Renal cancer in adults

Diagnosis, treatment and follow-up

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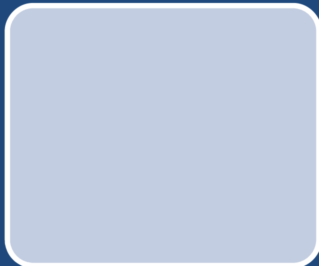
Background

- **Renal cancer in figures***

Men

- 1060 cases in 2012
- Age-standardized incidence: 15.8/100 000 per year



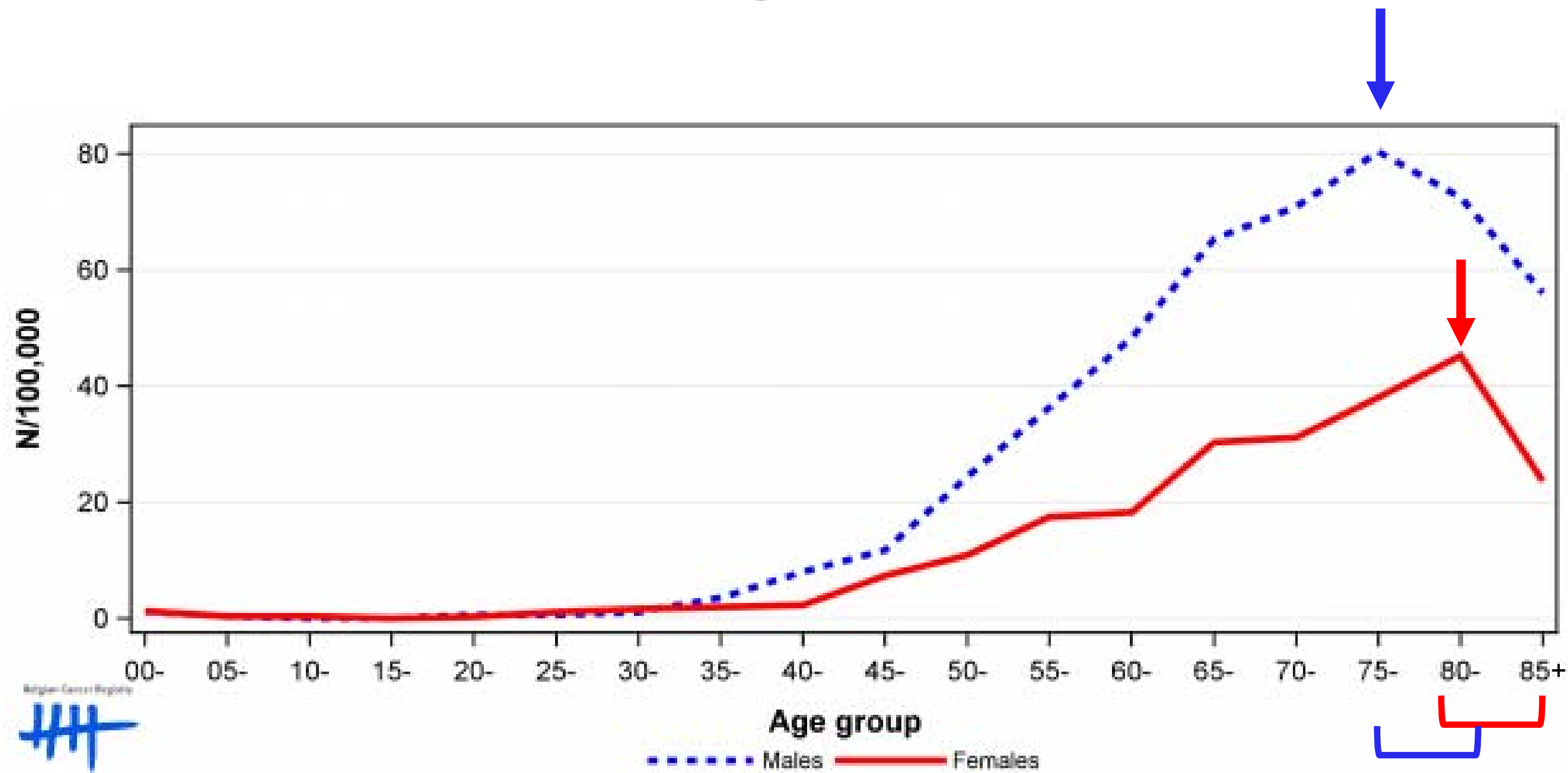
Women

- 600 cases in 2012
- Age-standardized incidence: 7.5/100 000 per year

* Belgian Cancer Registry

