UCCH Pathway

UCCH Guideline
Renal Cell Carcinoma

2.03.01 Anlage 11

Version Jun/2021

Hubertus Wald Tumorzentrum
Universitäres Cancer Center Hamburg
Ein Kompetenznetzwerk des UKE

Guideline Renal Cell Carcinoma

Version 07, Jun/2021

according to TNM classification 8th edition

Renal Cell Carcinoma board members

G. von Amsberg (Med. Oncology)
S. Minner (Pathology)
C. Reimer (UCCH)
M. Rink, C. Meyer (Urology)
U. Göbel (patient representative UCCH)

Responsible author	G. von Amsberg (Med. Oncology)/ M. Rink (Urology)
Implemented	Sep/2009
Revised	Jul/2012, Jul/2014, Mar/2016, June/2018, Feb/2019, Jun/2021
Next planned review	Jun/2023

Legend of Colours

= Therapeutic procedure

= Clinical or diagnostical condition

= Diagnostic procedure

= Clinical trial

= Supportive measure

= Referral

= Tumorboard (including post tumorboard interaction with patient that follows the principles of shared decision-making)

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Pathway: Renal Cell Carcinoma

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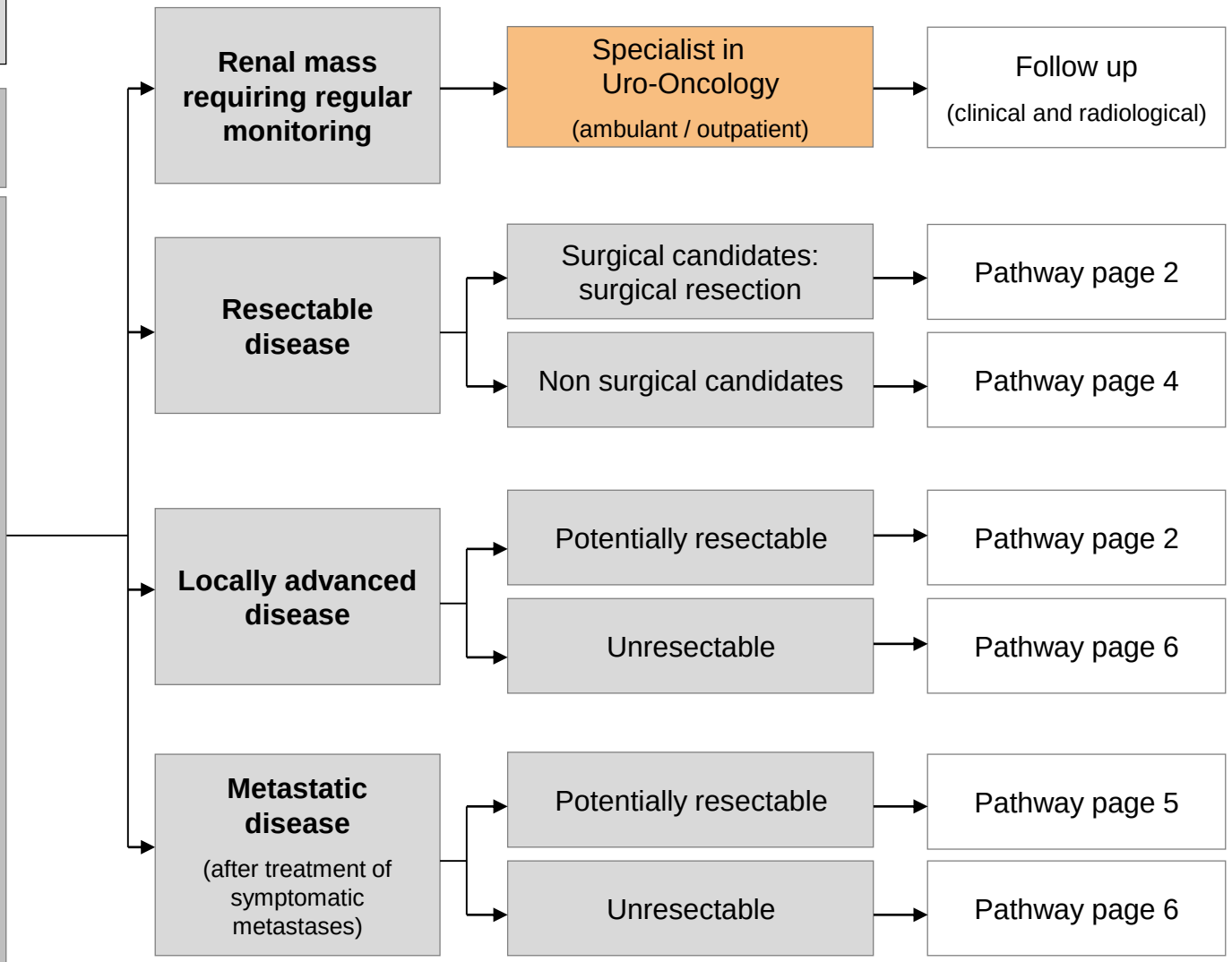
Renal mass suspicious for RCC

