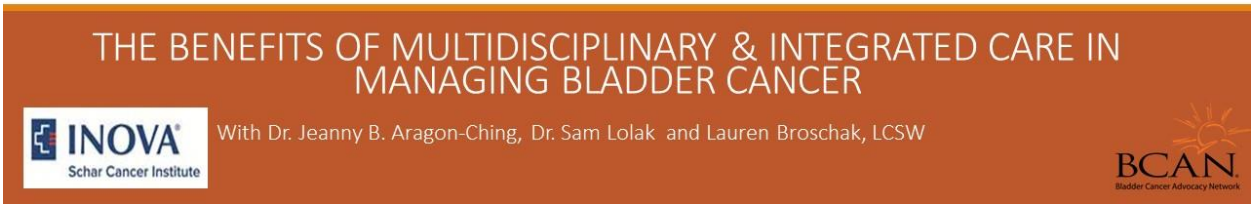
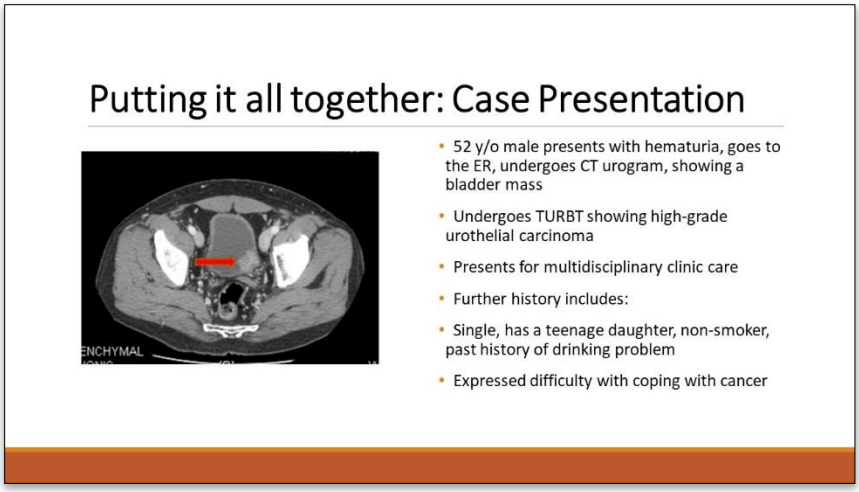
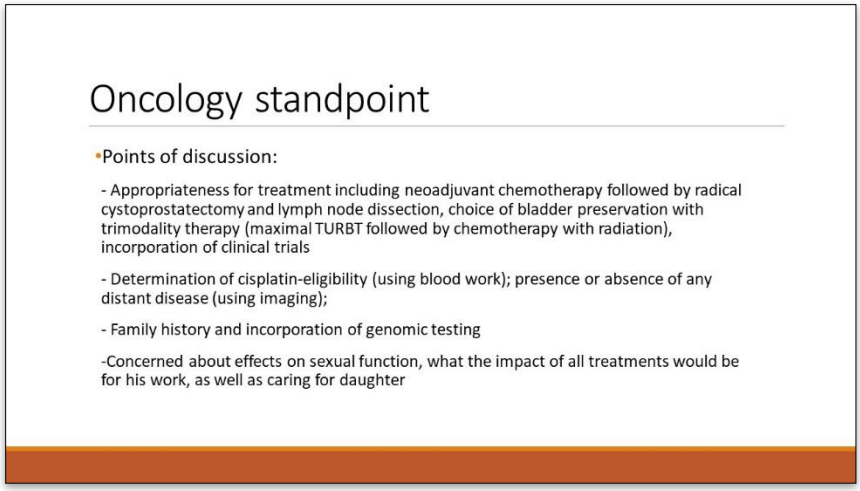


A Case Study on Multi-Disciplinary Care

What we want to do is put it all together in a case. We're looking at a 52-year old male who presents with hematuria, goes into the ER, undergoes a CT urogram showing a bladder mass. He undergoes TURBT showing high-grade urothelial carcinoma. He presents for a multidisciplinary care clinic. His further history includes that he's single, he has a teenage daughter, he's a non-smoker, has a history of drinking problem and expressed a difficulty with coping with cancer.