Background

- **Renal cancer in figures***



* Belgian Cancer Registry

Scope of the guideline

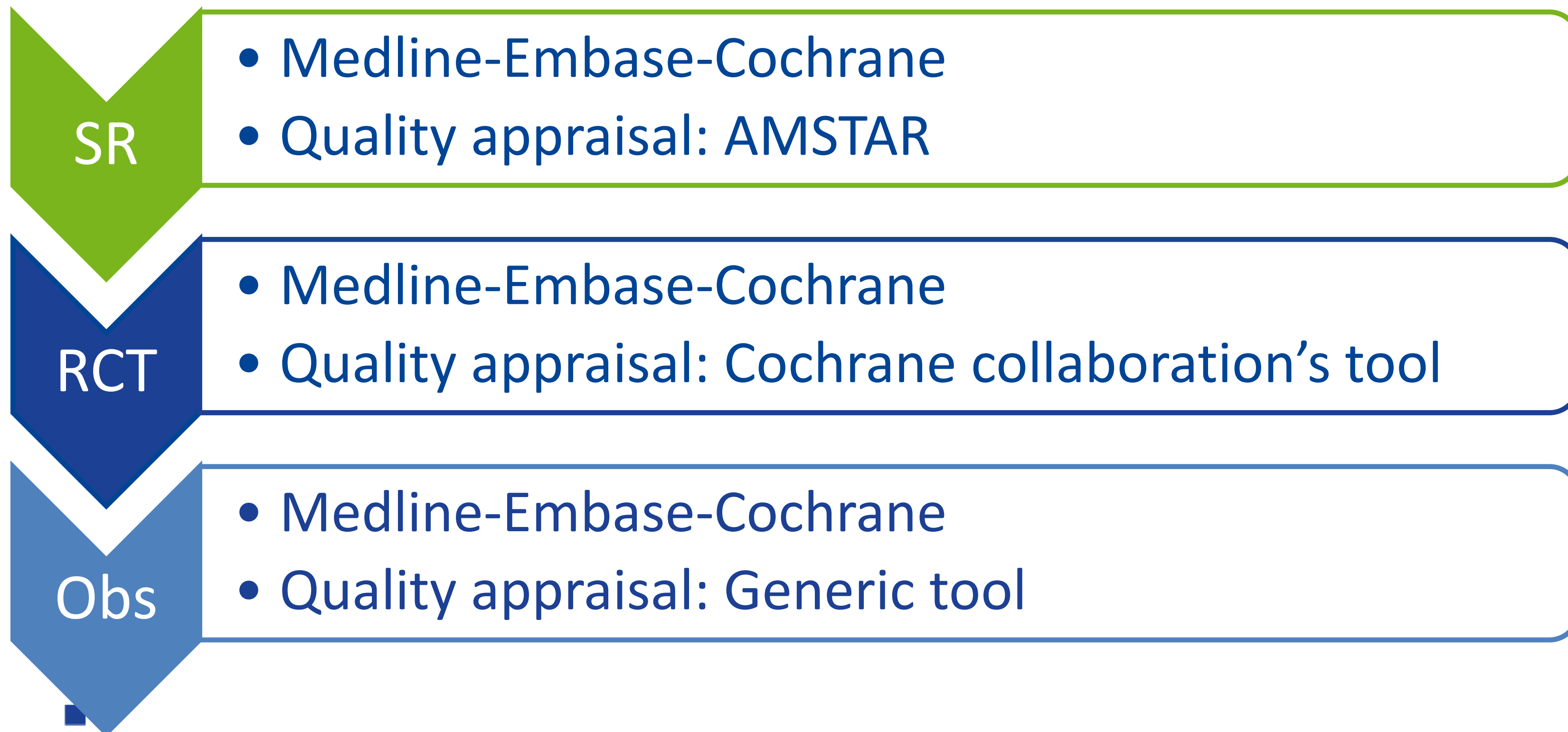
Methodology

- **23 questions to update**

Method	• Partial ADAPTE
Reference	• IKNL Niercelcarcinoom 2010 • AUA Follow-up for clinically localized renal neoplasms 2013 • EAU Guidelines on renal cell carcinoma 2014 update
Update	• Updated from search date on
GDG	• Online surveys & meetings

