Pan Birmingham NHS
Cancer Network

Guidelines for Management of Renal Cancer

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Changes Between Versions 2 and 3

Section 5 – updated bullets 5.3 and 5.4
Section 6 – updated bullet 6.1.2
Section 7 – updated bullet 7 (d)
Section 8 – updated bullet 8.1
Section 10 – updated
Section 11 – updated
Section 13 – updated

ENDORSED BY GOVERNANCE COMMITTEE

1. Scope of the guideline

This Guidance has been produced to support:

a) the management of patients presenting with symptoms suspicious of renal cancer
b) the management of patients found to have renal cancer

2. Guideline background

2.1 These guidelines are based on the referral guidelines for suspected cancer[1] (www.dh.gov.uk), Improving Outcomes for Urological Cancer – Manual[2] (www.nice.org.uk) and the European Association of Urology (EAU) Clinical Guidelines[3] (www.uroweb.org). They have been written by the Pan Birmingham Urology Network Site Specific Group (NSSG) which consists of local urology teams based at University Hospital Birmingham (UHBFT), Sandwell and West Birmingham (SWBHT), Heart of England (HEFT) and Good Hope Hospital (GHH).

Guideline statements

3. Referral from GPs

3.1 Patients with suspected urological cancer should be referred from GPs to local urology units according to the NICE referral guidelines[1].

3.2 Referrals deemed inappropriate by consultant urologists will be notified to the referring GP and to the relevant Commissioner according to agreed protocols to improve the quality of future referrals.

3.3 GPs will be notified of the diagnosis of cancer within 24 hours of the diagnosis being made, and will be kept informed of all aspects of the patients care at all times.

4. Multi disciplinary teams (MDTs)

Each team will hold regular MDT meetings. All patients with proven urological malignancy will be discussed by a MDT. Normally this will be the local MDT in the first instance, and the overall responsibility for the patient's management rests with the local MDT until referral has been agreed.

5. Referral

5.1 The most common presentation of renal cancer is haematuria, which should be referred as a 2 week wait. Local units should offer a haematuria clinic appointment to these patients.

5.2 Patients may also present with loin pain and/or a loin mass. In such cases a urinary tract ultrasound scan should be performed to confirm or exclude a diagnosis of renal cancer.

5.3 2 week wait referrals should be made:

a) in all adult patients of any age who present with visible haematuria
b) in all adult patients age 40 years and older who present with recurrent or persistent urinary tract infection associated with haematuria
c) in patients aged 50 years and older who are found to have unexplained non-visible haematuria (if under 50, assuming there is no proteinuria or raised creatinine, a non-urgent referral should be made)
d) in patients in whom ultrasound scanning reveals a solid renal mass suggestive of malignancy

5.4 Note: In all patients with symptoms suggestive of urinary infection who present with visible haematuria, investigations should be undertaken to diagnose and treat the infection before consideration of referral. If infection is not confirmed the patient should be referred urgently.

5.5 Patients with persistent loin pain *without* ultrasound confirmation of a renal mass, or with an ultrasound suggesting of benign cystic disease, do not merit urgent referral, but may be referred to a general urology clinic as a matter of routine. Patients with acute loin pain should have a CT KUB as this is the most accurate investigation and with a low dose technique.

6. Diagnosis and staging

6.1 Confirmation of diagnosis should be made by ultrasound scanning if not already performed, followed by CT (abdomen and thorax). Assessment should be made of the size and nature of the mass, the presence of tumour in the renal vein and IVC, the status of the para-aortic lymph nodes and the presence of metastatic disease. The thorax should routinely be scanned. In addition an assessment should be made of the nature and function of the contralateral kidney for second tumours and other disease. If there is doubt about the relative contribution to function of each kidney a DMSA renogram is appropriate.

6.1.1 Blood tests to exclude anaemia, polycythaemia and hypercalcaemia should be performed.

6.1.2 Renal biopsy is not normally performed, but may be indicated in selected cases where there is doubt about the radiological diagnosis or those to be treated by medical therapies. However consideration should be given to the action which might be taken in the event of a negative biopsy.

