2025-04-11
2025 대한결핵 및 호흡기학회
폐암 심포지엄

# Is **multidisciplinary team approach mandatory** for treatment decision?

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## ***- role of pulmonologist***

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# Today

- What is MDT?
- The benefits of MDT approach
- Real case discussed at MDT
- Role of pulmonologist at MDT

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# ChatGPT

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The **multidisciplinary team (MDT) approach** is not always *mandatory* for treatment decision-making, but in many clinical settings—especially in complex or serious conditions like cancer, stroke, or rare diseases—it is considered the **best practice** and often **strongly recommended**.

## Here's a breakdown:

✅ **When it's commonly used or expected:**

- **Cancer care:** MDTs are standard and sometimes required by guidelines or accreditation bodies.
- **Complex surgical cases:** Especially involving multiple organ systems.
- **Chronic diseases:** Like diabetes or heart failure, where multiple specialties contribute to comprehensive care.
- **Rehabilitation or palliative care:** To address medical, psychological, and social needs.
- **Pediatrics or geriatrics:** Where holistic care is important.

⚠️ **Is it legally mandatory?**

- Usually **not legally required**, unless specified by institutional policy or national guidelines.
- But **failing to involve an MDT** when it's the standard of care **can raise ethical or legal concerns**, especially if a poor outcome occurs.

# ChatGPT

Is multidisciplinary team approach 𝒹mandatory for treatment decision?

💡 **Why is MDT valuable?**

- Encourages collaboration between specialists.
- Ensures that all aspects of a patient's condition are considered.
- Improves accuracy of diagnosis and appropriateness of treatment plans.
- Often leads to better patient outcomes and satisfaction.

## Summary:

> **Not always mandatory, but often essential.**
> In high-stakes or complex cases, treatment decisions are ideally made through a multidisciplinary team approach to ensure safe, comprehensive, and patient-centered care.

# What is MDT?

- **MDT (Multidisciplinary Team)** in lung cancer

- is a group of healthcare professionals from different specialties who collaborate to plan and deliver the best possible care for a patient with lung cancer.

- Purpose of the MDT
  - Accurate diagnosis and staging
  - Individualized treatment planning
  - Shared decision-making
  - Coordinated, patient-centered care
  - Improved outcomes and quality of life

- Confirmation of the benefits of MDT care is critical to establish the need for MDT care!

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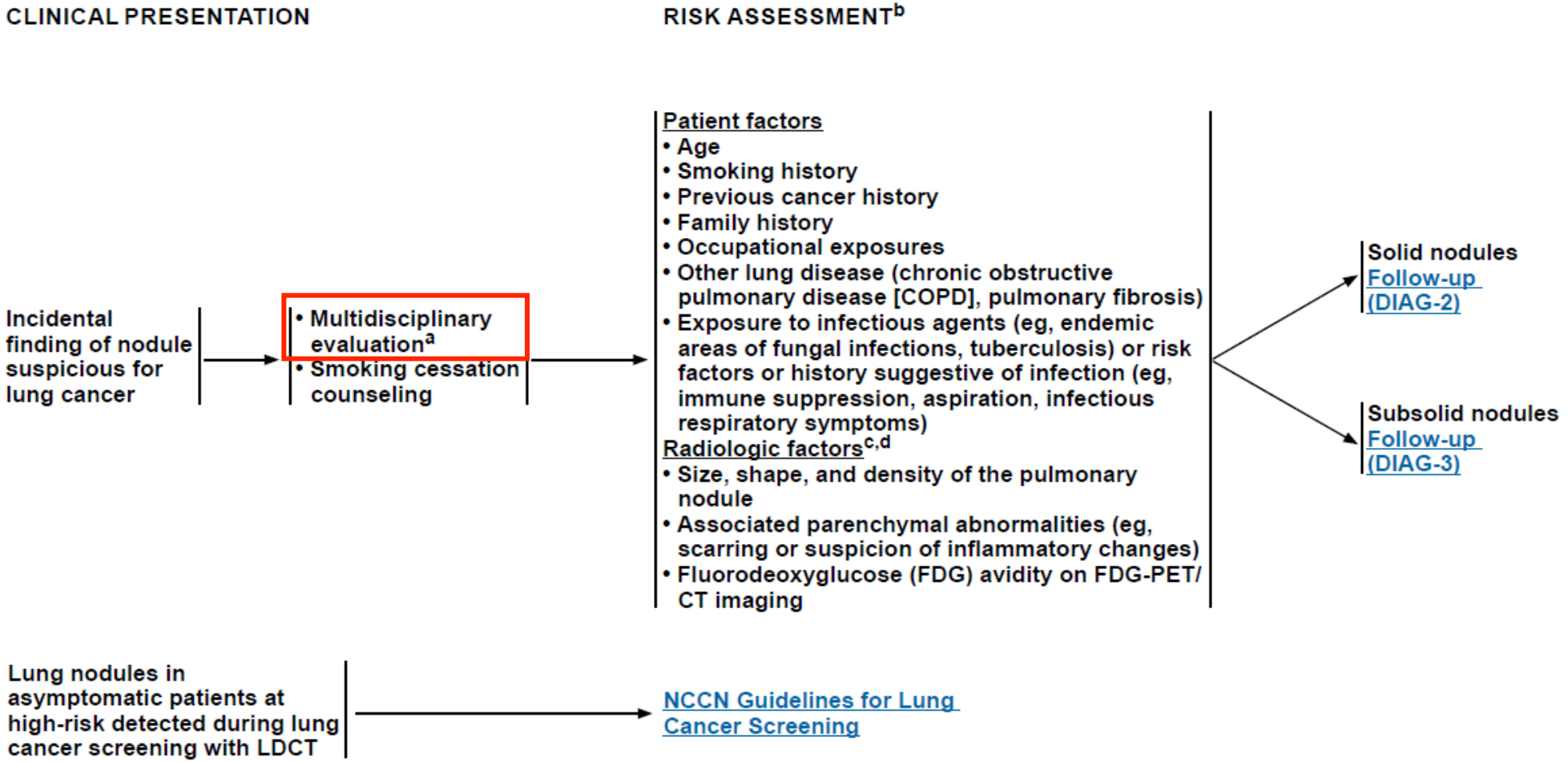
# NCCN guideline 2025 version 3