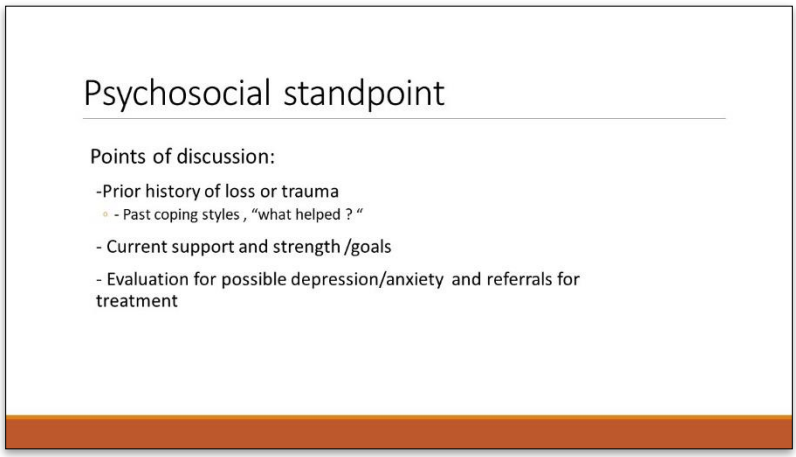
Dr. Aragon-Ching: This is an opportunity for us to come together. The setup is usually a multidisciplinary clinic where the urologist, the radiation oncologist, pathology and radiology are all in the same room discussing the case conference. In addition to that, we also have other allied healthcare professionals in the room. Is there a need for a genetic counselor, for instance, for someone young like this, if there was ever any family history? We also have physical therapists, sexual therapists because, especially if cancer happens in a young person and truly any age, there is such concerns. A lot of times the multidisciplinary clinic is a way to foster a lot of the patient's concerns.





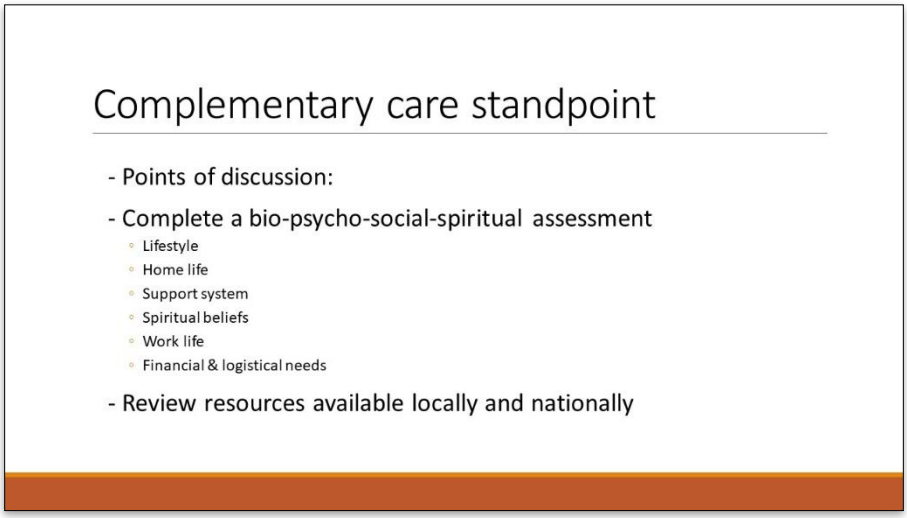
Certainly from an oncology standpoint, there are things that we discussed. From a medical standpoint, what is the appropriate choice of therapy? Is this patient keen on undergoing the standard recommendation of neoadjuvant chemotherapy followed by surgery? Most patients when they hear about surgery, that the bladder is being removed, the first and initial reaction is, "I don't want surgery." A lot of patients do seek for an alternative and therefore it is very important for us to be able to present, what is the data surrounding surgery versus, let's say, bladder preservation therapy or chemotherapy, which is combination of maximal TURBT followed by chemoradiation. Other medical conditions that may arise if the patient is otherwise cisplatin ineligible, meaning their kidney function may be impaired, they have bad hearing loss history or, for instance, they have bad neuropathy where cisplatin use maybe limiting.

