Helping patients make informed decisions. Two-year evaluation of the Gustave Roussy prostate cancer multidisciplinary clinic

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A B S T R A C T
Objectives: The initial treatment decision for newly diagnosed non-metastatic prostate cancer is complex. Multiple valid approaches exist, without a clear and absolute consensus for every clinical scenario, and therefore specialist opinions may vary. Multidisciplinary consultations focusing on shared decision-making aim to provide an apposite tool for the initial treatment decision. We have evaluated the first two years of activity of the Gustave Roussy Prostate Cancer Multidisciplinary Clinic (PCMC), dedicated to the initial decision-making for non-metastatic prostate cancer.

Methods: PCMC consists of two consecutive specialist consultations with a urological surgeon and a radiation oncologist, followed by a dedicated Tumor Board discussion. A study questionnaire was addressed to all PCMC patients via postal mail. Medical notes and questionnaire responses of 195 eligible patients were analyzed.

Results: The questionnaire response rate was 69% (134 patients). Complete satisfaction rate was high (114 of 118 responders, 97%). Patients were offered new treatment options in 55% of cases, and felt better informed in 98% (122 of 125 responders). The double consultation was considered useful (124 of 129 responders, 96%). Reported feeling of active participation was significantly elevated (117 of 131 responders, 89%), while 46% of patients (57 of 125) modified their decision on the management of their prostate cancer following their PCMC consultation.

Conclusions: The experience of a multidisciplinary consultation in the initial management of non-metastatic prostate cancer renders high patient satisfaction, improves their appreciation of feeling better informed, promotes active participation and shared decision-making and strongly influences their final decision.

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Introduction
The complexity of treatment strategies pertaining to non-metastatic prostate cancer (CaP) is well recognized, necessitating a co-operation between specialist colleagues, but also a significant input from the patients themselves [1]. The dramatic changes in incidence, diagnostic stage and mortality in the last 30 years resulted in modification of medical attitudes and development of a variety of management options (surgery, external-beam radiotherapy, brachytherapy, cryotherapy, high-intensity focused ultrasound, hormonal therapy, active surveillance, watchful waiting). For localized CaP there does not exist a clearly established, universally applied advantage of a given treatment modality over the others; treatment decision is an intricate process that ought to include risk assessment and precise disease extent and topography, amongst other factors.

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A need for multidisciplinary involvement and shared decision-making therefore evolved, highlighting the cardinal importance of patient education.

The Gustave Roussy Prostate Cancer Multidisciplinary Clinic (PCMC), inaugurated in March 2011, is a comprehensive weekly clinic for localized or locally advanced Cap patients requesting a second opinion, based on the model of shared decision-making. It offers expert specialist care in a collaboration between Gustave Roussy and the urological surgical teams of the Hôpital Bicêtre and Hôpital Saint Joseph, Paris, France. Access to the PCMC is via general practitioner or specialist referral, or at the patient’s own initiative.

This specialist clinic offers patients the opportunity to successively consult with a radiation oncologist and a urological surgeon, part of a dedicated 5-member team. Consultation time for each specialist is 45 min. All cases are discussed at the Genitourinary (GU) Tumor Board on the same day, with the further participation of medical oncologists, specialist and interventional radiologists and histopathologists. The final treatment plan is established at this multidisciplinary meeting. Patients were informed of the Tumor Board recommendation during a follow-up clinic or telephone consultation.

We consider the concept and design of this PCMC to be adapted to the specific setting of localized and locally advanced CaP. We present here an evaluation of the first two years of the Gustave Roussy PCMC activity.

Methods

Patient cohort

All patients seen in the PCMC clinic were included in the initial register; the following exclusion criteria were applied for the final cohort analysis, aiming for bias elimination:

- Absence of histopathological confirmation of prostatic adenocarcinoma.
- Pre-treated patients.
- Patients not specifically addressed to the PCMC Clinic, seen by a single specialist in regard with a previously established treatment plan.
- Patients belonging to Gustave Roussy staff.