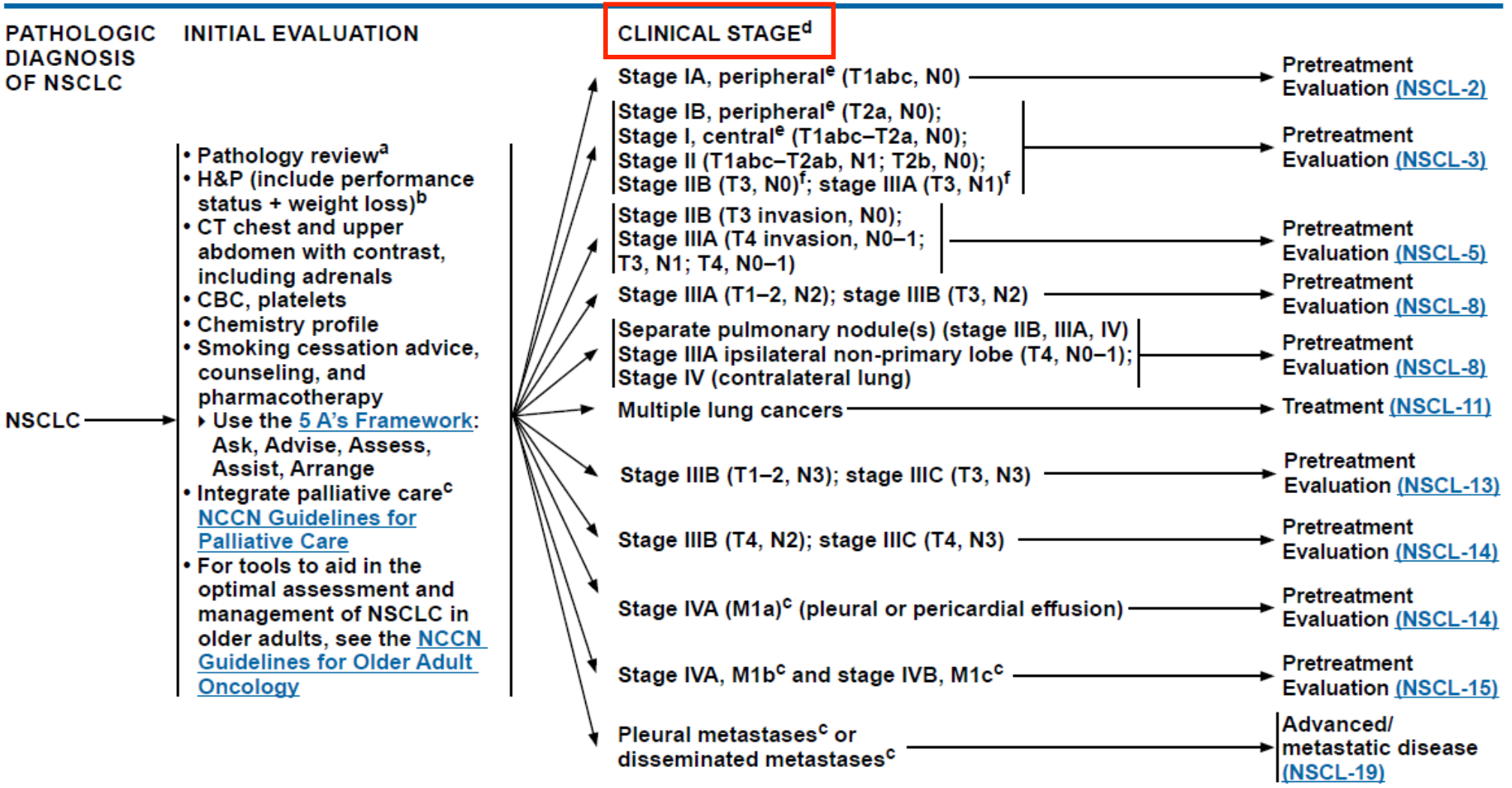
NSCLC




[a] Multidisciplinary evaluation including thoracic surgeons, thoracic radiologists, and pulmonologists to determine the likelihood of a cancer diagnosis and the optimal diagnostic or follow-up strategy.
[b] Risk calculators can be used to quantify individual patient and radiologic factors but do not replace evaluation by a multidisciplinary diagnostic team with substantial experience in the diagnosis of lung cancer.
[c] Principles of Diagnostic Evaluation (DIAG-A 1 of 3).
[d] The most important radiologic factor is change or stability compared with a previous imaging study.

# NCCN guideline 2025 version 3

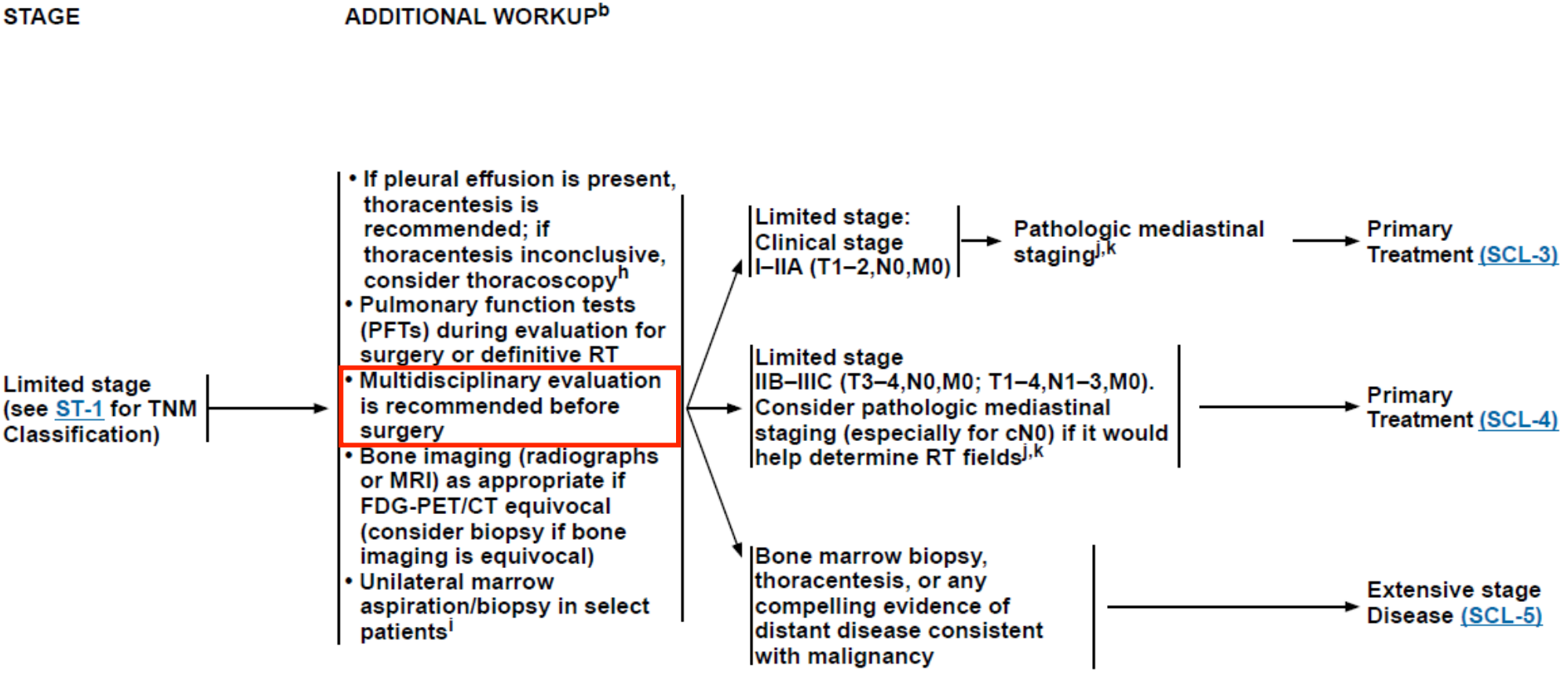





[a] Principles of Pathologic Review (NSCL-A).
[b] Enhanced frailty or geriatric assessments may predict complications better following treatment modalities, particularly surgery. A preferred frailty assessment system has not been established.
[c] Temel JS, et al. N Engl J Med 2010;363:733-742.
[d] For patients where more than one treatment modality (surgery, radiation therapy [RT], or systemic therapy) is usually considered, a multidisciplinary evaluation should be performed.
[e] Based on the CT of the chest: Peripheral = outer third of lung; Central = inner two thirds of lung.
[f] T3, N0 related to size or satellite nodules.