Work up

(via outpatient consultation of UKE-Urology)

- Baseline:
  - Physical exam
  - Lab exam
  - Re-evaluation of third party radiological findings / implementation of additional imaging (MRI/ Bx)
  - CT (MRI) scan abdomen
- Facultative:
  - Chest x-ray
  - CT chest (in case of malignant pathology)
- In case of suspected metastases:
  - Bone scan
  - CT/MRI head
- In case of uncertain dignity, primary metastatic disease or before starting systemic therapy
  - Fine needle biopsy
- Supportive:
  - Offer contact to self help group
  - Offer psychooncological support



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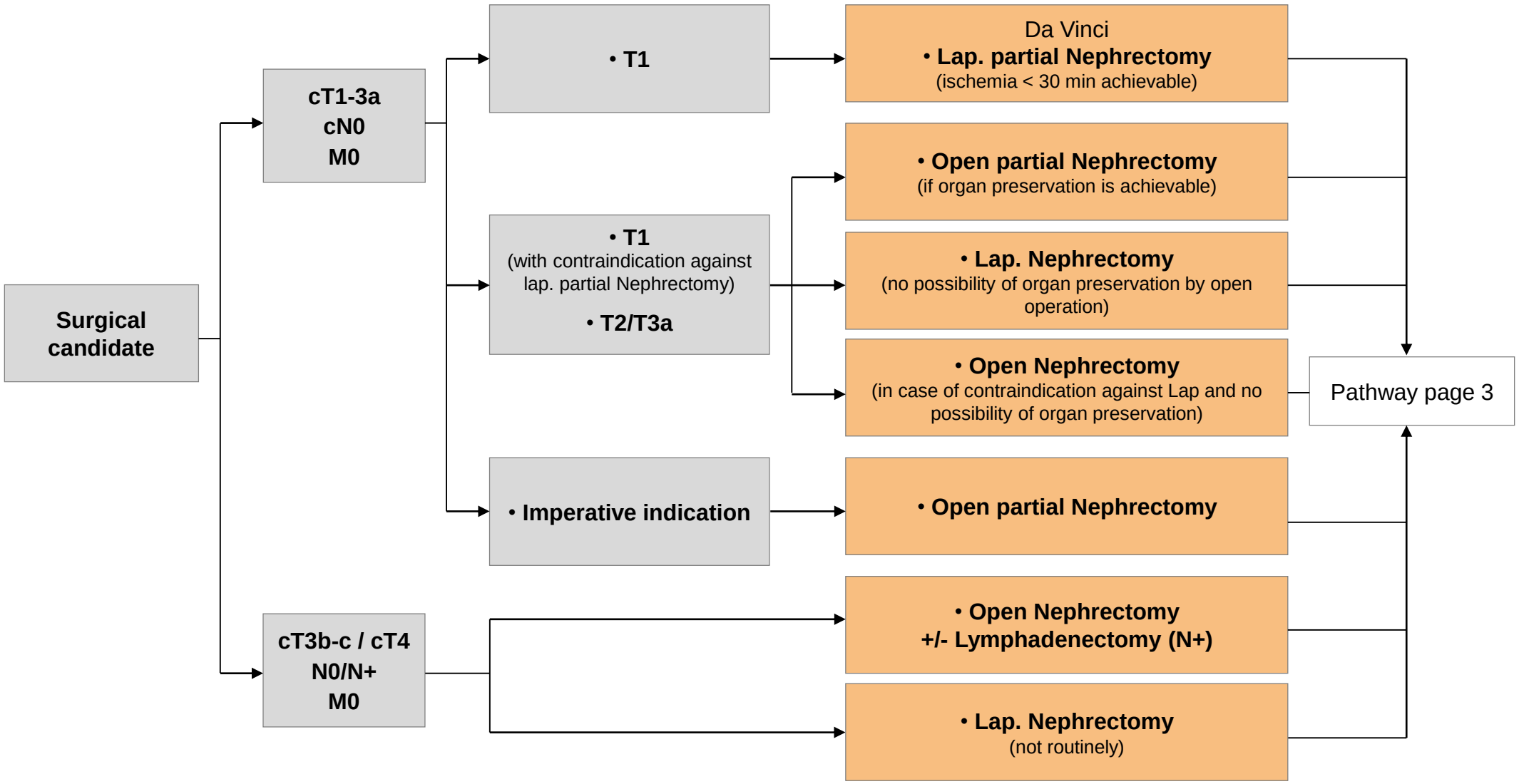
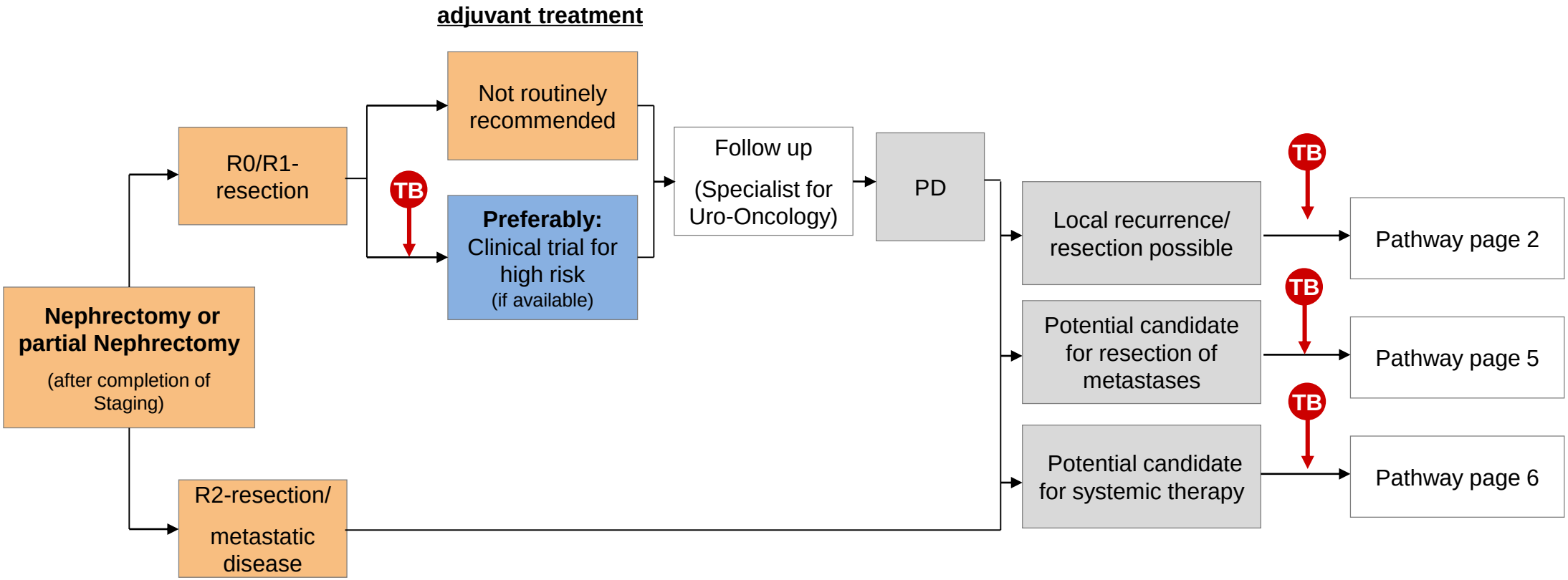
Pathway page 2: Surgical resection