7. Management of primary tumour - nephrectomy

Localised disease

7.1 The mainstay of treatment is radical nephrectomy, which is normally performed by the local urology team:

a) laparoscopic radical nephrectomy is the first choice for Renal Cell Carcinoma (RCC) provided there is no evidence of local spread
b) for larger tumours open radical nephrectomy remains as the mainstay of treatment
c) in smaller tumours consideration should be given to either nephrectomy or to partial nephrectomy (open or laparoscopic) (see also below)
d) in selected patients with tumours of 4cm or less, consideration should be given to ablative therapies

Advanced localised disease

7.2 If the tumour is seen to invade the IVC the patient should be referred to the specialist urological MDT for nephrectomy. For tumours extending above the diaphragm the cardiac surgical team based at UHBFT will need to be involved. Large tumours considered inoperable by the local team should be referred to a specialist urological MDT at either HEFT or UHBFT for a further opinion before surgery is ruled out. In these cases pre-operative tumour embolisation may be appropriate.

8. Small tumours, bilateral tumours and tumours in single kidneys

8.1 These are normally treated by partial nephrectomy. However consideration should be given to ablative therapies, which is available at the specialist centres (HEFT, UHBFT and SWBHT).

8.2 In smaller tumours of 4cm or less, in selected patients radio frequency ablation (RFA) remains an option in line with MDT discussion.

9. Advanced inoperable disease

Radiotherapy and/or embolisation may be appropriate in cases where either pain or haematuria are significant.

10. Metastatic disease

The removal of the primary renal tumour (cytoreductive nephrectomy) followed by systemic therapy should be considered in selected patients with metastatic disease and good performance status. The cytoreductive nephrectomy may result in a symptomatic benefit and is associated with a small chance of spontaneous regression of metastases (less than 1%). However the impact of the cytoreductive nephrectomy on the survival of patients with metastatic disease and suitable to VEGF targeted treatment is still not known. Two randomised clinical trial are currently addressing this question.

11. Adjuvant treatment

11.1 There is currently no evidence that renal cancer patients who have undergone radical surgery with no metastatic disease present will benefit from adjuvant treatment in terms of disease free survival and overall survival. Therefore adjuvant treatment should not be offered outside of approved clinical trials.

12. Follow up

12.1 Follow up is the responsibility of the team that managed the primary treatment. If the patient has been referred for primary treatment to a specialist team, follow-up by the referring team might be appropriate at a later date if both teams and the patient are in agreement. Long-term follow-up in primary care is appropriate if the patient‘s condition is stable.

12.2 Most patients will require the following follow up, however it is recognised that those with a high risk of recurrence may require more frequent monitoring.

a) at 3, 6 and 12 months for the first year
b) annually thereafter for 5 years

12.3 Follow-up for patients with advanced or metastatic disease

a) these patients will require an individual approach to follow-up, with referral to palliative care teams as required

13. Recurrent\progressive\metastatic disease

13.1 NICE or Pan Birmingham formulary approved drugs should be used first line for metastatic disease, in line with appropriate guidance. Drug funded via the Cancer Drug Fund (CDF) should also be considered when clinically indicated and within the relevant CDF policy.

13.2 Both Sunitinib and Pazopaninb are approved by NICE for treatment naive patient with metastatic or advanced renal cell carcinoma and ECOG performance status 0-1. Clinical trial data have shown Sunitinib and Pazopanib prolong progression free survival when compared with interferon alpha (Sunitinib)[3] or placebo (Pazopanib)[4] and should be offered to newly diagnosed patients. A clinical trial comparing Sunitinib with Pazopanib has recently been completed but the results are not yet available. Until then it is up to the MDT to decide which drug is more appropriate on a case by case basis.