# NCCN guideline 2025 version 3

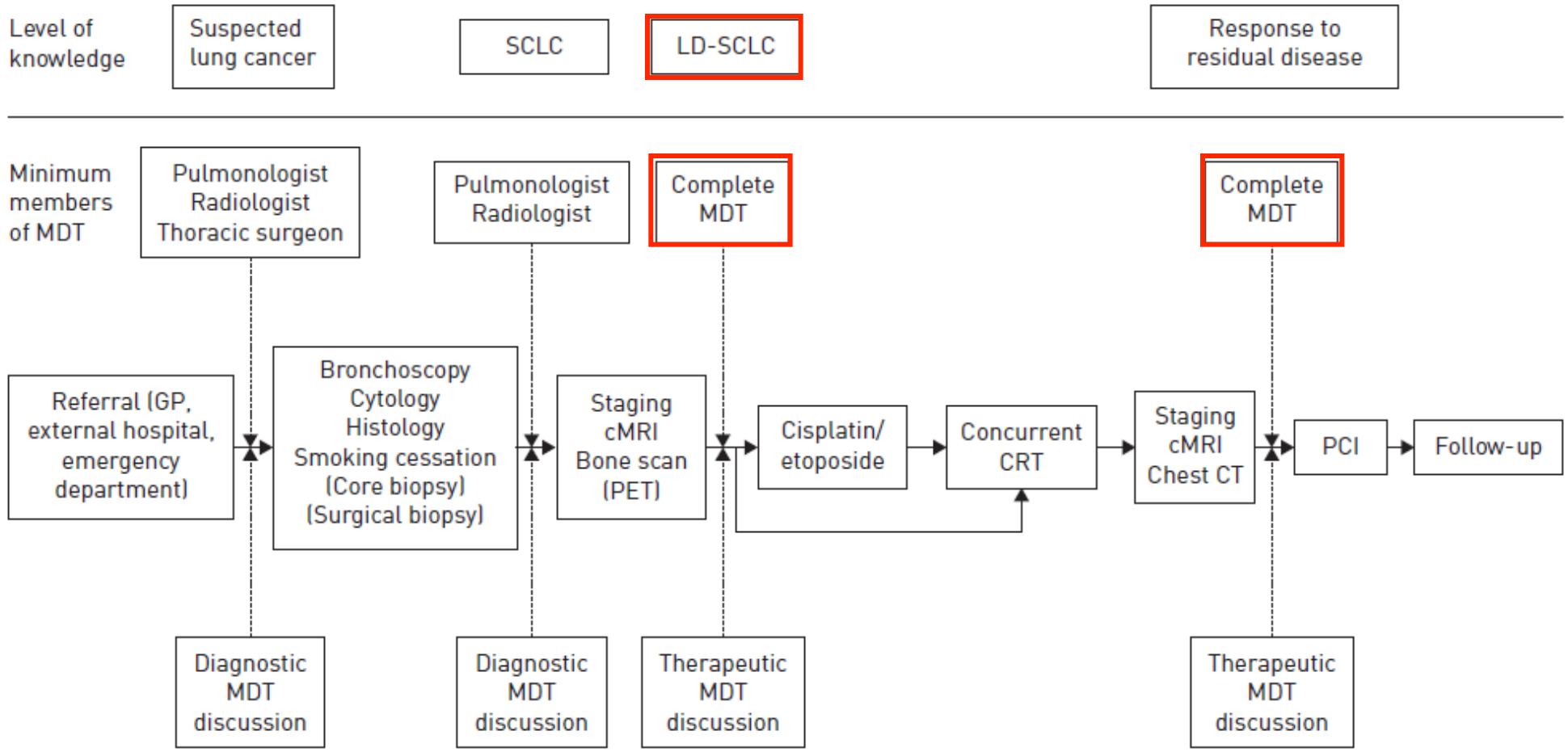
SCLC




[b] Workup of SCLC should be expedited, with studies done in parallel whenever possible.
[h] While most pleural effusions in patients with lung cancer are due to tumor, there are a few patients in whom multiple cytopathologic examinations of pleural fluid are negative for tumor and fluid is non-bloody and not an exudate. When these elements and clinical judgment dictate that the effusion is not related to the tumor, the effusion should be excluded as a staging element. Pericardial effusion is classified using the same criteria.
[i] Selection criteria include: nucleated red blood cells (RBCs) on peripheral blood smear, neutropenia, or thrombocytopenia suggestive of bone marrow infiltration.
[j] Principles of Surgical Resection (SCL-C).
[k] Mediastinal staging procedures include mediastinoscopy, mediastinotomy, endobronchial or esophageal ultrasound-guided biopsy, and video-assisted thoracoscopy. If endoscopic lymph node biopsy is positive, additional mediastinal staging is not required.

# MDT in SCLC patients

* Basic steps in the management of small cell lung cancer (SCLC).




Eur Respir J 2017; 50: 1700422

# Discrepancies across MDT care

- To evaluate the consistency of lung cancer case assessments across MDT, Denmark. (2021 to 2022)
- **60 fictitious case stories** with images > distributed to the **Four** lung cancer MDT conferences
- We compared the conclusions on assigned TNM stage and proposed treatment intent (curability)

| T-categories | Kappa (95% CI) |
|---|---|
| T0 | 0.49 |
| T1 | 0.57 |
| T2 | 0.44 |
| T3 | 0.40 |
| T4 | 0.71 |
| Tx | 0.02 |
| **Kappa combined for T-category** | **0.54** (0.44–0.65) |
| **N-categories** | **Kappa** (95% CI) |
| N0 | 0.91 |
| N1 | 0.60 |
| N2 | 0.69 |
| N3 | 0.84 |
| Nx | -0.01 |
| **Kappa combined for N-category** | **0.79** (0.69–0.88) |
| **M-categories** | **Kappa** (95% CI) |
| M0 | 0.81 |
| M1a | 0.60 |
| M1b | 0.59 |
| M1c | 0.90 |
| Mx | 0.04 |
| **Kappa combined for M-category** | **0.75** (0.63–0.87) |

**Table 3** Assessments of TNM single stages and stage groups

| TNM single stages | Kappa (95% CI) |
|---|---|
| IA | 0.61 |
| IB | 0.54 |
| IIA* | -* |
| IIB | 0.38 |
| IIIA | 0.43 |
| IIIB | 0.60 |
| IIIC | 0.25 |
| IV | 0.88 |
| x | 0.05 |
| **Kappa combined** | **0.62** (0.52–0.71) |
| **TNM stage groups** | **Kappa** (95% CI) |
| Stage I + II | 0.92 |
| Stage III | 0.75 |
| Stage IV | 0.88 |
| Stage x | 0.05 |
| **Kappa combined** | **0.82** (0.72–0.92) |

*) too few cases assessed to this stage

BMC Cancer 2024;24:1423

# Impact of MDT discrepancies on lung cancer outcome

- To evaluate the consistency of lung cancer case assessments across MDT, Denmark. (2021 to 2022)
- **60 fictitious case stories** with images > distributed to the **Four** lung cancer MDT conferences
- We compared the conclusions on assigned TNM stage and proposed treatment intent

**Table 7** The relationship between agreement on Stage Group versus full agreement by all MDT sites on curability ($P < 0.001$)

| All MDTs agree on Stage Group | All MDTs agree on curability | | |
|---|---|---|---|
| | No | Yes | Total |
| No | 9 | 2 | **11** |
| Yes | 7 | 42 | **49** |
| Total | **16** | **44** | **60** |

- 16 cases: MDT disagreed on treatment intent
- 11/16 cases → MDT disagreed stage (stage III)
- two cases
  → MDT agreed on the stage, but disagreed on treatment intent

BMC Cancer 2024;24:1423

# Survival Outcomes and MDT

- Stony Brook Cancer Center Registry
- lung cancer diagnosed between 2002 and 2016
- Multidisciplinary *vs.* traditional care (1,956 vs. 2,315)
- 1-, 3-, 5-, and 10-year survival outcomes

- LCEC Multidisciplinary Care

- multidisciplinary program

  "Lung Cancer Evaluation Center (LCEC)"

- The LCEC patients were defined as those who had, at a minimum, one clinical encounter with the MDT physicians and case presentation at the tumor board

| Characteristic | LCEC (n = 1956) | Non-LCEC (n = 2315) | *P* Value |
|---|---|---|---|
| Age at diagnosis, y | 67.1 ± 11.0 | 67.1 ± 11.7 | .85 |
| Male gender, % | 46.0 | 47.7 | .25 |
| Race, % | | | .73 |
| Asian | 1.0 | 0.7 | |
| Black | 4.2 | 4.5 | |
| White | 93.4 | 93.6 | |
| Other | 1.4 | 1.3 | |
| Histologic type, % | | | <.001 |
| Adenocarcinoma | 42.9 | 35.2 | |
| Squamous cell | 19.2 | 11.4 | |
| Small cell | 7.6 | 14.5 | |
| Other | 6.6 | 4.1 | |
| Unavailable | 18.7 | 34.8 | |
| Stage, % | | | <.001 |
| I | 40.3 | 14.0 | |
| II | 10.2 | 5.7 | |
| III | 25.8 | 20.0 | |
| IV | 23.7 | 60.3 | |
| Treatment | | | |
| Surgery, % | 39.8 | 15.8 | <.001 |
| Radiation, % | 46.9 | 50.7 | .01 |
| Chemotherapy, % | 42.5 | 50.4 | <.001 |