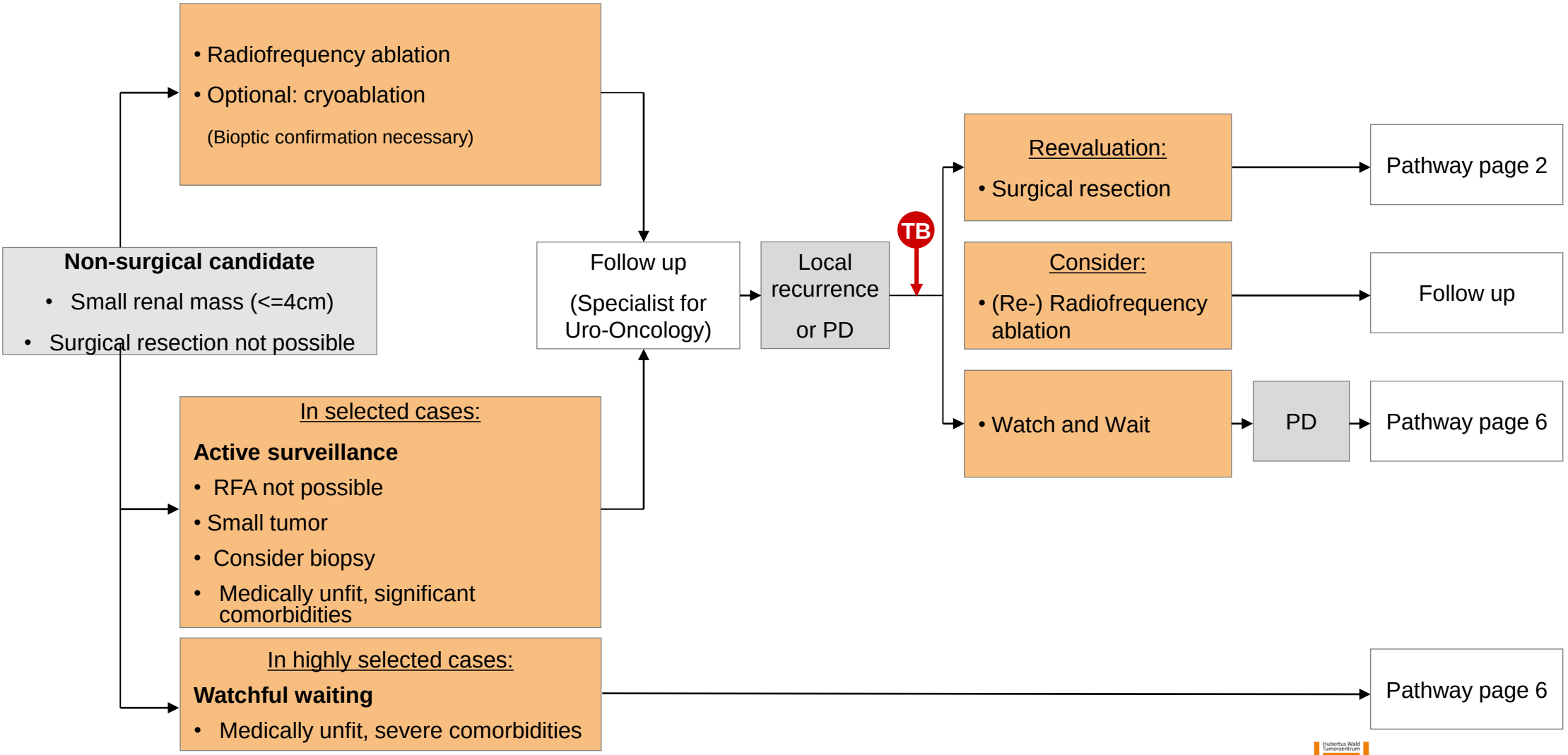


Pathway page 3: Surgical resection (continuation)



PD Progressive Disease

