STAMPEDE was initiated in 2005, docetaxel was the only approved agent that demonstrated survival benefit in CRPC. As the pace of new prostate cancer drug development has accelerated, and additional drugs with survival benefit have been approved, the plethora of ‘docetaxel plus’ studies have lost some relevance. Although STAMPEDE does not provide any support for the use of celecoxib in men with advanced or metastatic prostate cancer starting ADT, the results of other arms—particularly the abiraterone acetate arm—will be highly anticipated. Additionally, this innovative trial design might serve as a model in the prostate cancer field to evaluate the optimal use of the new, active agents in advanced prostate cancer.

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The benefits of multidisciplinary prostate cancer care

Leonard G. Gomella

The essential element of a multidisciplinary approach to patient care brings together prostate cancer specialists to educate patients and involve them in their medical decisions, which brings with it many benefits. Now, there is evidence that this approach also improves clinical outcomes in prostate cancer.

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The number and variety of treatment options for men with prostate cancer can be overwhelming to both the patient and his family. Decision making can be further complicated by the potential for poor outcomes and treatment regret. The highly publicized draft recommendation of the US Preventative Services Task Force dedicated considerable attention to reviewing the implications of prostate cancer screening and the potential effects on quality of life of active treatment. A multidisciplinary clinical approach to prostate cancer care can have much influence in mitigating these drawbacks.

Multidisciplinary prostate cancer care encompasses collaborative patient care by a team of different specialists who discuss all treatment options and provide individualized treatment recommendations to each patient. Although this general definition exists in the field of oncology, the models of multidisciplinary clinical care can differ greatly. In a recent paper, Magnani et al. reviewed their 6-year experience with their multidisciplinary prostate cancer clinic in Milan, Italy. I am in full agreement with their approach. In its purest (and arguably most effective) form, a true multidisciplinary clinical setting should include real-time interaction between the various specialists—including urologists, oncologists, radiologists and psychologists—and the patient. Other multidisciplinary practice...
models, such as an agreement amongst specialists to follow predefined care pathways or the discussion of cases at tumour board meetings, can be employed but lack the benefits of the real-time interactive model. These benefits include patients being satisfied with their treatment as well as feeling well-informed, cared for and comfortable. The essential element in the multidisciplinary approach is educating patients and involving them in their medical decisions, a concept known as ‘shared decision-making’. As noted by the US Institute of Medicine, shared decision-making is at the heart of patient-centred care that is “responsive to individual patient preferences, needs and values”.

The so-called paternalistic approach to patient care, where physicians make decisions that they think are best, is no longer considered the standard of care in medicine.

A 2011 Cochrane review studied a diverse group of patients (with different diseases) who used decision aids (pamphlets, videos and web-based tools) to assist with their medical decision making. These tools improved their knowledge of the treatment options, provided objective information on the benefits and potential adverse effects of treatment and enabled patients to make choices consistent with their personal values. However useful these tools might be, any decision on prostate cancer treatment must also take into consideration many additional factors such as tumour characteristics, patient age and comorbidities. Another vexing issue is that many of the treatment approaches, which range from active surveillance to numerous active treatments, have no clear advantages. Beyond cancer control, the improvements in the prostate cancer community of this 'treatment' as an appropriate standard of care. As active surveillance is also the focus of a clinical trial in their institute, enhanced recruitment to trials is another advantage of this care model. On the back of these successes, several groups from the USA, Europe and other nations have also designed their program and implementation of the multidisciplinary clinical approach to cancer care, including prostate cancer.

Additionally, the European School of Oncology has initiated discussions on the design, implementation and certification of Prostate Cancer Units following the lead of specialists in European Breast Cancer multidisciplinary care.

The benefits of a multidisciplinary clinic approach are clear. Similar to our data, the Milan Prostate Programme has shown high patient satisfaction scores in the setting of a well-designed clinic. But is this extra effort actually improving outcomes in men with prostate cancer? We recently reported for the first time that using our multidisciplinary clinic approach in prostate cancer improves overall survival outcomes. Our 5-year survival for men with localized low-risk disease approached 100%, which is to be expected based on published benchmarks. However, when analysing men with locally advanced high-risk disease, the improved outcomes at our centre were pronounced. For example, in men with high-risk pathologic T3 prostate cancer the 5-year survival approached 90% compared with a 78% overall survival of patients in the Surveillance, Epidemiology and End Results database. The body of encouraging literature is growing concerning the multidisciplinary clinical approach.

