable used to represent the urological cancer is the primary tumor site, obtained from the pathology report, according to the International Classification of Diseases - 10th Edition [23].

Primary tumor site was divided into five categories: penis, testis, prostate, kidney, and other urinary (renal pelvis, ureter, and bladder).

Independent variables

Demographic factors • Age and sex were chosen among factors to describe the population and estimate its distribution. Age in years was divided into three different categories: younger adults for values less than 39 included, adults for values ranging between 40 and 64, and older adults for values more than 65 included.

Change in management • The change in management was chosen as a nominal variable to assess any modification in the management decision before the MDM and after it, which has to be issued by the MDT, and adopted by the treating physician.

Analysis
Descriptive tables were made for the primary tumor site and for selected socio-demographic variables, age and sex. Another cross-tabulation was done for the change in management and the primary tumor site.

Statistical Package for Social Sciences (SPSS) was used to compute the data. Results were given by frequencies and percentages of modification in management decision according to the different urological cancers.

<table>
<thead>
<tr>
<th>TABLE I</th>
<th>DISTRIBUTION of the CANCER CASES by PRIMARY TUMOR SITE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Variable</td>
<td>Number</td>
</tr>
<tr>
<td>Primary tumor site</td>
<td></td>
</tr>
<tr>
<td>Penis</td>
<td>5</td>
</tr>
<tr>
<td>Prostate</td>
<td>82</td>
</tr>
<tr>
<td>Testis</td>
<td>7</td>
</tr>
<tr>
<td>Kidney</td>
<td>19</td>
</tr>
<tr>
<td>Bladder and urinary tract</td>
<td>76</td>
</tr>
<tr>
<td>Total</td>
<td>189</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>TABLE II</th>
<th>DISTRIBUTION of the STUDY POPULATION on SELECTED SOCIO-DEMOGRAPHIC CHARACTERISTICS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Variable</td>
<td>Penis</td>
</tr>
<tr>
<td>Age</td>
<td>N</td>
</tr>
<tr>
<td>Young adults</td>
<td>0</td>
</tr>
<tr>
<td>Adults</td>
<td>3</td>
</tr>
<tr>
<td>Older adults</td>
<td>2</td>
</tr>
<tr>
<td>Mean age</td>
<td>65.29</td>
</tr>
<tr>
<td>Standard deviation</td>
<td>12.88</td>
</tr>
<tr>
<td>Range</td>
<td>23-93</td>
</tr>
<tr>
<td>Sex</td>
<td>Male</td>
</tr>
<tr>
<td>Female</td>
<td>0</td>
</tr>
</tbody>
</table>
RESULTS

Table I represents the distribution of cancer cases according to the primary tumor site (Figure 1). The majority of cases are prostate cancer cases: 82 (43.4%). Seventy-six urothelial tumors (bladder and other urinary tract) were presented (40.2%). Renal cell carcinoma represented the third group with 19 cases (10.1%). The smaller two groups are those of testicular cancer with 7 cases (3.7%) and penile cancer with 5 cases (2.6%).

One hundred and fifty-two were included in the study population, defining all patients with newly diagnosed urological cancers presented to the MDTs of NDS-UMC between July 2012 and July 2014 (173 males and 16 females). Socio-demographic characteristics of the study population of the five groups of urological cancer have been represented (Table II). The study population appears to be around 65 years old, the youngest patient being 23 years old and the oldest 93 years old. All patients with penile cancer are either adults (40-64 years old, 3 cases) or older adults (> 65 years old, 2 cases). Prostate cancer cases are mainly older adults (68.3%), with a minority of adults (31.7%). Younger adults constitute the main group of testis cancer cases (5 out of 7 cases) with only two cases older than 40 years old. Kidney cancer patients are distributed as follows: younger adults (5.3%), adults (42.1%), and older adults (52.6%). As for bladder and urothelial tumors, cases consist mostly of older adults (65.8%), fewer adults (33.9%) and one younger adult (1.3%) (Figure 2). The number of males (173) is predominant to that of females (16) because tumors of the female genital organs are not included. Uroinary tumors were predominant in males: 73.7% of kidney tumors (versus 26.3% in females), and 84.4% of bladder and urothelial tumors (versus 15.6% in females).

Changes in management decisions were represented according to the primary tumor site with their respective percentages (Table III). Overall, MDMs changed the initial management decision of the treating physician in 77 cases (40.7%). Two cases of penile cancer had a change in management, i.e. 40.0% of the total number of cases presented to MDMs. Prostate cancer patients had their management plans modified in 35 cases out of 82 cases (42.7%). Four cases of testicular cancer had change in management (57.1%), 7 cases of kidney cancer (36.8%) and 29 cases of bladder and urothelial cancer (38.2%).

