What does the medical oncologist expect from the surgeon

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A Balanced Approach

But this isn‘t always the case…

The two extremes

- The over-enthusiastic who believes that everything can be cured by surgery

- The defeatist who believes a cancer-patient is going to die anyway …quite soon….

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Patient CS

- Female patient, 46 years at diagnosis of RCC
- 1996 nephrectomy and thrombectomy cava thrombus
- 1998 diagnosis of metastatic disease: pancreatic gland, IFN-alpha, SD
- 2000 resection of pancreatic metastases
- 2002 new pancreatic metastasis: pancreatectomy
- 2009 NNS left kidney
- 2010 surgery lung metastasis
- 2010 thyroidectomy due to metastasis
- 2012: RFA left kidney
- March 2012: CNS metastasis, **observation**
- January 2013: family doctor refers the patient who is concerned about the brain metastasis to medical oncologist
- stereotactic radiosurgery…

Has this Patient Undergone Appropriate Treatment?

- YES:
  - Survival since diagnosis of metastatic disease: **14 years**
  - Case underlines the tremendous importance of metastasectomy
- No:
  - Metastasectomy has created a second disease: IDDM
  - Surgeon failed to understand the benefit of local treatment of brain mets→ unnecessary progression of a former small brain lesion
  - Surgeon failed to discuss the case with others, e.g neurosurgeons, medical oncologists etc

The two extremes

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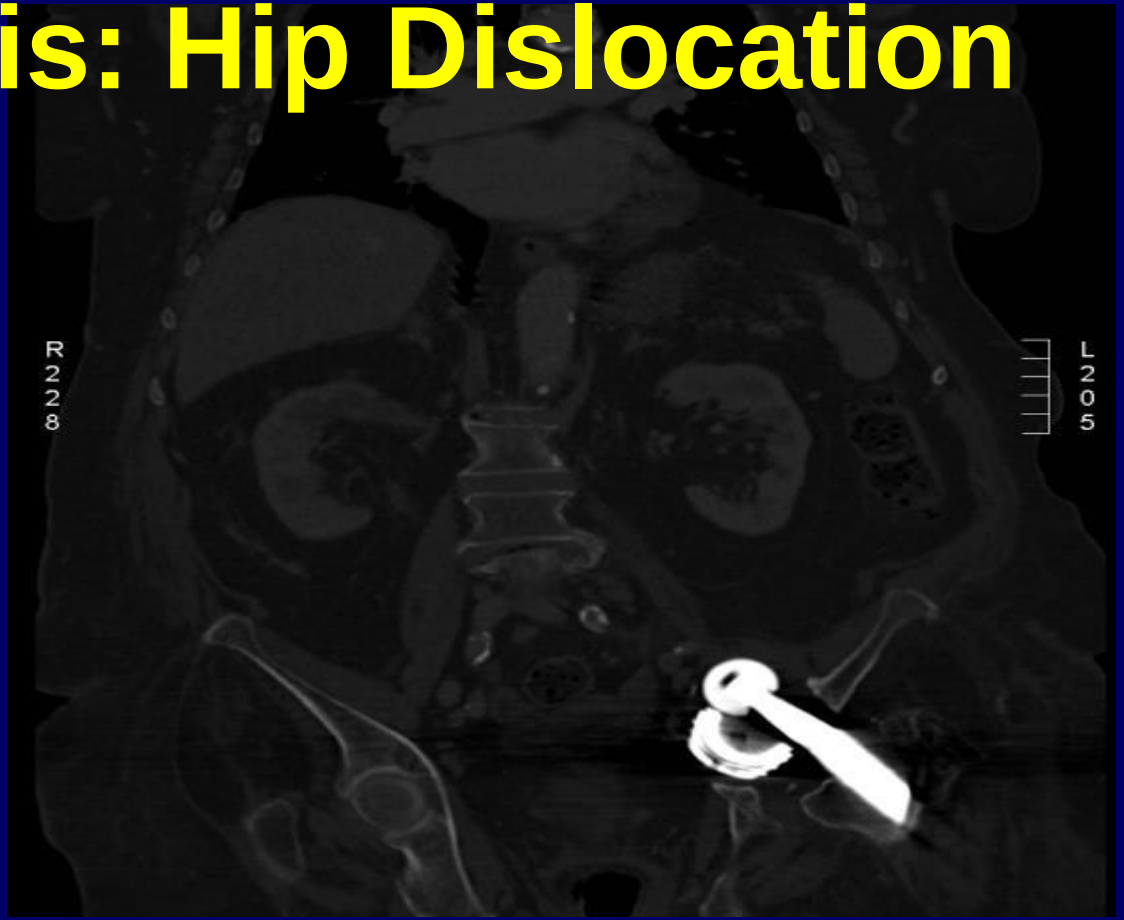
Patient MG