For physicians interested in establishing a multidisciplinary prostate cancer clinic there must be an unwavering long-term commitment from all parties, which cannot be underestimated. The institution, support staff, medical specialists, nurses, social workers and other health-care professionals must be partners in the vision of the centre. At our multidisciplinary clinic at the Kimmel Cancer Center, we have demonstrated many benefits including high levels of patient satisfaction and enhanced learning opportunities for all participants. Our group has also demonstrated a defined oncological outcome benefit to many patients with this approach. We look forward to Magnani and et al. providing similar long-term data on their enhanced prostate cancer outcomes with their successful patient-centric multidisciplinary approach to prostate cancer.

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Outcomes of gastric-segment bladder reconstruction

Ajay K. Singla

Although early studies of gastrocystoplasty reported good long-term outcomes with few adverse effects, some more recent studies have contradicted this view—a recent report has shown high complication rates and poor outcomes. The use of the technique remains controversial and can be recommended only in a select group of patients.

Sinhaiko first reported the use of a gastric segment for bladder reconstruction in an animal model in 1956, but the technique gained popularity—particularly in paediatric patients—following a 1988 report by Adams et al. that described gastric-segment bladder reconstruction as a viable solution in severely compromised patients.

To create the gastric segment, a wedge of gastric tissue is harvested from the greater curvature of the stomach and mobilized on its vascular pedicle, which is based on the right gastroepiploic artery. The resulting patch is brought into the pelvis and anastomosed on to the already opened dome of the bladder in two layers. A suprapubic tube and nasogastric tubes are placed to drain the bladder and the stomach, and patients are placed on H2 blockers for 3–6 months postoperatively.

The gastric segment provides several advantages over the use of traditional intestinal segments, including reduced chloride reabsorption, decreased mucus production, decreased urinary infection in acidic urine, lower risk of stone formation and avoidance of complications from short bowel syndrome. In contrast to the intestine, the stomach wall acts as a barrier to ammonium and chloride absorption—indeed, it excretes acid. Gastrocystoplasty seems to be particularly advantageous for patients with renal insufficiency and metabolic acidosis, and the ideal segment for use in children with cloacal exstrophy, who also have deficient bowel. The disadvantages of the gastric segment include severe metabolic alkalosis, dehydration and haematuria–dysuria syndrome. Since the original report by Adams and colleagues, a number of long-term complications have been reported, which has restricted the use of stomach for bladder reconstruction.

A recent study by Castellan et al. has provided more up-to-date data regarding recommendations for the use of gastric segments in bladder reconstruction, reporting high incidence of complications and drawing disappointingly negative conclusions. Castellan et al. collected data from 29 patients with median age of 6.6 years (range 2–36 years) who were followed up for a mean 13.9 years (range 9–16.5 years). The procedure was carried out for multiple indications including neurogenic bladder (n = 21), cloacal exstrophy (n = 5) and other anomalies (n = 3). Gastrocystoplasty was the procedure used in the majority of patients (n = 22), six patients underwent composite augmentation and one had a gastric reservoir created. 52% of patients developed complications, including haematuria–dysuria syndrome (24%), decreased capacity or compliance associated with incontinence or hydronephrosis (9.5%), bladder or reservoir tumours (10%) and stones in one patient (3%). Malignancy developed in three patients 11–14 years after their surgery; all three of these patients eventually died of metastatic disease. In the face of such data, the authors recommended against the use of gastric-segment reconstruction.

Previous studies have both supported and contradicted this conclusion. Early experience with the use of gastric segments in lower urinary tract reconstruction had been promising in both the paediatric and adult patient population. In 1997, we reported our own results in 22 adult patients—14 of whom had augmentation gastrocystoplasty and eight of whom underwent construction of a continent gastric reservoir; mean follow-up was 9.8 months. In this early study, renal function remained stable or improved in all patients, although there was a significant decrease in urinary pH and two patients developed hypochloremic alkalosis. All patients were completely continent after the procedure, with no problems in mucus production. There was no mortality or significant morbidity and it was concluded that stomach offers a good alternative to ileum or colon for bladder reconstruction. Sheldon et al. had previously reported similar results in the paediatric literature in a study that included 23 patients (mean age 6.1 years) who underwent gastrocystoplasty. They reported a mean bladder

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