NHS England

Guidelines for the Management of Renal Cancer

West Midlands Expert Advisory Group for Urological Cancer

West Midlands Clinical Networks and Clinical Senate

Coversheet for Network Expert Advisory Group Agreed Documentation

This sheet is to accompany all documentation agreed by the West Midlands Strategic Clinical Network Expert Advisory Groups. This will assist the Clinical Network to endorse the documentation and request implementation.

EAG name	Urological Cancer Expert Advisory Group	
Document Title	Guidelines for the management of renal cancer	
Published date	December 2016	
Document Purpose	• The referral of patients presenting with symptoms suspicious of renal cancer. • The management of patients with renal cancer.	
Authors		
References		
Consultation Process	Guidelines drawn up as result of Urology workshop March 2016 with opportunity for comment via e-mail post workshop.	
Review Date (must be within three years)	December 2019	
Approval Signatures:	**EAG Chair** 	**Network Clinical Director** 

Guidelines for the management of renal cancer

1. Scope of the Guideline

This Guidance has been produced to support the following:

The management of patients with symptoms suspicious of Renal Cancer.
The management of patients found to have Renal Cancer.

2. Guideline Background

These guidelines are based on the NICE referral guidelines for suspected cancer (nice.org.uk/guidelines/ng12), Improving Outcomes for Urological Cancer – Manual (www.nice.org.uk) and the European Association of Urology (EAU) Clinical Guidelines (www.uroweb.org).

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

3.2 Referrals deemed inappropriate by consultant urologists will be notified to the referring GP and to the relevant PCT according to agreed protocols.

3.3 GPs should be notified of the diagnosis of cancer by the end of the next working day following the patient being informed of the diagnosis, and will be kept informed of all relevant aspects of the patients care.

4. Multidisciplinary Teams (MDTs)

4.1 Each team will schedule weekly MDT meetings.

4.2 All patients with proven urological malignancy will be considered by a MDT.

4.3 Normally this will be the local MDT in the first instance, and the overall responsibility for the patient's management rests locally until referral has been agreed and accepted.

5. Patient Information and Counselling

5.1 All patients should have 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 (CNS) who is a

member of the relevant MDT. The patient should have a defined method of access to the urology team, and will be informed of their key worker.

5.2 Access to psychological counselling should be available if required.

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

6. Clinical Trials

6.1 Trial entry should be considered wherever possible.

7. Screening

7.1 There is no formal screening programme for renal cancer. However many renal cancers now presenting are found on incidental ultrasound scanning of the abdomen

7.2 The West Midlands Regional Genetics Service (http://www.bwhct.nhs.uk/index/genetics-wmfacs-home.htm) are happy to advise patients referred with a history of close family members with:

- 2 or more close relatives with renal cell cancer
- Early onset RCC (<35 years)
- Bilateral multicentric RCC aged <50 years
- Single case of RCC and personal or family history suggesting a RCC susceptibility syndrome

8. Referral Guidelines

Many patients will present with an incidental renal mass on imaging.
Some patients present with haematuria
Patients may present with metastatic disease or paraneoplastic symptoms.

8.1 Suspected renal cancers will be referred urgently via the 2 week wait.

9. Staging

9.1 Patients with a lesion suspicious of cancer in the kidney require staging CT abdomen and thorax. Further imaging with MRI or bone scan may be required.

9.2 Biopsy is rarely indicated, but may be considered, after MDT discussion, if there is significant doubt over the diagnosis or appropriateness of definitive surgery.

10 Multidisciplinary Team

10.1 Patients should be discussed at the local MDT after the staging scans.

10.2 Patients being considered for nephron sparing surgery (NSS) should be discussed at specialist MDT

10.3 Patients with disease into the vena cava should be discussed at the specialist MDT

10.4 Extension to the level of the hepatic vessels or above should lead to MDT discussion about referral to a specialist team for resection with the support of the cardiac team – locally at University Hospital Birmingham

10.5 Patients with bilateral disease or who will require dialysis should be referred to the specialist MDT

11 Palliative care

11.1 Patients for palliative radiotherapy or systemic therapies or clinical trials should be referred to the appropriate oncologist.

12 Primary Treatment

12.1 Localised disease

12.1.1 Radical surgery can be performed as an open or laparoscopic procedure; laparoscopic surgery for T2 tumours is the standard of care – the option of laparoscopic surgery should be offered to all patients, where viable.

12.1.2 Nephron sparing surgery (partial nephrectomy) should be standard for T1a and T1b tumours if technically feasible

12.1.3 Observation may be appropriate for selected patients

12.1.4 Nephron sparing surgery should also be considered for the following:

- Tumours in solitary kidneys
- Patients with disease in the contralateral kidney
- Patients with congenital disease at higher risk of new tumours

This should be performed by the specialist team.

12.1.5 Patients unfit for surgery with symptoms from their renal cancer such as pain or gross bleeding may be considered for embolisation.

12.1.6 Image-guided percutaneous and minimally invasive techniques, e.g. percutaneous radiofrequency ablation (RFA) and cryotherapy have been suggested for patients unfit for or unwilling to have surgery. Indications include small renal cortical lesions in elderly patients, patients with genetic predisposition to multiple tumours, solitary kidney, or bilateral tumours.

Consideration may be given by the MDT to refer to a centre that can offer such treatment in selected cases

12.1.7 At present there is no evidence for the use of adjuvant therapy. Clinical trials should be considered.

12.2 Surgery for metastatic disease is rarely curative. However, there is some evidence of a survival benefit with a cytoreductive nephrectomy and it should therefore be considered at MDT discussion. Isolated metastases may be considered for metastasectomy as guided by the specialist MDT.

12.3 Radiotherapy for metastatic disease is effective for symptom control and should be considered

13 Systemic therapy for metastatic disease

13.1 Sunitinib and Pazopanib are NICE-approved standard first line therapies for good performance status patients. Temsirolimus and Everolimus are available via the West Midlands Cancer Drugs Fund for patients fulfilling the cohort policy definitions. Clinical trials should always be considered.

14 Follow-up

Follow up after surgery is dependent on risk of recurrence and fitness of patient for further intervention. Symptoms will trigger appropriate investigations.