Data collection

The data source was the hospital electronic and paper records and a dedicated questionnaire. Data were collected in a dedicated Excel-based database (Microsoft Inc, Washington, USA). Table 1 presents an outline of the recorded data. The patient socioeconomic status was scored according to the French 2003 classification of Professions and Socio-Professional Categories [2]. All PSA measurements and biopsies were performed outside Gustave Roussy prior to the consultation date. The weight and volume of the prostatic gland were estimated based on MRI, CT, ultrasound imaging and clinical examination. The T.N.M. classification was according to the 7th AJCC edition [3]. The clinical T stage was scored based on the information in the medical notes; since the precise T2 stage scoring was available for only a small subset of patients, it was not included in the analysis. Apical involvement and capsular and seminal vesicle involvement were scored based on available information (clinical examination, imaging, localization of positive cores).

This study was designed as an early service evaluation, and therefore of a short follow-up, so no long-term data on oncologic outcome could be retrieved.

| Table 1 | Collected data/analysis variables. |
|---------|-----------------------------------|
| Personal data | Marital status | Socio-economic status |
| Consultation details | Consultation year | Initial/s opinion consultation |
| | | Consultation order (surgery/radiotherapy) |
| | | Consulting urologist |
| | | Consulting radiotherapist |
| Comorbidities | Cardiovascular disease | Previous TURP |
| | Family history of prostate cancer | IPSS score |
| | Presence of nocturia | Presence of hesitancy |
| | Presence of terminal dribbling | Presence/quality of erection |
| PSA | Total number of cores | Total number of positive cores |
| | Number of positive cores in the right lobe | Number of positive cores in the left lobe |
| Prostate biopsy: core number | | |
| Prostate biopsy: length | Total length of biopsy cores | Total length of tumour |
| | Total length of tumour in the right lobe | Total length of tumour in the left lobe |
| Gleason score | Total Gleason score | Primary grade of Gleason score |
| | Secondary grade of Gleason score |
| Prostate Weight/Volume | Estimated weight & volume of the prostate gland |
| TNM classification | Clinical T stage |
| Imaging | MRI performed |
| | Local extension on MRI |
| | Pathological lymph nodes on MRI |
| | CT scan performed |
| | Pathological lymph nodes on CT |
| | Bone scan performed |
| | Findings indicative of metastasis |
| Multimodal staging (clinical, biopsy, imaging) | Apical involvement |
| | Capsular infiltration |
| | Seminal vesicle infiltration |
| Prognostic stage | NCCN stage |
| Proposed treatment plans | D’Amico classification |
| | Pre-existing treatment plan (if applicable) |
| | Consultant urologist proposal |
| | Consultant radiotherapist proposal |
| | Multidisciplinary team proposal |
| | Chosen treatment modality |
| | Modification of pre-existing choice |
| | Place of treatment |
| Patient choice | Modification of place of treatment |

Questionnaire

The project questionnaire was designed and dispatched via postal mail at two time-points at a 5-month interval, accompanied by an introductory letter and prepaid postage envelope, in accordance with national legislations. The questionnaire enquired upon patient satisfaction, perception of the consultation experience, and aimed to collect complementary information on CaP management after the time of PCMC consultation (Table S1).

Statistical analysis

The reported percentages in the descriptive statistics are estimated on the total number of the cohort (n = 195). The reported percentages relevant to questionnaire responses refer to the total number of received responses, unless otherwise specified. The percentage values were rounded to the nearest unit.
Results

We identified 215 consecutive patients seen in the PCMC clinic during the period March 2011-December 2013. A total of 20 patients were excluded from the analysis as per the above exclusion criteria. The final analysis was performed on 195 patients. Of them, 91 patients consulted in 2011 and 104 patients in 2012. A flowchart of study procedure is shown in Fig. 1. A total of 134 questionnaires were returned (69%). Question-specific response rates varied greatly (39–68%) (Table S2). Patient and disease characteristics and consultation specifics are detailed in Table 2.