Among the 112 cases that were not affected by the MDMs, the decision taken by the team confirmed that of the treating physician in 96 cases (86.2% of non-modified cases), thus not affecting it. In two other cases (1.7%), the decision of the MDT was different from the initial decision of the treating physician, but the physicians abided willingly by the management planned before the MDTs. However, the MDT’s decisions were refused by the patients themselves or not applied due to change in circumstances in 10 cases (8.9%): 6 refusals, 1 surgical contraindication, 2 deaths, and 1 referral to another MDT.

Table IV represents age and change in management according to the Gleason score.
decisions in prostate cancer cases according to Gleason score of differentiation (Figure 3). Age means are 65.67, 66.75, 65.78, 71.83 and 77.75 respectively for Gleason scores 6, 7, 8, 9 and 10. Prostate adenocarcinomas with Gleason score 7 are affected the most by MDMs (15 out of 29 cases, 51.7%), followed by those with score 9 (4 out of 8, 50.0%), 8 (8 out of 18, 44.4%), 10 (2 out of 5, 40.0%) and 6 (27.3%).

Change in management decisions in bladder cancer cases are represented in Table V. In tumors with $T \leq 1$ (Tis, Ta, T1), MDMs changed 20.0% of decisions (11 out of 44 cases). 85.7% of T2 tumors had change in their management decisions (6 out of 7 cases), as well as for tumors with $T \geq 3$ (T3a, T3b, T4a, T4b), in 85.7% of cases (12 out of 14) (Figure 4).

**DISCUSSION**

To our knowledge, this is the first study about multidisciplinary cancer care in Lebanon. The prospective design of our study and its coverage of all cases presented to NDS-UMC helped us in defining and identifying the influence of the multidisciplinary care on diagnostic and therapeutic decisions taken by the team.

The distribution of cancer cases according to primary tumor sites is fairly similar to that of the NCR: 43.4% versus 42.1% in prostate cancer and 3.7% versus 3.6% in testicular cancer, 10.1% versus 8.1% in renal tumors, 40.2% versus 45.6% in urothelial tumors. Penile cancer cases were distinct (2.6% and 0.6%) primarily because of the re-inclusion of patients’ cases. This helps us believe that cases presented to NDS-UMC’s MDT are representative of cancer patients in the Lebanese population (Table I).

Concerning socio-demographic variables, and compared to the national demographics of urological cancers, our penile cancer cases are all adults and older adults, (0% of younger adults in both the study’s and the national populations). Prostate cancer patients have similar proportions (0%, 31.7%, 68.3% for younger adults, adults and older adults respectively, and 0.8%, 29.5% and 69.7% in the national registry). Testicular cancer cases are younger in our population (71.4%, 28.6%, and 0% versus 59.0%, 39.3% and 1.7%). Our renal cancer cases are older than those of the Lebanese population (5.3%, 42.1% and 52.6% for younger, adults and older adults, versus 10.3%, 38.9% and 55.6%). Bladder and other urinary cases have higher proportions of older adults (1.3%, 32.9% and 65.8% respectively versus 1.8%, 37.5% and 61.2% in the NCR) (Table II).

Table II shows similarity between sex distribution in renal cancer in our study (73.7% of males and 26.3% of females) and renal cancer cases registered in the NCR (69.4% of males and 30.6% of females). However, difference is remarkable in bladder and urothelial tumors (84.4% and 15.6% versus 78.6% and 21.4%) [2].

The results obtained in our study for the change in management for urological cancers (40.7%) (Table III) strongly discord with the results of Acher et al. (1.6%) [6], and are closer, though more significant, to the results of Kurpad et al. (32.1%) [7], in all urological cancers studied, showing an important impact of the MDTs on clinical decisions taken by the treating physician in NDS-UMC.

Furthermore, results of change in modification of the different urological cancers do not totally correlate with the findings of Kurpad et al. Bladder tumors (38.2%) and renal tumors (36.8%) are similarly modified in our study and theirs; 43.5% in bladder tumors and 35.8% in

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**TABLE V**

<table>
<thead>
<tr>
<th>Change in management</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
</tr>
<tr>
<td>≤ T1</td>
<td>11</td>
</tr>
<tr>
<td>T2</td>
<td>6</td>
</tr>
<tr>
<td>≥ T3</td>
<td>12</td>
</tr>
</tbody>
</table>

*Change in management (%)*
renal tumors. On the other side, prostate cancer cases are more modified by MDMs in our study (42.7%) than in Kurpad’s (21.8%). Testicular cancer is also incomparable between our result in change in management (57.1%) and Kurpad’s (28.6%). This finding might be explained by the reinclusion of same patients’ cases after the discovery of new elements of diagnosis. Penile cancer cases could not be compared to Kurpad et al. because of their inclusion with other tumors (scrotal tumors and other urinary tumors) [7]. Unlike the previous study, testicular and prostate cancer cases were the ones to be the most modified by MDMs in our series. This can be explained by the complexity of the monitoring of testicular tumors after surgery on one side, and the variety of treatment modalities for prostate cancer in curative and palliative care. In contrast to prostate and testicular cancer, bladder tumors are more frequent and with less complex treatment guidelines. Similarly, renal cell carcinoma’s main treatment is surgery alone, unless metastatic [24].