- Female patient, 74 years
- Fully active, no major morbidities
  - hypothyroidism (T4 replacement),
  - obesity (BMI 30)
- History of total endoprosthesis (femoral head necrosis)
- December 2010: pain left hip followed by inability to walk

Diagnosis: Hip Dislocation

Surgery planned

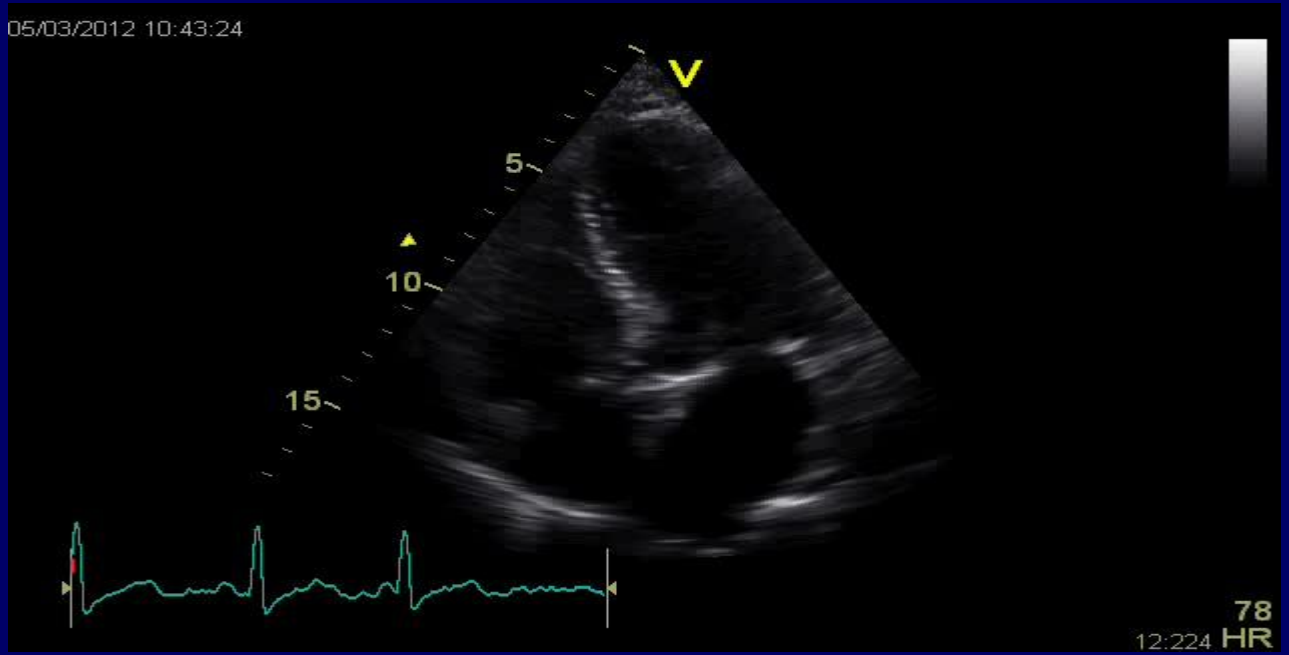


Pre-Surgical Investigations and Findings

- Investigations
  - ECG: sinusrhythm, HR 61/min, normal ST-segment and T-waves
  - BP: normal
  - Chest-x-ray: no abnormalities
  - Lab: electrolytes normal, creatinine 1.29, normal liver function, mild anemia, thrombocytosis