Treatment proposals during the PCMC consultation depended on disease recurrence risk. Overall, three, two and one options were offered for low, intermediate and high-risk patients, respectively. At the subsequent GU Tumor Board, one or two treatment options were suggested for the majority of low- and intermediate-risk patients, while for high-risk patients a single recommendation was usually made. Table 3 gives an account of treatment recommendations by the PCMC specialists and the GU Tumor Board.

Concordance rate amongst the PCMC clinic specialists was 96.6%, with complete concordance for all proposals at 67.4% (for patients for which more than one was made). Concordance between the radiation oncologist and Tumor Board was 94.4%, and between the surgeon and Tumor Board was 97.3% (complete concordance rates of 55.8% and 65.4% respectively).

The eventual treatment choices were recorded in the medical files or communicated via the questionnaire for 71% of patients (outlined in Table S3). The percentages of surgery and radiotherapy (external beam or brachytherapy) choices did not differ (29.2% and 29.8% respectively). The final patient choice was in agreement with the Tumor Board recommendation in 93.4%; concordance was 93.4% and 84.5% with the surgeon and radiation oncologist proposals, respectively.

Since this was a second-opinion consultation, all patients had previously seen a urological surgeon elsewhere, and had an established histological diagnosis and a provisional treatment plan. More than half of responding patients (55%) reported that, during their Gustave Roussy PCMC consultation, they were offered treatment options not considered during their initial consultation. Patient satisfaction rate was almost absolute, with 114 of 118 (96.6%) and 4 of 118 (3%) of responding patients reporting complete and moderate satisfaction, respectively. The great majority of responders (122 of 125, 97.6%) felt better informed, either

![Fig. 1. PCMC study consort diagram.](image-url)
Table 2
Patient characteristics and consultation specifics.