Clinical Lung Cancer 2018;19(4):346-51

# Survival Outcomes and MDT

**Table 3** Overall Survival Rates at 1-, 3-, 5-, and 10-Years for All Cases and for a Subset of Propensity-matched Cases[a]

| Survival Duration | Surviving, % | | |
|---|---|---|---|
| | LCEC | Non-LCEC | *P* Value |
| All cases | | | |
| 1-y | 72.6 | 44.8 | <.001 |
| 3-y | 43.6 | 16.9 | <.001 |
| 5-y | 31.7 | 9.1 | <.001 |
| 10-y | 14.5 | 4.4 | <.001 |
| Propensity-matched cases[a] | | | |
| 1-y | 76.5 | 69.9 | .003 |
| 3-y | 47.1 | 39.4 | .002 |
| 5-y | 33.6 | 23.0 | <.001 |
| 10-y | 14.3 | 9.7 | .121 |

**Table 4** Five-year Cox Proportional Hazard Models for All Cases and a Subset of Propensity-matched Cases[a]

| Factor | HR | 95% CI |
|---|---|---|
| All cases | | |
| Group, LCEC patient | 0.64 | 0.57-0.73 |
| Age at diagnosis | 1.00 | 1.00-1.00 |
| Male gender | 1.32 | 1.18-1.47 |
| Marital status, married | 0.83 | 0.74-0.92 |
| History of alcohol consumption | 0.92 | 0.83-1.03 |
| History of smoking | 1.27 | 1.03-1.60 |
| History of hypertension | 0.98 | 0.88-1.11 |
| History of diabetes | 1.20 | 1.02-1.42 |
| Family history of cancer | 1.03 | 0.97-1.09 |
| Stage at diagnosis | 1.66 | 1.58-1.76 |
| Propensity-matched cases[a] | | |
| Group, LCEC patient | 0.65 | 0.54-0.77 |
| Age at diagnosis | 1.00 | 1.00-1.00 |
| Male gender | 1.29 | 1.10-1.51 |
| Marital status, married | 0.84 | 0.72-0.98 |
| History of alcohol consumption | 0.84 | 0.72-0.98 |
| History of smoking | 1.38 | 1.02-1.86 |
| History of hypertension | 0.97 | 0.82-1.15 |
| History of diabetes | 1.19 | 0.95-1.49 |
| Family history of cancer | 1.02 | 0.94-1.11 |
| Stage at diagnosis | 1.68 | 1.57-1.80 |

* Improved survival benefit from usage of an MDT model *vs.* a traditional care model in the treatment of lung cancer.

Clinical Lung Cancer 2018;19(4):346-51

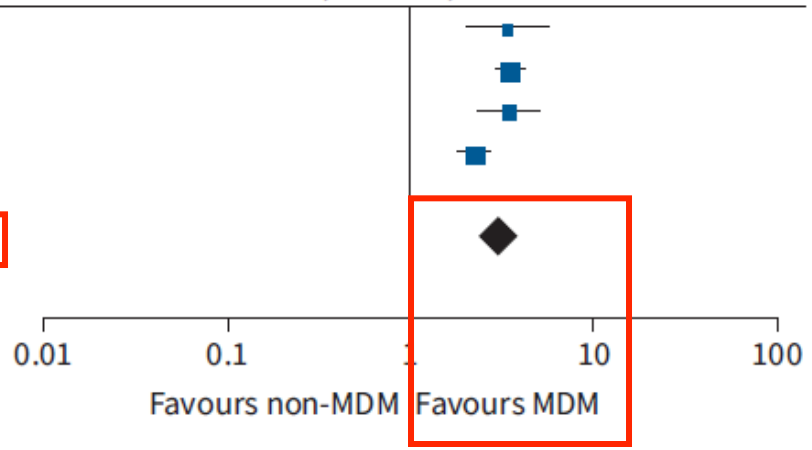
# Multidisciplinary meeting (MDM) review in NSCLC

- Systematic review/meta-analysis to explore literature evidence of clinical impacts of MDM exposure.
- RCTs and observational cohort studies including adults with NSCLC, searched on 31 May 2021.
- MDM review *vs.* no MDM
- 2947 citations were identified, and 20 studies were included

a) Tissue confirmation of diagnosis

| Study or subgroup | Experimental Events | Experimental Total | Control Events | Control Total | Weight | OR M–H, random, 95% CI |
|---|---|---|---|---|---|---|
| Boxer, 2011 | 483 | 504 | 422 | 484 | 16.2% | 3.38 (2.03–5.64) |
| Lin, 2022 | 5733 | 5900 | 3388 | 3728 | 32.5% | 3.45 (2.85–4.17) |
| Mitchell, 2013 | 62 | 206 | 49 | 449 | 20.0% | 3.51 (2.31–5.35) |
| Nemesure, 2020 | 983 | 1179 | 598 | 865 | 31.3% | 2.24 (1.81–2.76) |
| Total (95% CI) | | 7789 | | 5526 | 100.0% | 3.01 (2.30–3.95) |
| Total events | 7261 | | 4457 | | | |

Heterogeneity: $Tau^2$=0.05; $Chi^2$=10.08, df=3 (p=0.02); $I^2$=70%
Test for overall effect: Z=8.01 (p<0.00001)