An Echocardiography is Performed…

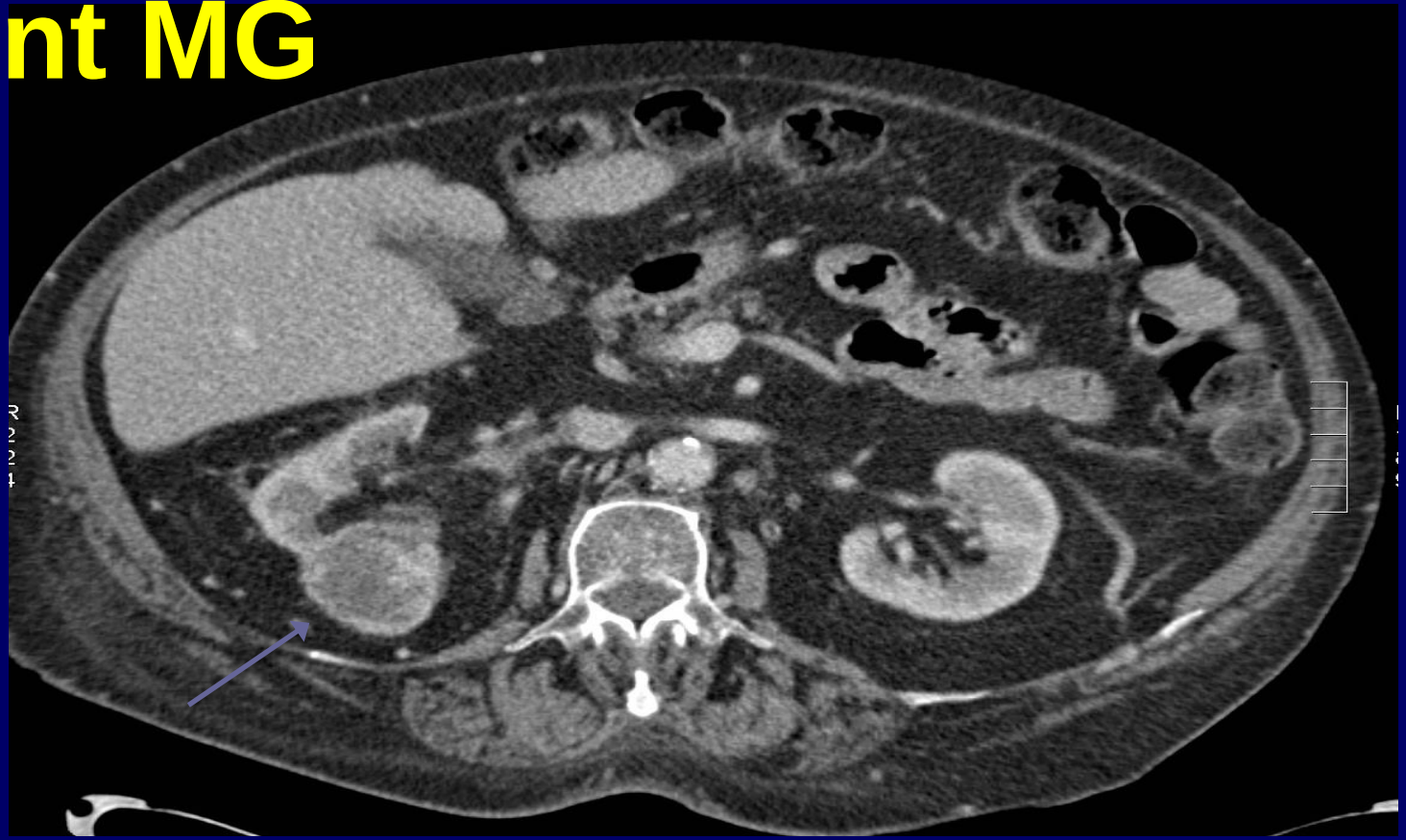
6 cm Thrombus Right Atrium



Consequence

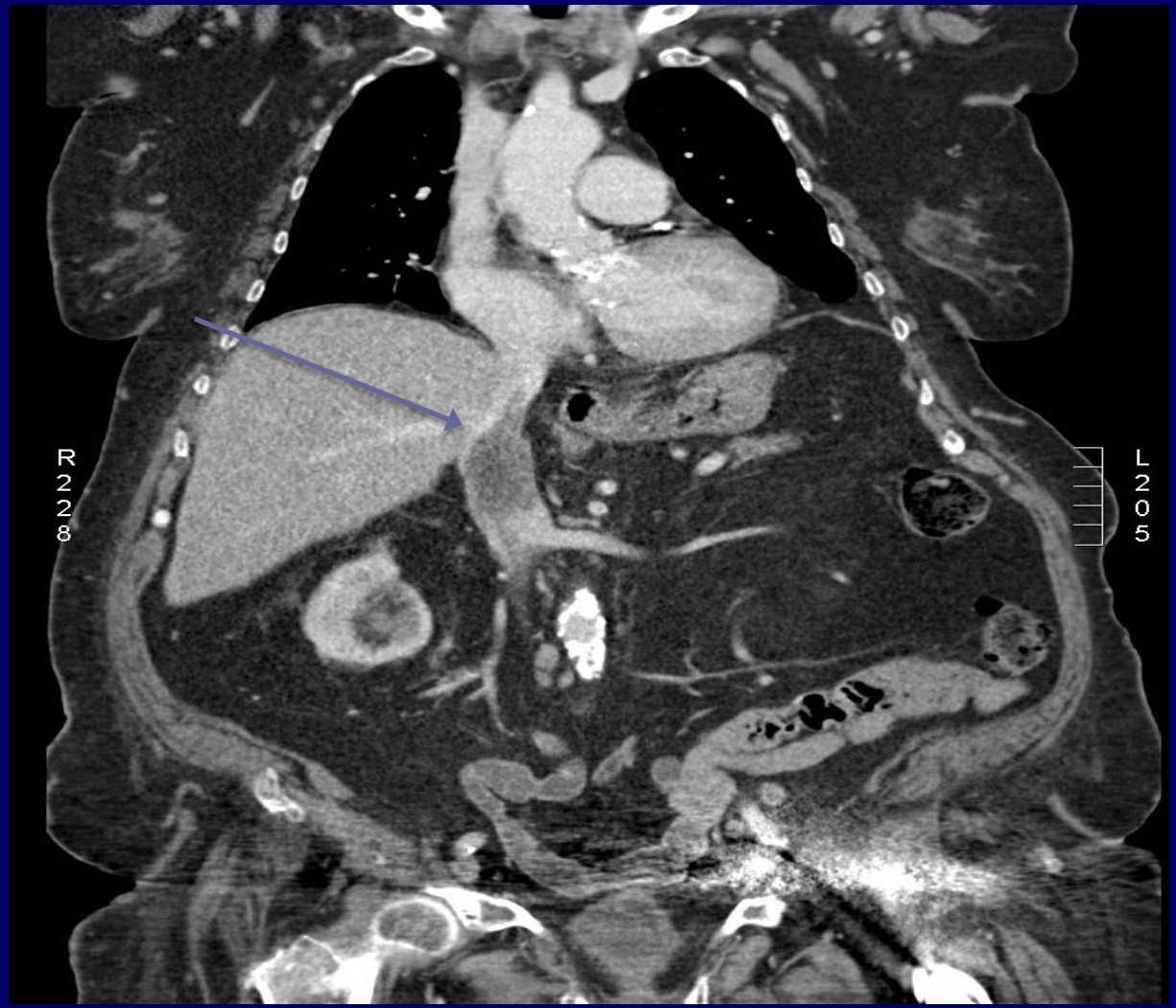
- Surgery postponed
- CT scans…

Patient MG



RCC right kidney

Patient MG



VCI-thrombus