Methodology

- **1 full search question:** ***Long-term outcomes of partial nephrectomy (PN) and radical nephrectomy (RN) in localized tumour RCC***



Clinical recommendations

Diagnosis

Recommended

- CT or MRI
- CT thorax for tumour ≥ T2 or ≥ N1 or M1
- Biopsy before ablative or systemic therapy

Not Recommended

In routine

- Bone scan
- Brain imaging
- PET-CT

Best Practice

- Use the current TNM classification system
- Use grading systems and classification of renal cell carcinoma subtypes

Prognosis

Recommended

- TNM
- Nomogram
- Integrated prognostic system

Not Recommended

Molecular prognosis marker

Treatment

✓ Short life expectancy, frail patients (elderly)or comorbid patients

Recommended

→ If small masse(s), offer active surveillance

→ Otherwise, ablative therapy (radiofrequency ablation or cryotherapy)

Treatment

✓ Surgical patients

Recommended

T1-2 N0 M0

→ Laparoscopic partial nephrectomy in centres with laparoscopic expertise

→ If not technically feasible, laparoscopic radical nephrectomy in centres with laparoscopic expertise

→ Excision of caval thrombus + if supradiaphragmatic thrombus treatment centre with expertise in cardiopulmonary surgical-technical protocols

Recommended

≥ T2 or ≥ N1 or M1

→ Cytoreductive nephrectomy

Treatment

✓ Surgical patients

Not recommended

➔ Adjuvant therapy

➔ Radical nephrectomy when partial nephrectomy is feasible

➔ In routine

* Adrenal gland removal

* Lymph node dissection (except when clinically proven, for staging purpose or local control)

* Embolization

Treatment

✓ Patients non eligible for surgery

Recommended

Systemic treatment

→ *First-line therapy:*

ALL: Sunitinib, pazopanib LOW OR INTERMEDIATE RISK: Bevacizumab + IFN-α LOW RISK: Temsirolimus

→ *Second-line therapy*

ALL: Sorafenib AFTER CYTOKINES: Sorafenib, sunitinib or pazopanib AFTER VEGF-PATHWAY: Axitinib, Everolimus

→ *Third-line therapy*

ALL: Everolimus or sorafenib

Recommended

Palliative care:

→ Embolization

→ General recommendations (see KCE report 115B)

Treatment

✓ Patients non eligible for surgery

Not recommended

➔ *First-line therapy*

Cytokine agents

IFN-α

IL-2

Follow-up

Recommended

- ➔ ACTIVE SURVEILLANCE: CT or MRI within 6 months of initiation followed by imaging (US, CT or MRI) at least annually thereafter
- ➔ ABLATIVE THERAPY: CT or MRI +/- intravenous contrast at 3 and 6 months, followed by annual CT or MRI thereafter for 5 years
- ➔ LOW-RISK DISEASE (pT1, N0, Nx, M0; R0): no routine imaging follow-up
- ➔ MODERATE TO HIGH-RISK: baseline chest and abdominal scanning (CT or MRI) within 3 to 6 months following surgery with follow-up imaging (CT or MRI) every six months for at least three years and annually thereafter to 5 five

Patient support

Best Practice

→ The patient must have the opportunity to be fully informed about his condition, the treatment options, and consequences. Information should be correct, communicated in a clear and unambiguous way and adapted to the individual patient. Patient preferences should be taken into account when a decision on a treatment is taken. Special attention should be given to breaking bad news and coping with side effects.

→ Psychosocial support should be offered to every patient, from diagnosis on

Guideline

Implementation

Evaluation

Update guideline

Colophon

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