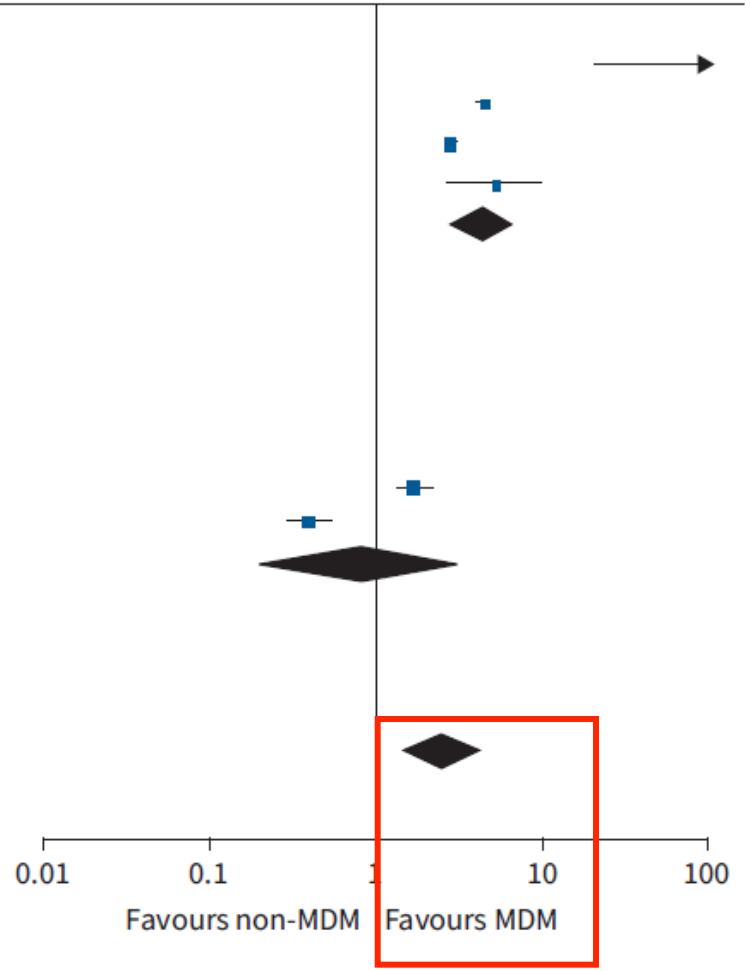



Eur Respir Rev 2024; 33: 230157

# Multidisciplinary meeting review in NSCLC

b) Clinical staging

| Study or subgroup | Experimental Events | Experimental Total | Control Events | Control Total | Weight | OR M–H, random, 95% CI |
|---|---|---|---|---|---|---|
| Overall | | | | | | |
| Boxer, 2011 | 504 | 504 | 363 | 484 | 3.6% | 337.26 (20.91–5440.50) |
| Freeman, 2015 | 6031 | 6627 | 4572 | 6627 | 20.5% | 4.55 (4.12–5.02) |
| Lin, 2022 | 4845 | 5900 | 2305 | 3728 | 20.5% | 2.84 (2.58–3.11) |
| Stone, 2018 | 285 | 295 | 760 | 902 | 16.3% | 5.33 (2.76–10.26) |
| Subtotal (95% CI) | | 13326 | | 11741 | 60.9% | 4.36 (2.79–6.81) |
| Total events | 11665 | | 8000 | | | |
| Heterogeneity: $Tau^2$=0.13; $Chi^2$=60.11, df=3 (p<0.00001); $I^2$=95% | | | | | | |
| Test for overall effect: Z=6.45 (p<0.00001) | | | | | | |
| Geographic region | | | | | | |
| Ray, 2021 metropolitan | 787 | 864 | 2969 | 3464 | 19.8% | 1.70 (1.32–2.19) |
| Ray, 2021 regional | 787 | 864 | 1858 | 1931 | 19.3% | 0.40 (0.29–0.56) |
| Subtotal (95% CI) | | 1728 | | 5395 | 39.1% | 0.83 (0.20–3.44) |
| Total events | 1574 | | 4827 | | | |
| Heterogeneity: $Tau^2$=1.03; $Chi^2$=46.66, df=1 (p<0.00001); $I^2$=98% | | | | | | |
| Test for overall effect: Z=0.26 (p=0.80) | | | | | | |
| Total (95% CI) | | 15054 | | 17136 | 100.0% | 2.55 (1.43–4.56) |
| Total events | 13239 | | 12827 | | | |
| Heterogeneity: $Tau^2$=0.43; $Chi^2$=244.23, df=5 (p<0.00001); $I^2$=98% | | | | | | |
| Test for overall effect: Z=3.15 (p=0.002) | | | | | | |
| Test for subgroup differences: $Chi^2$=4.75, df=1 (p=0.03), $I^2$=78.9% | | | | | | |



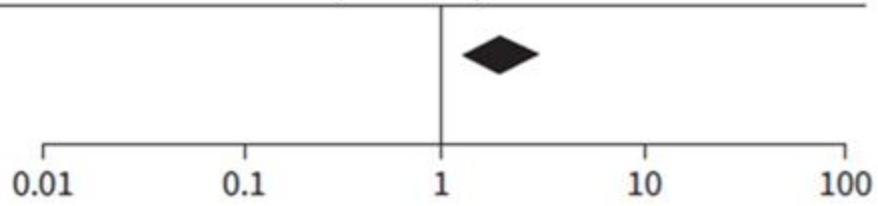

Eur Respir Rev 2024; 33: 230157

# Multidisciplinary meeting review in NSCLC

a) Surgery

| Study or subgroup | Experimental Events | Experimental Total | Control Events | Control Total | Weight | OR M–H, random, 95% CI |
|---|---|---|---|---|---|---|
| Total (95% CI) | | 12063 | | 12404 | 100.0% | 2.00 (1.28–3.13) |
| Total events | 3345 | | 1877 | | | |

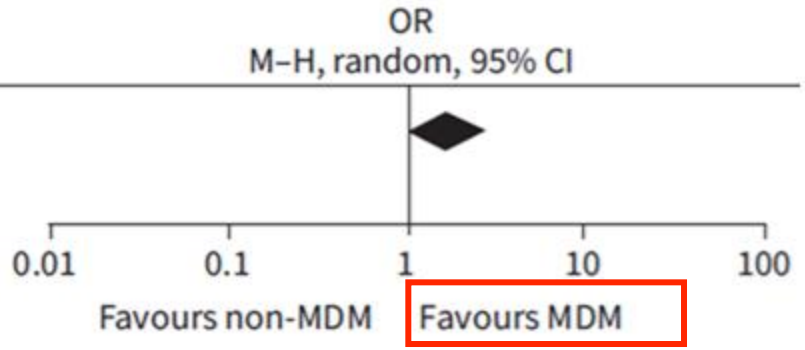
Heterogeneity: $Tau^2$=0.32; $Chi^2$=180.12, df=6 (p<0.00001); $I^2$=97%
Test for overall effect: Z=3.03 (p=0.002)




c) Chemotherapy

| Study or subgroup | Experimental Events | Experimental Total | Control Events | Control Total | Weight | OR M–H, random, 95% CI |
|---|---|---|---|---|---|---|
| Total (95% CI) | | 11689 | | 26948 | 100.0% | 1.67 (0.98–2.83) |
| Total events | 6104 | | 12704 | | | |

Heterogeneity: $Tau^2$=0.44; $Chi^2$=423.47, df=6 (p<0.00001); $I^2$=99%
Test for overall effect: Z=1.90 (p=0.06)

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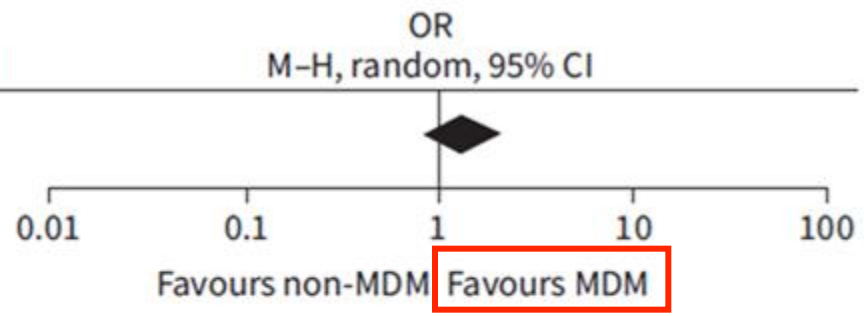
# Multidisciplinary meeting review in NSCLC

b) Radiotherapy

| Study or subgroup | Experimental Events | Experimental Total | Control Events | Control Total | Weight | OR M–H, random, 95% CI |
|---|---|---|---|---|---|---|
| Total (95% CI) | | 11737 | | 26983 | 100.0% | 1.35 (0.85–2.17) |
| Total events | 5821 | | 10176 | | | |

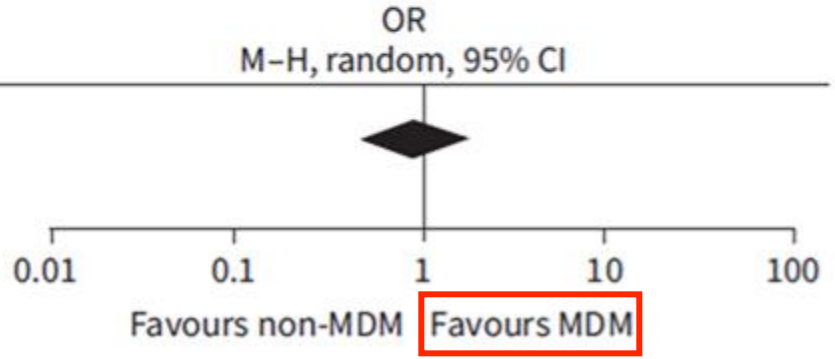
Heterogeneity: Tau²=0.40; Chi²=399.08, df=7 (p<0.00001); I²=98%
Test for overall effect: Z=1.27 (p=0.21)




d) Palliative care

| Study or subgroup | Experimental Events | Experimental Total | Control Events | Control Total | Weight | OR M–H, random, 95% CI |
|---|---|---|---|---|---|---|
| Total (95% CI) | | 13533 | | 11875 | 100.0% | 0.93 (0.47–1.84) |
| Total events | 2838 | | 2815 | | | |