Referred to Urologist

- Biopsy: cc-RCC
- **NO DISTANT METASTASES**

The Beginning of a Troublesome Story

Urologist

Heart surgeon

Plan: radical nephrectomy and thrombectomy

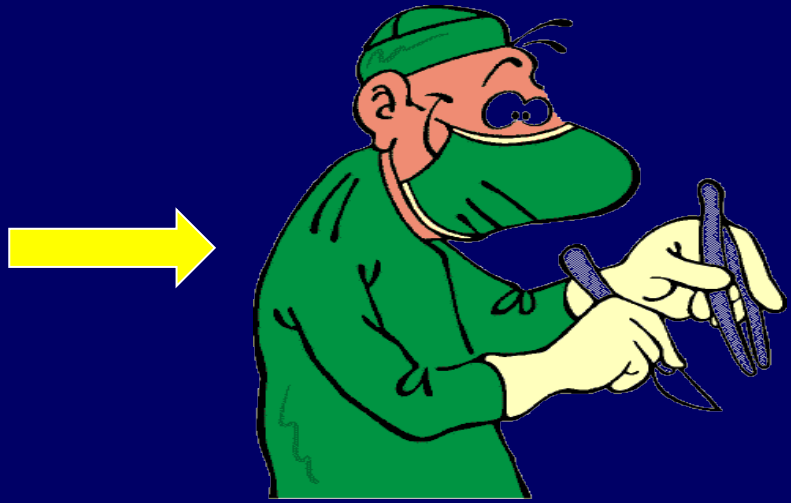
Expected 5 year DFS: 58%[1]