| Consultation motive (number, %)  | 84 (62.7) | 39 (29.1) | 21 (15.7) | 13 (9.7) | 14 (10.4) |
|----------------------------------|-----------|-----------|-----------|-----------|-----------|
| Advice of friends/family         |           |           |           |           |           |
| Medical referral                 |           |           |           |           |           |
| Internet-based information       |           |           |           |           |           |
| Inadequate prior information     |           |           |           |           |           |
| Consultation order (number, %)   |           |           |           |           |           |
| Surgery then radiation oncologist| 25 (12.8) |           |           |           |           |
| Radiation oncologist then surgery| 129 (66.1)|           |           |           |           |
| Order not recorded               | 13 (6.7)  |           |           |           |           |
| Joint consultation               | 20 (10.2) |           |           |           |           |
| Surgeon only                     | 3 (1.6)   |           |           |           |           |
| Radiation oncologist only        | 5 (2.6)   |           |           |           |           |
| Age (yrs)                        | 42–81     | 63.5      | 63.8      | 59        | 68        |
| Range                            |           |           |           |           |           |
| Median                           |           |           |           |           |           |
| Mean                             |           |           |           |           |           |
| Q1                               |           |           |           |           |           |
| Q3                               |           |           |           |           |           |
| Age group (number, %)            |           |           |           |           |           |
| 40–49                            | 8 (4.1)   | 45 (33.1) | 102 (52.3)| 40 (20.5) |
| 50–59                            |           |           |           |           |
| 60–69                            |           |           |           |           |
| 70–81                            |           |           |           |           |
| Prior history (number, %)        |           |           |           |           |           |
| Cardiovascular disease           | 88 (64.2)|           |           |           |           |
| TURP                             | 10 (7.5)  |           |           |           |           |
| LUTS (number, %)                 |           |           |           |           |           |
| Terminal dribbling               | 26 (24.8)|           |           |           |           |
| Hesitancy                        | 23 (30.0)|           |           |           |           |
| IPSS score                       |           |           |           |           |           |
| <7                               | 46 (56.1)|           |           |           |           |
| 8–19                             | 36 (43.9)|           |           |           |           |
| 20–35                            | 2 (2.4)  |           |           |           |           |
| Prostate volume (cm³)            |           |           |           |           |           |
| Range                            | 15–140    |           |           |           |           |
| Median                           | 40        |           |           |           |           |
| T stage                          |           |           |           |           |           |
| T1                               | 98 (62.4)|           |           |           |           |
| T2                               | 49 (31.2)|           |           |           |           |
| T3                               | 10 (6.4) |           |           |           |           |
| T4                               | 0 (0)     |           |           |           |           |
| Imaging                          |           |           |           |           |           |
| MRI prostate-pelvis              | 144 (73.8)|           |           |           |           |
| CT abdomen-pelvis                | 57 (29.2)|           |           |           |           |
| CT & MRI                         | 31 (15.9)|           |           |           |           |
| Bone scan                        | 2 (1.0)  |           |           |           |           |
| PSA (ng/ml)                      |           |           |           |           |           |
| Median                           | 7.3       |           |           |           |           |
| <10                              | 139 (71.3)|           |           |           |           |
| 10–20                            | 43 (22.0)|           |           |           |           |
| ≥20                              | 12 (6.2) |           |           |           |           |
| Unknown                          | 1 (0.5)  |           |           |           |           |
| Prostatic biopsies               |           |           |           |           |           |
| Median number of cores           | 12        |           |           |           |           |
| Median number of positive cores  | 3         |           |           |           |           |
| Median tumor length (mm)         | 7         |           |           |           |           |
| Capsular involvement             | 28 (12)  |           |           |           |           |
| Seminal vesicle involvement      | 14 (7)   |           |           |           |           |
| Gleason score                    |           |           |           |           |           |
| 6                                | 95 (48.7)|           |           |           |           |
| 7                                | 84 (43.1)|           |           |           |           |
| 7 (3 + 4)                        | 65        |           |           |           |           |
| 7 (4 + 3)                        | 15        |           |           |           |           |
| Unknown                          | 4         |           |           |           |           |
| 8                                | 11 (5.6) |           |           |           |           |
| 9                                | 1 (0.5)  |           |           |           |           |
| 10                               | 0 (0)     |           |           |           |           |
| Unknown                          | 4 (2.1)  |           |           |           |           |
| D’Amico classification           |           |           |           |           |           |
| Low risk                         | 73 (37.4)|           |           |           |           |
| Intermediate risk                | 89 (45.7)|           |           |           |           |
| High risk                        | 25 (12.8)|           |           |           |           |
| Metastatic                       | 8 (4.1)  |           |           |           |           |

1 Estimated for the total of returned questionnaires (n = 134).
2 More than one answer to this question was possible.
3 Estimated for the total of analyzed patients (n = 195).
4 Estimated for the total of patients for whom relevant information was recorded.

Discussion

The PCMC proposes an interdisciplinary consultation time with emphasis on management options and patient choice. It is a time of information, reflection and decision-making. The participating oncology specialists practice different therapeutic modalities and therefore have distinct medical cultures. These double, long, expert consultations serve to optimize provision of specialist information and care. The diversity of provided information, if moderate and not contradictory, may act to facilitate the reflection process of the patient. The sequential consultations with the two specialists, frequently accompanied by his family, feature the patient himself in the centre of the action as the common denominator.

This shared decision-making is a multilevel process influenced by several factors, such as history of cardiovascular disease or recent transurethral resection of the prostate (TURP). The nature and severity of urinary symptoms also influence management decisions; surgery allows for improvement of obstructive symptoms, whilst radiotherapy (either brachytherapy or external beam irradiation) might worsen them. Irritative symptoms frequently worsen after radiotherapy, while surgery is associated with increased risk of urinary incontinence [4]. Their assessment equally allows for decision on the indication for symptomatic medical treatment or a combined modality.

Interestingly, the median age of our cohort (63.5 years) was significantly lower than the national median for CaP diagnosis (70 years) [5], indicating that younger patients were more actively seeking a second opinion and participation in the decision-making process [6].

