Prostate cancer treatment choices:

the GP's role in shared decision making

TALKING WITH THE PATIENT ABOUT DIAGNOSIS AND TREATMENT DECISIONS

Ted is a 65-year-old retired arts teacher. He was recently diagnosed with localised prostate cancer. He has been to see the urologist to discuss his prognosis and treatment options.

Men and clinicians face difficult decisions with regards to treatments for prostate cancer. For our patients, they can be faced with a choice of radical treatments, which carry a high risk of incontinence and sexual dysfunction, or active surveillance, which can be perceived to go against the strong public cancer narrative of 'find it early and treat it'. Although studies such as the PROTECT trial suggest minimal reductions in mortality from aggressive treatments when compared with active surveillance,¹ prostate cancer still causes a significant number of cancer-related deaths. Predicting the long-term outcomes for men with a diagnosis of localised disease is difficult, although new methods for understanding a man's risk and informing treatment decisions are being developed and refined. Clearly communicating the potential risks, benefits, and uncertainties with men is vital to help them navigate these difficult choices, which can be made easier with their GP by their side.

Ted hasn't come to a decision about whether to undergo radical treatment for his prostate cancer or active surveillance. He makes an appointment to see you to run through his options.

Most patients place a high level of trust in their GP.² It is one of the privileges of our profession that we build relationships through continuity of care, and some patients seek their GP's opinion on big treatment decisions for conditions such as cancer. Continuity of care increases our understanding of the complexities and nuances of the patient's medical history, their preferences for treatment, their social circumstances, and their quality of life. In the Netherlands, the concept of a 'time out' consultation with a GP has been trialled to work with older patients with cancer to help them make treatment decisions.³ The patient has an opportunity to talk over their diagnosis and treatment options, consider them in the context of their personal circumstances, and think about any further issues for clarification with their hospital specialist before making a

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treatment decision. It is intended to support patient involvement in making a choice about their cancer treatment, not to change their decision or replace consultations with a hospital specialist.

Men value receiving clear information about their treatment choices for prostate cancer. Discussions with a specialist are important, especially when considering whether to commence active surveillance, but prostate cancer patients also want to be able to talk to a healthcare professional about any questions or concerns that arise prior to or during their treatment.⁴ GPs can play a role here, and can use their knowledge of the patient regarding their personal priorities and communication style to give information in a manner the patient is more likely to understand.

COMMUNICATING RISK

Ted's urologist explained the potential benefits and harms of surgery, radiotherapy, and active surveillance, quoting the latest numbers needed to treat and numbers needed to harm.

GPs manage risk all the time. We use the clinical information gathered and our knowledge of our patients to help make decisions about tests and treatments with the patient. How these risks are presented to the patient needs to be individually tailored, and this will become more important in the future with the development of more complicated risk prediction tools integrating clinical, genetic, and psychosocial data,⁵ and their greater use in primary care. GPs are more familiar with cancer risk

prediction tools, such as Qcancer and the Macmillan Cancer Decision Support tool, to help identify patients at higher risk of a new cancer diagnosis who may warrant further investigation.⁶ For patients such as Ted, there is a freely available online tool called Predict Prostate (<https://prostate.predict.nhs.uk/>), which produces personalised information regarding prognosis and adverse effects of treatment. Predict Prostate was developed in a collaboration between urologists, geneticists, epidemiologists, mathematicians, psychologists, and media and communications experts.⁷ Individual prognostic and risk information is presented in six different modalities for different patient preferences, catering for patients with a preference for visual representations, as for Ted, or for patients who prefer numerical risk information (Figures 1 and 2). It is intended to augment discussions between patients with prostate cancer and clinicians about their treatment options. Use of the tool has been shown to reduce the considerable variance, even among experts, in estimating the risks of mortality from a new cancer diagnosis and the likelihood of treatment being recommended.⁸

ALONG THE CANCER CONTINUUM

Ted opts for active surveillance, and regularly attends the surgery for PSA blood tests.

Figure 1. Predict Prostate prognostic information.