Heterogeneity: Tau²=0.66; Chi²=283.62, df=5 (p<0.00001); I²=98%
Test for overall effect: Z=0.20 (p=0.85)

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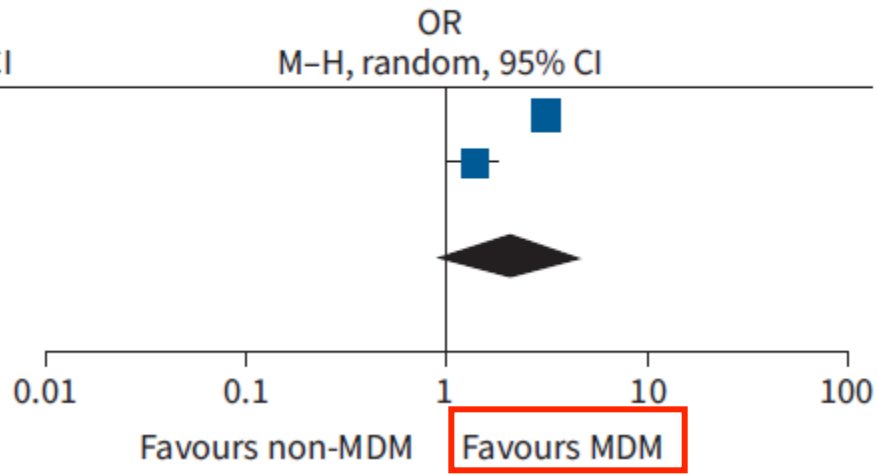
# Multidisciplinary meeting review in NSCLC

c) Clinical trial enrolment

| Study or subgroup | Experimental Events | Experimental Total | Control Events | Control Total | Weight | OR M–H, random, 95% CI |
|---|---|---|---|---|---|---|
| Freeman, 2015 | 1127 | 6627 | 398 | 6627 | 51.4% | 3.21 (2.84–3.62) |
| Lin, 2022 | 135 | 5900 | 63 | 3728 | 48.6% | 1.36 (1.01–1.84) |
| Total (95% CI) | | 12527 | | 10355 | 100.0% | 2.11 (0.91–4.89) |
| Total events | 1262 | | 461 | | | |

Heterogeneity: $Tau^2$=0.35; $Chi^2$=26.69, df=1 ($p<0.00001$); $I^2$=96%

Test for overall effect: Z=1.75 (p=0.08)

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# Multidisciplinary meeting review in NSCLC

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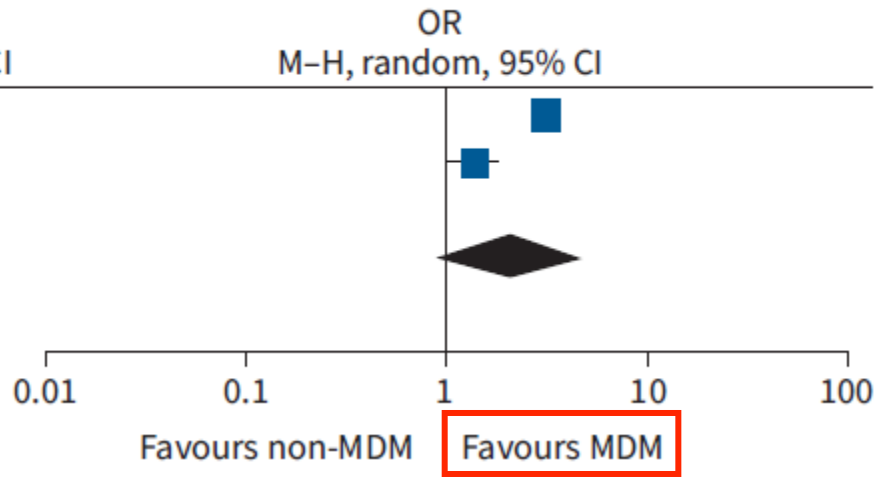
| Study or subgroup | Experimental Events | Experimental Total | Control Events | Control Total | Weight | OR M–H, random, 95% CI |
|---|---|---|---|---|---|---|
| Freeman, 2015 | 1127 | 6627 | 398 | 6627 | 51.4% | 3.21 (2.84–3.62) |
| Lin, 2022 | 135 | 5900 | 63 | 3728 | 48.6% | 1.36 (1.01–1.84) |
| Total (95% CI) | | 12527 | | 10355 | 100.0% | 2.11 (0.91–4.89) |
| Total events | 1262 | | 461 | | | |

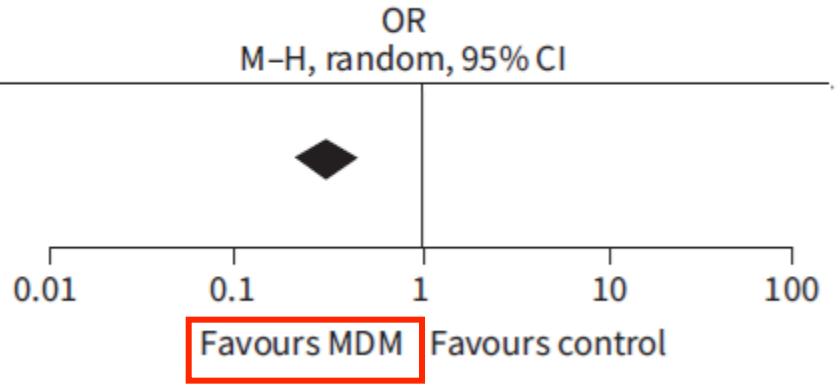
Heterogeneity: $Tau^2$=0.35; $Chi^2$=26.69, df=1 (p<0.00001); $I^2$=96%
Test for overall effect: Z=1.75 (p=0.08)




e) No active treatment

| Study or subgroup | Experimental Events | Experimental Total | Control Events | Control Total | Weight | OR M–H, random, 95% CI |
|---|---|---|---|---|---|---|
| Total (95% CI) | | 2321 | | 5736 | 100.0% | 0.32 (0.21–0.50) |
| Total events | 268 | | 1478 | | | |

Heterogeneity: $Tau^2$=0.18; $Chi^2$=22.44, df=4 (p=0.0002); $I^2$=82%
Test for overall effect: Z=5.12 (p<0.00001)
Test for subgroup differences: $Chi^2$=6.72, df=1 (p=0.010); $I^2$=85.1%



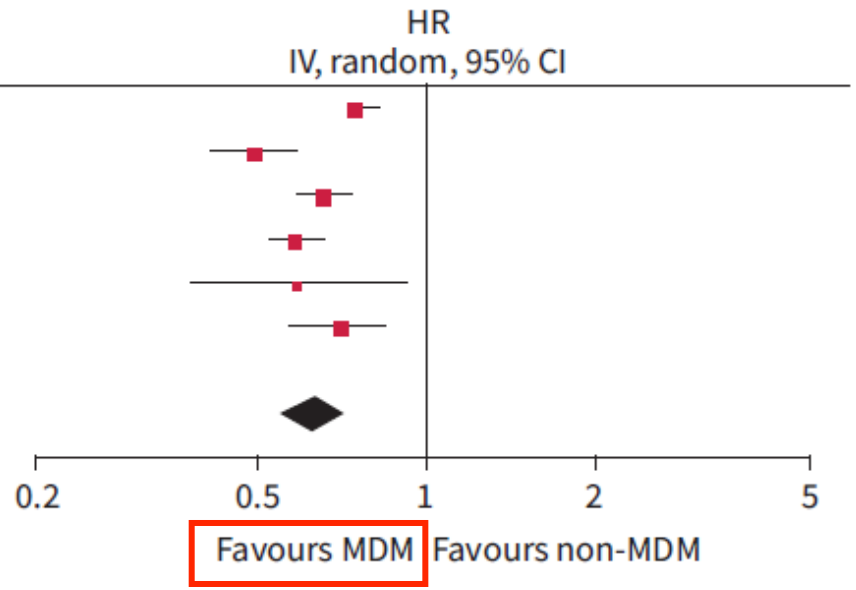

Eur Respir Rev 2024; 33: 230157

# Multidisciplinary meeting review in NSCLC

a) Overall survival HR

| Study or subgroup | log(HR)±SE | Weight | HR IV, random, 95% CI |
|---|---|---|---|
| Lin, 2022 | −0.2877±0.028 | 21.6% | 0.75 (0.71–0.79) |
| Pan, 2015 | −0.7133±0.0909 | 16.4% | 0.49 (0.41–0.59) |
| Ray, 2021 metropolitan | −0.4308±0.0581 | 19.5% | 0.65 (0.58–0.73) |
| Ray, 2021 regional | −0.5447±0.0557 | 19.7% | 0.58 (0.52–0.65) |
| Rogers, 2017 | −0.5276±0.2245 | 7.0% | 0.59 (0.38–0.92) |
| Stone, 2018 | −0.3567±0.0959 | 15.9% | 0.70 (0.58–0.84) |
| Total (95% CI) | | 100.0% | 0.63 (0.55–0.72) |