It ought to be highlighted that the few de novo metastatic patients were purposefully not excluded from our analysis (Table 2), although they represent a minority of patients in our cohort as the PCMC clinic was designed for patients with localized and locally advanced disease. In the era of changing paradigm for de novo metastatic CaP [7–9], lymph-node only pelvic disease or even oligometastatic patients may benefit from a primary locoregional treatment alone or in combination with upfront systemic therapy and could therefore derive benefit from consulting early after diagnosis with specialists involved in locoregional treatments.

The main limitations of our study include memory bias (questionnaires dispatched at an average of two years after the consultation), information bias (the measured outcome was subject to receiving a written response), and associated selection bias, as the obtained answers may not be representative of the cohort (patients with stronger opinions are generally more likely to respond). A further bias could refer to the order of specialist consultations; indeed for clinic scheduling purposes the majority of patients consulted with the radiation oncologist first followed by the surgeon (129 patients, 66%). That could lead to under-representation of certain aspects of clinical elements pertaining to the decision-making, should it was felt that they might have been sufficiently exposed in the preceding consultation.
The concordance rates amongst specialists and Tumor Board were highly satisfactory. Although the input of a medical oncologist was obtained in the GU Tumor Board discussion, the presence of a medical oncologist in the PCMC consultation itself would optimize management both for localized CaP and for newly-diagnosed metastatic patients [10], and most likely further improve the concordance rates between PCMC and Tumor Board, as well as enrich the discussions regarding potential participation in novel agent trials, as the latter have now moved forward to the early convalescence: 48-month quality-of-life outcomes after treatment for metastatic prostate cancer. J Natl Cancer Inst 2009;101:888–92

The double specialist consultation received significant appreciation, providing patients with valid scientific approaches and management details, but also enhancing confidence in the recommendations towards finalizing a treatment plan, and providing them with a feeling of active participation.

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Appendix A. Supplementary data
Supplementary data associated with this article can be found, in the online version, at https://doi.org/10.1016/j.ctro.2018.07.001.

References
[1] Horwich A, Hugosson J, de Reijke T, Wiegel T, Fizazi K, Kataja V, Panel Members; European Society for Medical Oncology. Prostate cancer: ESMO Consensus Conference Guidelines 2012. Ann Oncol 2013;24: 1141–62.
[2] Nomenclature des professions et catégories socioprofessionnelles des employés d’entreprise PCS-FSE 2003. http://www.insee.fr/fr/methodes/nomenclatures/pcse/pcese2003/doc/Brochure_PCS_FSE_2003.pdf.
[3] Edge S, Byrd DR, Compton CC, Fritz AG, Greene FL, Trotti A (eds). AJCC cancer staging manual. 7th ed., American Joint Committee on Cancer; 2010.
[4] Gore JL, Kwan L, Lee SP, Reiter RE, Litwin MS. Survivorship beyond convalescence: 48-month quality-of-life outcomes after treatment for localized prostate cancer. J Natl Cancer Inst 2009;101:888–92.
[5] Institut National du Cancer, “Épidémiologie du cancer de la prostate en France métropolitaine-Données essentielles,” lesdonnes.e-cancer.fr, Online. Available: 32

