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Second Opinions in Prostate Cancer

By Chuck Dinerstein, MD, MBA — November 7, 2016

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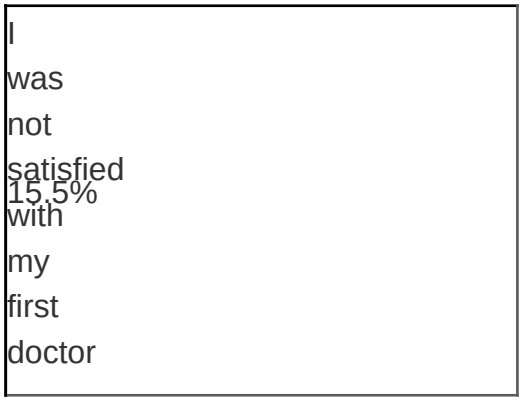
This morning Archana Radhakrishnan et al. from Johns Hopkins and the University of Pennsylvania, published a paper [1] in Cancer on who and why patients seek second opinions on prostate cancer. Despite recommendations from both the National Cancer Institute and the American Cancer Society for cancer patients to seek second opinions regarding treatment, there is little substantive medical literature on the behavior surrounding second opinions.

The Findings

- 4676 men identified diagnosed with localized prostate cancer and in the Pennsylvania Cancer Registry within the greater Philadelphia region were mailed surveys along with nominal payment for their completion. 51.1% (2386) responded.
- The majority of respondents were Caucasian, privately insured and with some college education or higher. The majority had lower risk tumors and clinical staging of 1
- 40% sought second opinions with about half having more than one reason

I wanted more information about my cancer	50.8%	
	I wanted to be seen by the best doctor I could	46.3%
	I was encouraged by a family member or friend to get a second opinion	31%
	I wanted to find out about a treatment my first doctor didn’t offer	25%



- Men seeking second opinions tended to be younger and better educated citing the need for more information as their reason. Younger men also sought the ‘best’ doctor.
- About 80% received ‘definitive treatment’ (radical prostatectomy or radiation therapy) the second opinion did not alter this percentage and was not associated with “receiving surgery.”

The Discussion

- “It is noteworthy that certain motivations for seeking second opinion – wanting more information, wanting the best doctor, or receiving encouragement from friends/family – were actually associated with higher rates of surgery. Our results suggest that second opinions may be common in prostate cancer; *however, the extent to which they promote delivery of high-value care remains less clear.* [Italics added]
- “It is possible that these men obtained second opinions because they wanted or were encouraged to have surgery and wanted the best doctor to perform it. In this context, second opinions may sometimes function as a way to carry out a planned treatment, rather than a way to explore treatment options.”
- “second opinions, in and of themselves, may be insufficient to reduce overtreatment among this group.”
- “across different types of cancer, the motivations and context for seeking second opinions differ.”

Reflections

First, this is a welcome contribution to the literature that should develop if we, as physicians, are indeed focused on delivering patient-centered care. For the patients under consideration watchful waiting (observation), radiation therapy, surgery, and hormonal manipulation in various combinations are all considered acceptable treatment. That said, there seems to be a bias in the article, even if unstated; that second opinions will reduce the overuse of surgery and promote high-value care. I believe it is fair to point out that of the physician authors, one is a radiation oncologist, the rest internists.

As a surgeon, I have always been perplexed by why surgery, which is admittedly more invasive than medical management, was always couched as the aggressive, radical alternative; while medical management was posited as more deliberative and conservative. The author's state and I would agree that decisions about prostate cancer treatment are “preference-sensitive.” So their statement that second opinions ability “*promote delivery of high-value care remains less clear”* seems, at least to this surgeon, to cover an implicit bias that radiotherapy is the better option.

I found this article published in Urology from 1997, Comparison of perspectives on prostate cancer: analyses of survey data [2], another survey, this by telephone of 1000 patients who participated in a prostate cancer support group and a selection of urologists drawn from a marketing program. The demographics of the patient group was similar to those of the current study, white, educated and predominately with an early prostate disease. Nearly 80% of patients and urologists “prefer aggressive therapy” again posited as radical prostatectomy. But interestingly, while both groups focused on the efficacy of treatment, their definitions were quite different. “Patient goals with therapy included preservation of quality of life (45%), extension of life (29%), and delaying disease progression (13%), whereas physicians overwhelmingly focused on treatment efficacy (86%) [extension of life], with side effects (43%) and costs (29%) being secondary considerations.” The other interesting, but not surprising finding from this paper is that recall of the therapeutic discussion was markedly different for these groups. “Whereas almost 100% of physicians stated that they always discussed important considerations such as options for no therapy, life expectancy with and without therapy, patient preferences, costs, and changes in sexual function, only about one-fifth of patients recalled similar discussions.”

As a vascular surgeon I have had to deliver bad news, diagnostic or treatment information that is devastating to the patient, often to the physician, but that requires further action. I have seen the discussion end with the delivery of bad news, even though the doctor, patient, and family continue talking for 15 or 20 minutes. The cognitive processing stops. Perhaps, the second opinion serves the need that a second discussion would provide, a chance to catch one’s breath, refocus on what is important, and then make a choice from the available options.

When my patient's faced difficult decisions, I encouraged them to involve their family in the decision-making process and to get a second opinion. The recommendation served two important purposes. First, it eliminated the concern that I would be hurt or offended if they sought other views - it opened the door, second and more importantly, it assured me that when the patient returned for surgical care, they would be more confident in the decision and their upcoming surgery. Consider it superstition or experience, but the hesitant, unprepared patient doesn't fare as well and requires a lot more time and care.

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[1] http://doi.wiley.com/10.1002/cncr.30412
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