Level of TT is not an independent prognostic factor[1]

Ciancion G et al., *J Urol* 2010

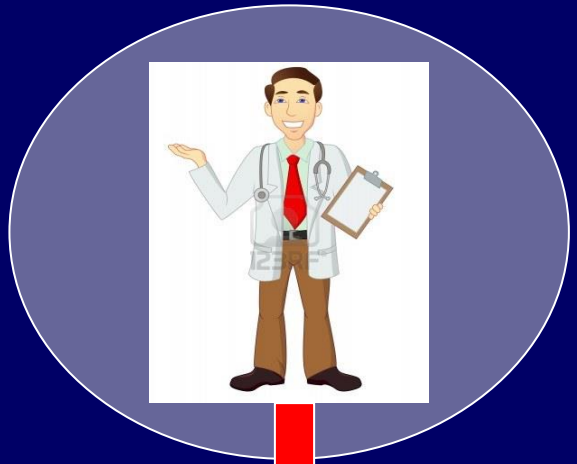
The Beginning of a Troublesome Story

Difficulties to walk due to
hip dislocation Obesity



Heart surgeon: patient with cancer!!!
ECOG 3 (wheelchair)
„this patient will not benefit from surgery“

Phone Calls and Tumorboards



However: The medical oncologist is a difficult person…

- who unnessecarily prolongs the duration of the tumorboard by reminding the surgeons
- …that this otherwise healthy patient could be cured by surgery
- that in contrast to surgery, chronic medical treatment is unlikely to cure her
- that ECOG 3 in this case is a misinterpretation because the inability to walk is entirely due to an orthopedic problem
- …and that if the patient was really ECOG 3, chronic medical treatment can‘t be considered „safer“ than surgery, because these agents have side effects after all …

The former relaxed and optimistic patient is meanwhile scared to death an prefers medical treatment from her kind medical oncologist

Treatment

- Begins TKI-treatment January 2010
- Best response: SD
- Side effects:
  - diarrhoea 2, stomatitis 1, hypertension 3
- Tolerability: appears acceptable
- However: patient perceives her QoL as poor
- In a wheelchair-bound patient diarrhoea grade 2 might be a heavy burden
- Patient starts thinking that all of this wouldn‘t be necessary if she had undergone surgery…

Course of the Treatment

- After 9 months of treatment, still SD
- Intermittend TKI-interruption required due to wound healing problems
- Medical oncologist calls surgeons:
- „*Patient still stable, no mets, no internal issues, no symptoms from atrial thrombus, no rhythm disorders, anticancer treatment needs to be interrupted for unknown period, please perform surgery*“
- Surgeon: *…“what‘s the point if she is stable anyway…“*

What Does the Patient Want in the First Place?

The (kind) medical oncologist wants the very best outcome for the patient….

Orthopedic surgeon

HIP SURGERY
IS PLANNED!!!

At Least One Problem Solved for the Patient?

Orthopedic surgeon

ANESTHESIOLOGIST

Treatment Outcome

- Progressing RCC
- Still free of metastases for 30 months
- Normal LVF, normal liver and kidney function
- Poor QoL
  - due to inability to walk properly
  - due to difficulties to manage otherwise mild side effects because of immobility

Conclusion
What Does the Medical Oncologist Expect from the Surgeon?

- Message for the over-enthusiastic surgeon (less troublesome):
- be balanced, stay informed about other treatment options
- Message for the defeatists: as surgery may tremendously improve QoL and outcome of a patient with (m)RCC…
- I (kindly) ask you to do what you were trained for…
- ….SURGERY!!!
- I expect you not to ask too much…
- …because I have already carefully thought it through
- …and I would have done it myself if I was so skilful as you….