Even after treatment decisions have been made by the patient, their GP remains integral to their ongoing cancer care. Patients who have undergone radical treatments, such as prostatectomy or radiotherapy, will need support if they develop physical and/or psychosexual side effects, which can potentially last for many months afterwards.⁹ Patients opting for active surveillance will often attend their GP surgery for regular PSA testing, with results being communicated to the urology team. Signs of cancer recurrence or progression are monitored for in primary care, and acted on swiftly. GPs should receive a personalised plan for men on active surveillance, outlining the frequency of PSA testing for the individual patient and thresholds that require reassessment in hospital.⁴ Any patient with cancer may need psychological and/or social support, and as GPs we develop an awareness of an individual patient's social circumstances to identify more isolated patients who may need additional supports and follow-up. The GP's role in active surveillance is evolving, and shared-care approaches to incorporate screening for distress and survivorship planning have been piloted. The ProCare Trial, conducted in Australia, showed that such a multifaceted model was cost-effective compared with usual care and preferred by patients. It also achieved similar outcomes to usual care in terms of quality of life and psychological distress.¹⁰

A PIVOTAL ROLE FOR GPs

In summary, managing prostate cancer is

Figure 2. Predict Prostate treatment risk information.

challenging. It is a relatively common form of cancer, with a wide spectrum of disease whose clinical course is hard to predict, and has treatments that can cause significant morbidity. Men diagnosed with localised prostate cancer have difficult treatment decisions to make, and the support and guidance of their GP using tools such as Predict Prostate can help them navigate their cancer journey.

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REFERENCES

- Hamdy FC, Donovan JL, Lane JA, *et al*. 10-year outcomes after monitoring, surgery, or radiotherapy for localized prostate cancer. *N Engl J Med* 2016; **375**(15): <http://www.nejm.org/doi/10.1056/NEJMoa1606220> [accessed 8 Nov 2019].
- GPs trusted more than any other profession. *Pulse Today* 2015; **27 Oct**: <http://www.pulsetoday.co.uk/home/finance-and-practice-life-news/gps-trusted-more-than-any-other-profession/20030295.article> [accessed 8 Nov 2019].
- de Wit NJ. A 'time out consultation' in primary care for elderly patients with cancer: better treatment decisions by structural involvement of the general practitioner. *Eur J Cancer Care (Engl)* 2017; **26**(3): DOI: <https://doi.org/10.1111/ecc.12711>.
- Merriel SWD, Hetherington L, Seggie A, *et al*. Best practice in active surveillance for men with prostate cancer: a Prostate Cancer UK consensus statement. *BJU Int* 2019; **124**(1): 47–54.
- Usher-Smith J, Emery J, Hamilton W, *et al*. Risk prediction tools for cancer in primary care. *Br J Cancer* 2015; **113**(12): 1645–1650.
- Price S, Spencer A, Medina-Lara A, Hamilton W. Availability and use of cancer decision-support tools: a cross-sectional survey of UK primary care. *Br J Gen Pract* 2019; DOI: <https://doi.org/10.3399/bjgp19X703745>.
- Thurtle DR, Greenberg DC, Lee LS, *et al*. Individual prognosis at diagnosis in nonmetastatic prostate cancer: development and external validation of the PREDICT Prostate multivariable model. *PLoS Med* 2019; **16**(3): e1002758.
- Thurtle DR, Jenkins V, Pharoah PD, Gnanapragasam VJ. Understanding of prognosis in non-metastatic prostate cancer: a randomised comparative study of clinician estimates measured against the PREDICT prostate prognostic model. *Br J Cancer* 2019; **121**(8): 715–718.
- Donovan JL, Hamdy FC, Lane JA, *et al*. Patient-reported outcomes after monitoring, surgery, or radiotherapy for prostate cancer. *N Engl J Med* 2016; **375**(15): <http://www.nejm.org/doi/10.1056/NEJMoa1606221> [accessed 8 Nov 2019].
- Emery JD, Jefford M, King M, *et al*. ProCare Trial: a phase II randomized controlled trial of shared care for follow-up of men with prostate cancer. *BJU Int* 2016; **119**(3): 381–389.