13.3 Everolimus has been approved by the West Midlands Cancer Drugs Fund panel for funding from the CDF for patients who have failed one previous vascular endothelial growth factor targeted therapy and have a Karnofsky performance status ≥ 70 (CDF policy WM/CDF/2).

13.4 Temsirolimus has been approved by the West Midlands Cancer Drugs Fund panel for funding from the CDF for patients with poor prognosis for whom Sunitinib is unsuitable. Poor prognosis criteria must be fulfilled for funding (CDF policy WM/CDF/22).

13.5 Pazopanib has been approved by the West Midlands Cancer Drugs Fund panel for funding from the CDF for patients who are unable to tolerate Sunitinib. Patients must have received Sunitinib within the NICE TA 169 and have an ECOG performance status 0-1 (CDF policy WM/CDF/25).

14. Patient information and counselling

14.1 All patients will be given access to appropriate written information during their investigation and treatment, and on diagnosis will be given the opportunity to discuss their management with a clinical nurse specialist who is a member of the relevant MDT. The patient should have a method of access to the urology team at all times.

14.2 Access to psychological counselling will be available if required. All patients should undergo a Holistic Needs Assessment and onward referral as required.

15. Palliative care

Palliative care services will be made available to all patients as deemed appropriate by the MDT.

16. Clinical trials

16.1 Wherever possible, patients who are eligible should be offered the opportunity to participate in National Institute for Health Research portfolio clinical trials and other well designed studies.

16.2 Where a study is only open at one Trust in the Network, patients should be referred for trial entry. A list of studies available at each Trust is available from Pan Birmingham Cancer Research Network. Email: PBCRN@westmidlands.nhs.uk .

16.3 Patients who have been recruited into a clinical trial will be followed up as defined in the protocol.

17. Staging

17.1 Staging data for 70% of all cancers (90% of stageable cancers) should be collected electronically and transferred to the West Midlands Cancer Intelligence Unit (WMCUI).

17.2 All Trusts

a. the Trust should send electronic extracts from their histopathology system regularly to the WMCIU
b. the Trust should send imaging extracts for cancer patients electronically to the WMCIU regularly, who have established remote access for the WMCIU to their radiology information system

17.3 For cancers diagnosed clinically or those that have not had surgery

a. Clinical TNM stage should be recorded on the MDT database

17.4 For those with invasive cancer who have had surgery

a. MDTs should record the full cancer registry dataset onto their MDT database at the time of discussion at the MDT meeting and send extracts to the WMCIU on a regular basis

Monitoring of the guideline

Adherence to the Network guidelines may from time to time be formally monitored.

References

1. National Institute for Health and Clinical Excellence (2005). Referral guidelines for suspected cancer. http://www.nice.org.uk/pdf/cg027niceguideline.pdf
2. Improving Outcomes for Urological Cancer - Manual (www.nice.org.uk)
3. European Association of Urology (EAU) Clinical Guidelines (www.uroweb.org).
4. Motzer, R.J., et al., Sunitinib versus interferon alfa in metastatic renal-cell carcinoma. N Engl J Med, 2007. **356**(2): p. 115-24
5. Sternberg, C.N., et al., Pazopanib in locally advanced or metastatic renal cell carcinoma: results of a randomized phase III trial. J Clin Oncol, 2010. **28**(6): p. 1061-8

Authors of Versions 1 and 2

Mike Foster	Consultant Urologist
Dev Sarmah	Consultant Urologist
Emilio Porfiri	Consultant Medical Oncologist
Lara Barnish	Project Lead

Authors of Version 3

Rupesh Bhatt	Consultant Urologist
Emilio Porfiri	Consultant Medical Oncologist

Approval Signatures

Pan Birmingham Cancer Network Governance Committee Chair

Name: Karen Deeny

Signature:  Date: July 2012

Pan Birmingham Cancer Network Manager

Name: Karen Metcalf

Signature:  Date: July 2012

Urology Network Site Specific Group Chair

Name: Rupesh Bhatt

Signature: Date: July 2012

ENDORSED BY GOVERNANCE COMMITTEE