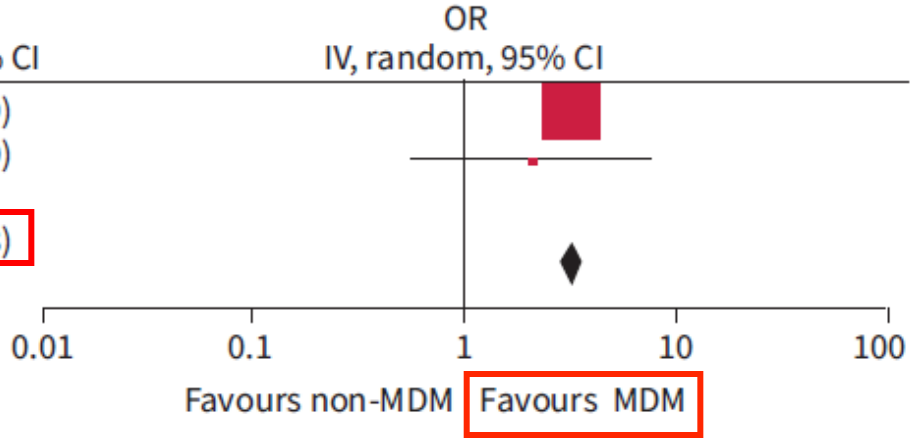
Heterogeneity: $Tau^2$=0.02; $Chi^2$=34.27, df=5 (p<0.00001); $I^2$=85%
Test for overall effect: Z=6.49 (p<0.00001)




b) 1-year survival

| Study or subgroup | log(OR)±SE | Weight | OR IV, random, 95% CI |
|---|---|---|---|
| Bilfinger, 2018 | 1.1781±0.0657 | 99.1% | 3.25 (2.86–3.69) |
| Bydder, 2009 | 0.734±0.6802 | 0.9% | 2.08 (0.55–7.90) |
| Total (95% CI) | | 100.0% | 3.23 (2.85–3.68) |

Heterogeneity: $Tau^2$=0.00; $Chi^2$=0.42, df=1 (p=0.52); $I^2$=0%
Test for overall effect: Z=17.95 (p<0.00001)