There was no change in diagnosis made after the MDMs, which is discordant with the 14% of overall change in diagnosis seen in the study of Kurpad et al. [7]. This is probably the effect of the irregular presence of diagnosis specialists (radiologists and pathologists) in MDMs, and the lack of presentation of radiological films and pathological images as well as the focus of the team on the treatment strategy, especially on the urologists’ side.

Among cases that were not modified by MDMs, 86.2% were unmodified because of the simplicity of the case, mainly in localized renal and bladder tumors, where no further discussion between the urologist and the team was needed beyond confirmation of the decision; 11.4% constituted an obstacle related to the patient or the disease progression, whether because of change in the clinical course or death, or because of the refusal of the patient of a certain treatment modality, usually chemotherapy and radiation therapy [25]. This could be explained by the fear the patients have of secondary effects and toxicity of these two treatment modalities, or by the lack of information they get from their treating physician.

To further understand the pattern of modification caused by MDMs, prostate tumors were described according to the Gleason score of differentiation, which appears to increase with age in our patients. This crescently matches the epidemiology of prostate cancer, except for familial cases where aggressive tumors are found at an early age [10]. The management of prostate cancer cases with Gleason score 7 was the most modified by MDTs (51.7%) because of the variety of treatment modalities and monitoring methods and terms available [9]. Contrarily, tumors with Gleason score 6 were the least modified by MDTs (27.3%) due to the certainty and straightforward decision of radical prostatectomy or other radical treatment [10]. However, prostate cancer cases with a Gleason score of 8 to 10 were more frequently modified than with score 6 (45.1% - 27.3%), because of the presence of extension and the need of adjuvant treatments, but less frequently modified than score 7 because of the well-known palliative measures in advanced prostate cancer [17].

Bladder tumors were divided in order to show more relevance of the MDT influence according to the tumor size. Effectively, the most important impact was in tumors of T ≥ 2. Treatment guidelines are clear enough regarding surgical resection of superficial tumors and need for local therapy. Exposure of urologists to bladder tumors due to their frequency (45.6% of all urological tumors in Lebanon in 2008) [2], and the systematic surveillance by cystoscopy and biopsies or resection when needed, explain the unimportant modification in management of superficial bladder tumors (20.0%), most of which are local and low grade. However, complexity of surgery, neo-adjuvant and adjuvant therapies for advanced bladder tumors explains the higher impact of MDTs on tumors with T2 and above [20]. Those results could not be compared with those of Kurpad et al., since they merged all tumors together in TNM staging [7].

A wide range of modifications in initial management decisions has been noticed during the study; reviewing a diagnostic test (pathology or radiology report), changing or adding periods of surveillance, type of surveillance (physical exam, laboratory analysis or imaging), changing the type of surgery (among urologists), changing or adding a modality of treatment (chemotherapy, radiation therapy, hormonal therapy, immunotherapy). Therefore, our results are inclusive of all the modifications and cannot discern between minimal and more important ones, whereas Kurpad et al. divided their cases into four categories as cited in the literature [7].

It should be noted that our study encountered several limitations: first, the use of a prospective study design precludes the testing of many hypotheses, and is known to have an influence on people being watched during a study, which is the Hawthorn effect. Second, this study focused on a relatively small population (N = 189). Third, our interpretations in this study are limited to the management decision taken after the meeting, and do not take into consideration the physician’s compliance to the MDT’s decision since no chart review was done after the meetings. Our study did not measure outcomes or oncological end points. The study had also a low budget and no fund. However, we managed all these limitations to get many significant findings and a valid result over the study’s inquiry, and these obstacles did not affect the main purpose of the research.

CONCLUSION

To conclude, this study shows that multidisciplinary team meetings have a substantial impact on the initial management plan of patients newly diagnosed with urological cancers.

Change in management is the most important in testicular cancer, low-grade prostate cancer and high-grade
bladder cancer, less important in renal cancer. Multidis-
ciplinary team meetings do not have an influence on ini-
tial diagnosis made by the physician. Further studies
need to be done to assess physicians’ compliance and
outcomes on patients.

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