A lot of those are factors we have to take into consideration. When we see the patient, we review the pathology. Every so often, we find that the pathology is not read as it should be. We may find that the diagnosis may not be what we think it is. Certainly, treatment changes because there are certain histologic subtypes where it may not make a lot of sense to proceed with neoadjuvant chemotherapy and the surgery would be the right appropriate decision to make. Certainly, a lot of the interaction with a lot of the psychosocial aspects of care and that is where we engage Dr Lolak and, of course, Lauren and I'll have them speak to the different aspects of a patient's care.



Dr. Lolak: For this question, certainly there are several points of discussion. We want to explore a little more, maybe in a more private setting of his prior history of loss or trauma, either before the cancer or when he was growing up because you know sometimes issues associated with cancer can trick some of what we call old wounds, the past traumas or loss. We also want to know how he coped in the past, how he was dealing with his adversity in the past. Maybe there are some strategies that he used and it was successful. We can ask him, "What was helpful in the past when you were dealing with adversity?" You want to certainly explore the level of current support and strength to see if there's something that we can help increase the support, strengthen the support or fill some of the gaps in the area that he doesn't have a whole lot of support.

Dr. Lolak: Also wanting to know his goals. What are his goals? It's not just about the cancer, but his function, his work, his relationships, things in life so that sometimes that can inform, what are the priorities in terms of his treatment? Then suddenly with his history, we want to screen him for a possible depression and anxiety and then appropriate referrals for treatment, whether it's a psychosocial treatment that we touched on or including a medication treatment.



Lauren Broschak: With Dr. Lolak, we would likely go over the bio-psycho-social-spiritual assessment. I also do that often in clinics with Dr. Aragon-Ching. For our patient, we would be looking at his lifestyle in general, and that would include diet and exercise. From there we can determine, are there any additional referrals that would need to be made? Does our dietician, should they also be coming in and having an additional conversation? Or are we going to consult our exercise therapist? Looking at home life. That includes support at home, both emotional and physical, ability to navigate the home. Are there stairs that will be difficult during therapy or after surgery? Ability to cook. Is there any difficulty standing and cooking or tolerating certain foods? Is there any need for durable medical equipment either now or post-surgery or post-treatment.

Support systems like Dr. Lolak touched on, were friends and family involved? How about spiritual support? Is there any need to supplement that as well, whether that's through Dr. Lolak and some therapy? Or, are we looking at adding some support groups or finding ways that they can get supported by others who understand what he's going through?

The spiritual. We will dive into that a little bit more. What are the spiritual beliefs, if they have any? If he does, we would encourage spiritual engagement or maybe bring in our chaplain to provide additional support from their work-life. Is he planning to work through treatment? If so, what type of support does he receive? Does his boss know about that or does his colleagues know about his diagnosis? Are they supportive to him taking some time off to go through treatment? If he needs to go on short term disability, does he need assistance with the disability paperwork or writing a letter to get some time off? Etc...

Then there are financial and logistical needs, looking at his income, any payment assistance needs for treatment, transportation, housing, etc... Then we would review the resources in general. If some of these didn't point out specific referrals that we would want to make, we would also want to go over everything that is available, from groups, to peer-to-peer support, mind-body classes, exercise programs, and specifically talking about why those might be helpful. Nutrition consults. If he didn't bring up a specific need for nutrition, we want to let him know that it's there anyways, should he be interested in talking to them now or down on the line.

Stress relief, case management therapy, psychiatry therapy, and making sure that he's aware of everything that's available here in our center at Link with Cancer, but also in our community outside of our program, as well as nationally and online that there's lots of resources available.