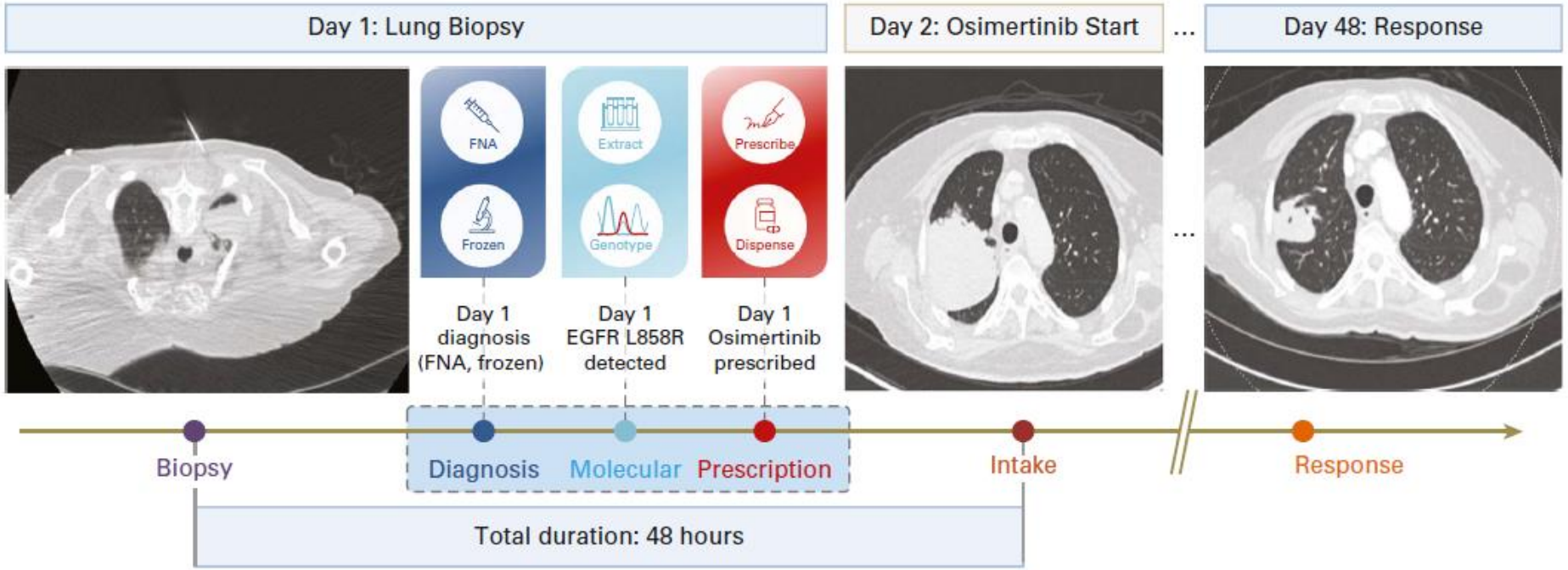



Eur Respir Rev 2024; 33: 230157

# Expanding MDT in Pre-diagnostic Care of Lung Cancer

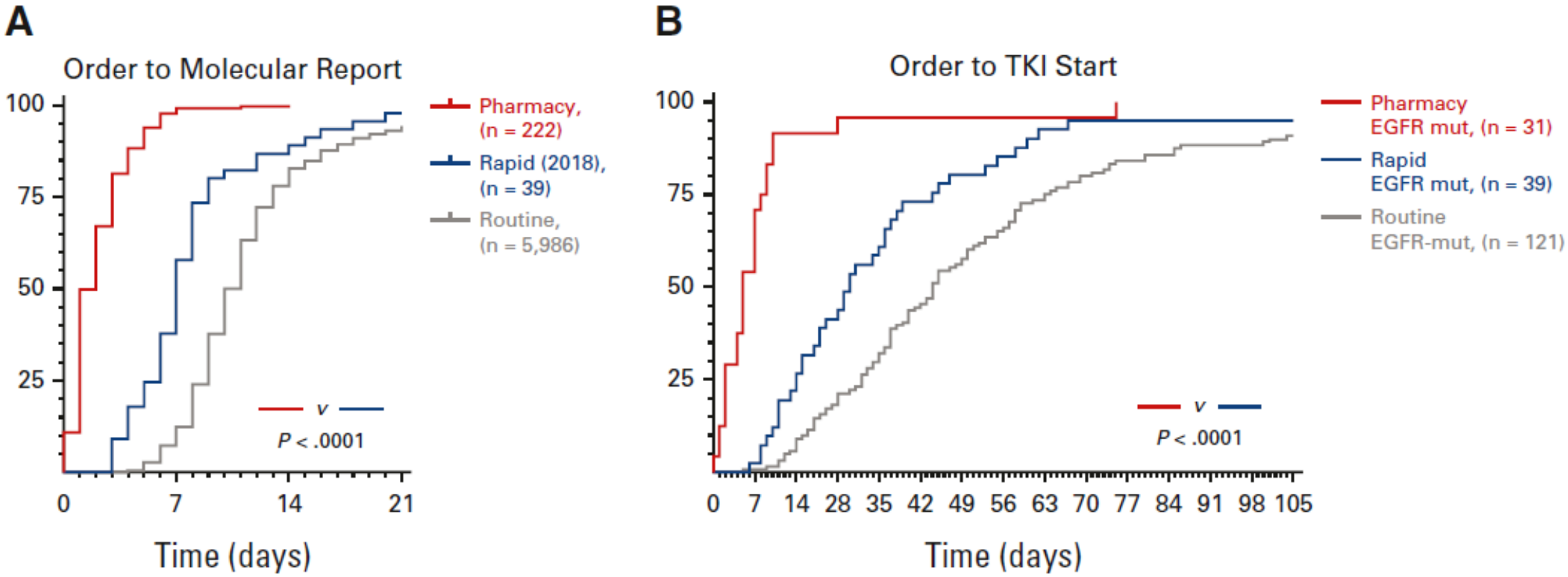
- ***Integrated Radiology, Pathology, and Pharmacy Program*** to minimize delays in initiating osimertinib.
- Parallel workflows (interventional radiology, surgical pathology, and early pharmacy engagement)
- Between January 2020 and December 2021, 222 patients participated in the intervention.
- The median turnaround time from biopsy to EGFR results was <u>1 workday</u>

Boston, MA.




JCO Oncol Pract 2023;19(9):786-792

# Expanding MDT in Pre-diagnostic Care of Lung Cancer




| | integrated pharmacy | rapid EGFR | routine NGS using FFPE |
|---|---|---|---|
| EGFR results | 1 day | 7 days | 11 days |
| median time to treatment | 5 days | 23 days | 37 days |

JCO Oncol Pract 2023;19(9):786-792

# Today

- What is MDT?
- The benefits of MDT approach
- Real case discussed at MDT
- Role of pulmonologist at MDT

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- ➢ N2 disease
- ➢ Double primary vs. metastasis
- ➢ M1 lesion

# Today

Session II. Recent advances in Lung Cancer Treatment

4. The evolving combination treatment landscape of advanced EGFR-mutant NSCLC - 김수한(부산의대 내과)

5. Optimal treatment options in unresectable stage III NSCLC - 김인애(건국의대 내과)

6. Updated treatment strategies in SCLC - 박승용(전북의대 내과)

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➢ N2 disease

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# ChatGPT

what is role of pulmonologist at MDT in the treatment of lung cancer?

The **pulmonologist** plays a *central role* in the **multidisciplinary team (MDT)** for lung cancer care, especially in the **diagnosis**, **staging**, and **management planning**. Here's a clear breakdown of their key responsibilities:

1. Diagnostic Evaluation
2. Staging
3. MDT Collaboration

- ➢ Helps determine if the patient is surgical candidate, needs CTx or palliative care
- ➢ Advises on fitness for invasive procedures and pulmonary function

4. Pulmonary Optimization & Support
5. Patient Counseling

- ➢ Manages underlying lung disease to optimize patient for surgery or treatment.
- ➢ Provides pre-op pulmonary evaluation
- ➢ Monitors and treats complications like pneumonitis or airway obstruction.

# Today

- What is MDT?
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- Role of pulmonologist at MDT

- ➢ MDT among different HC professionals
- ➢ MDT with interventional pulmonologist
- ➢ Role of pulmonologist in MDT

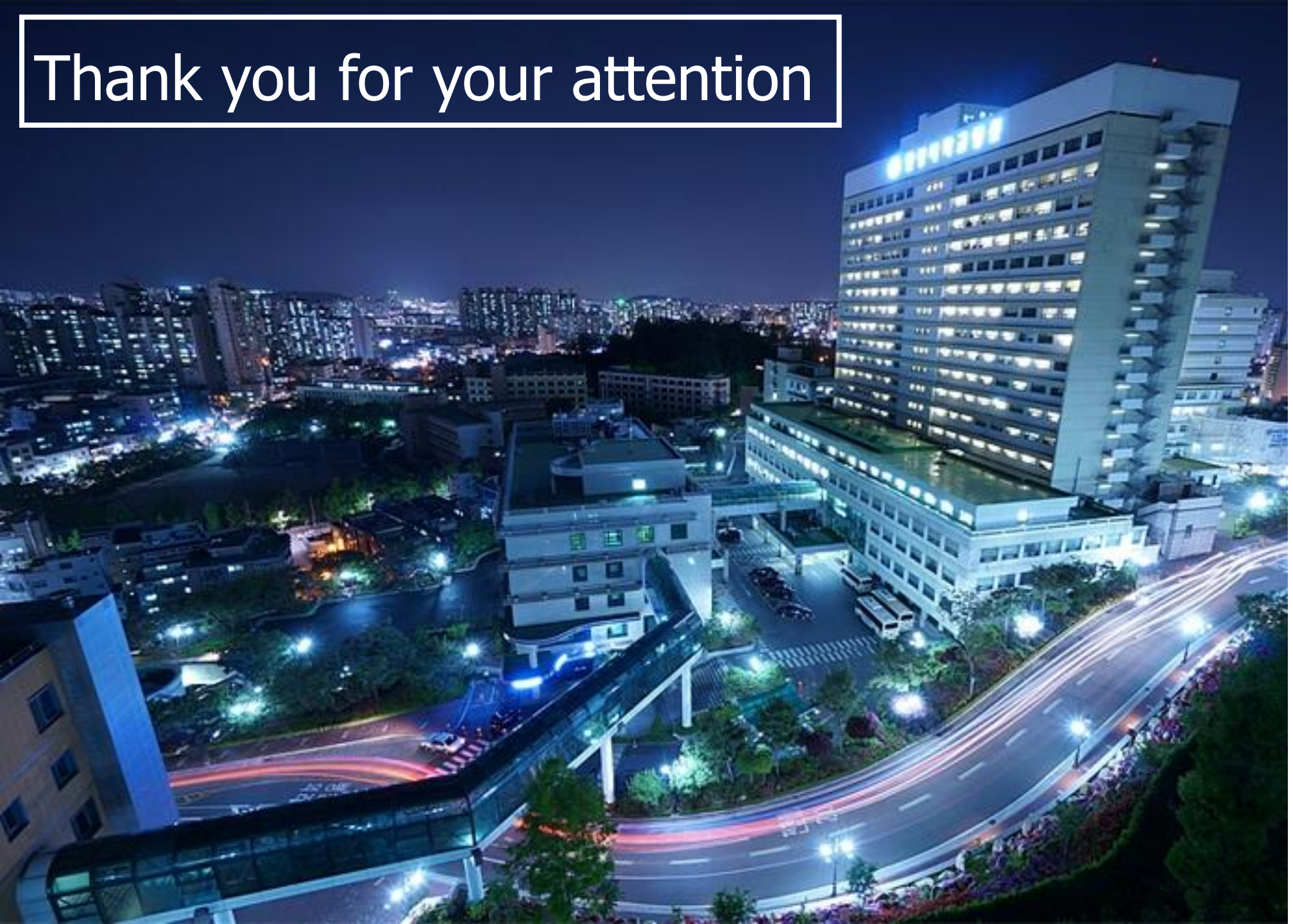
# What is MDT?

- **MDT (Multidisciplinary Team)** in lung cancer

- is a group of healthcare professionals from different specialties who collaborate to plan and deliver the best possible care for a patient with lung cancer.

- Purpose of the MDT
  - Accurate diagnosis and staging
  - Individualized treatment planning
  - Shared decision-making
  - Coordinated, patient-centered care
  - Improved outcomes and quality of life

# Thank you for your attention



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