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### Table 3

| PCMC recommended treatment options | Active surveillance | Surgery | RT | Brachytherapy | HT | Other | Unknown |
|-----------------------------------|-------------------|--------|----|---------------|----|-------|--------|
| **Low risk (n = 72)**             |                   |        |    |               |    |       |        |
| Initial                           | 10 (13.9)         | 24 (33.3) | 5 (6.9) | 5 (6.9) | 0 (0.0) | 1 (1.4) | 40 (55.5) |
| Radiation oncologist              | 34 (47.2)         | 60 (83.3) | 33 (45.8) | 43 (59.7) | 0 (0.0) | 3 (4.2) | 1 (1.4) |
| Surgeon                           | 29 (40.3)         | 51 (70.8) | 28 (38.9) | 26 (36.1) | 0 (0.0) | 7 (9.7) | 1 (1.4) |
| MDT                               | 26 (36.1)         | 39 (54.2) | 19 (26.4) | 32 (44.4) | 0 (0.0) | 8 (11.1) | 1 (1.4) |
| **Intermediate risk (n = 89)**    |                   |        |    |               |    |       |        |
| Initial                           | 3 (3.4)           | 34 (38.2) | 13 (14.6) | 2 (2.2) | 1 (1.1) | 2 (2.2) | 49 (55.0) |
| Radiation oncologist              | 2 (2.2)           | 73 (82.0) | 82 (92.1) | 18 (20.2) | 0 (0.0) | 5 (5.6) | 0 (0.0) |
| Surgeon                           | 1 (1.1)           | 70 (78.6) | 67 (56.3) | 16 (17.9) | 0 (0.0) | 7 (7.9) | 3 (3.4) |
| MDT                               | 2 (2.2)           | 60 (67.4) | 50 (56.2) | 9 (10.1) | 1 (1.1) | 8 (9.0) | 2 (2.2) |
| **High risk (n = 24)**            |                   |        |    |               |    |       |        |
| Initial                           | 0 (0.0)           | 3 (12.5) | 4 (16.7) | 0 (0.0) | 0 (0.0) | 0 (0.0) | 18 (75.0) |
| Radiation oncologist              | 0 (0.0)           | 7 (29.2) | 23 (95.8) | 0 (0.0) | 0 (0.0) | 1 (4.2) | 2 (0.0) |
| Surgeon                           | 0 (0.0)           | 6 (25.0) | 22 (91.7) | 0 (0.0) | 1 (4.2) | 1 (4.2) | 0 (0.0) |
| MDT                               | 0 (0.0)           | 1 (4.2) | 21 (87.5) | 0 (0.0) | 1 (4.2) | 3 (12.5) | 0 (0.0) |
| **Metastatic (n = 8)**            |                   |        |    |               |    |       |        |
| Initial                           | 0 (0.0)           | 0 (0.0) | 2 (25.0) | 0 (0.0) | 1 (12.5) | 0 (0.0) | 5 (62.5) |
| Radiation oncologist              | 0 (0.0)           | 0 (0.0) | 5 (62.5) | 0 (0.0) | 0 (0.0) | 1 (12.5) | 0 (0.0) |
| Surgeon                           | 0 (0.0)           | 0 (0.0) | 4 (50.0) | 0 (0.0) | 0 (0.0) | 5 (62.5) | 0 (0.0) |
| MDT                               | 0 (0.0)           | 0 (0.0) | 4 (50.0) | 0 (0.0) | 0 (0.0) | 1 (12.5) | 0 (0.0) |
| **Total (n = 195)**               | 13 (6.7)          | 61 (31.3) | 24 (12.3) | 7 (3.6) | 2 (1.0) | 4 (2.0) | 112 (57.4) |
| Radiation oncologist              | 37 (19.0)         | 140 (71.8) | 143 (73.3) | 61 (31.3) | 3 (1.5) | 12 (6.2) | 2 (1.0) |
| Surgeon                           | 31 (15.9)         | 127 (65.1) | 121 (62.0) | 52 (26.7) | 3 (1.5) | 18 (9.2) | 6 (3.1) |
| MDT                               | 29 (14.9)         | 104 (53.3) | 90 (46.1) | 41 (21.0) | 6 (3.1) | 21 (10.8) | 4 (2.0) |

1 Percentages in brackets refer to the respective (sub-)cohort total.
2 The total cohort number includes the 2 patients whose prostate cancer diagnosis was on TRUP.
3 HT refers to hormonal treatment alone, while hormonal treatment (short or long course) combined with RT is included in the RT group.

Conclusion
The evaluation of the first years of the Gustave Roussy PCMC indicated high levels of patient satisfaction and a perceived sense of being better equipped to make their final decision on treatment. The double specialist consultation received significant appreciation, providing patients with valid scientific approaches and management details, but also enhancing confidence in the recommendations towards finalizing a treatment plan, and providing them with a feeling of active participation.