Pathway page 4: Non-surgical candidates



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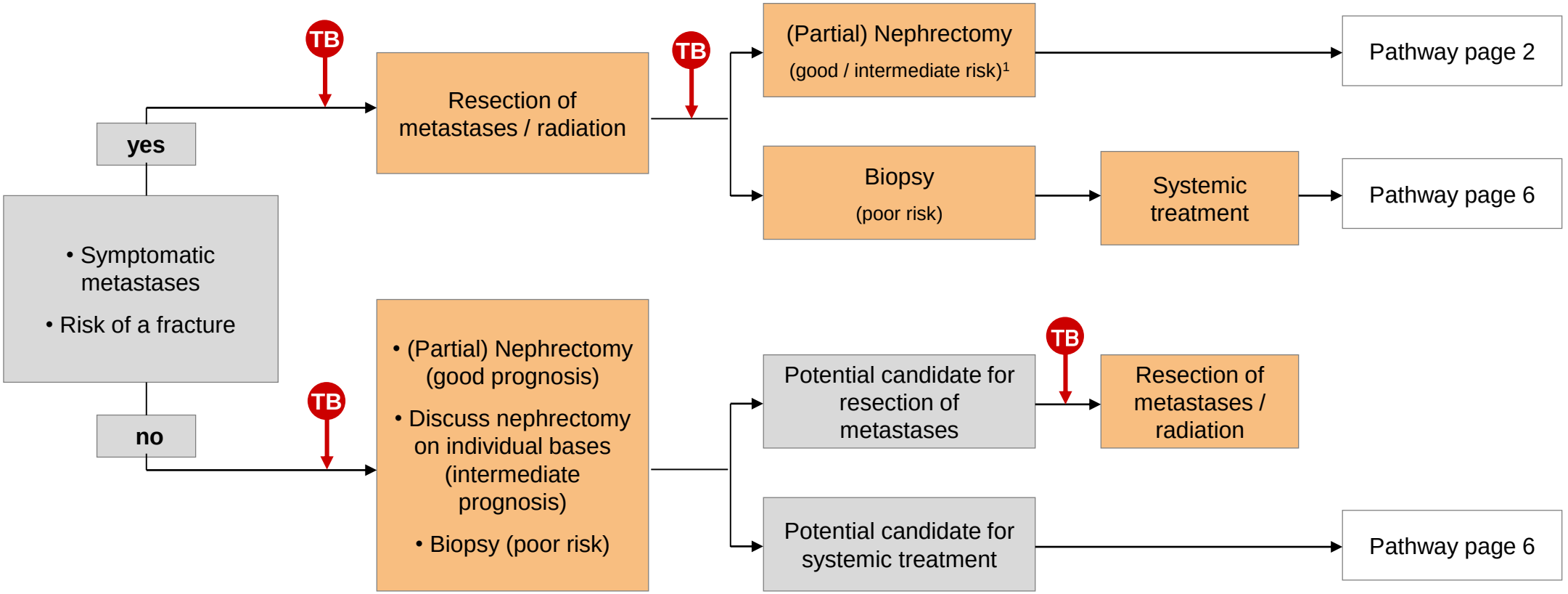
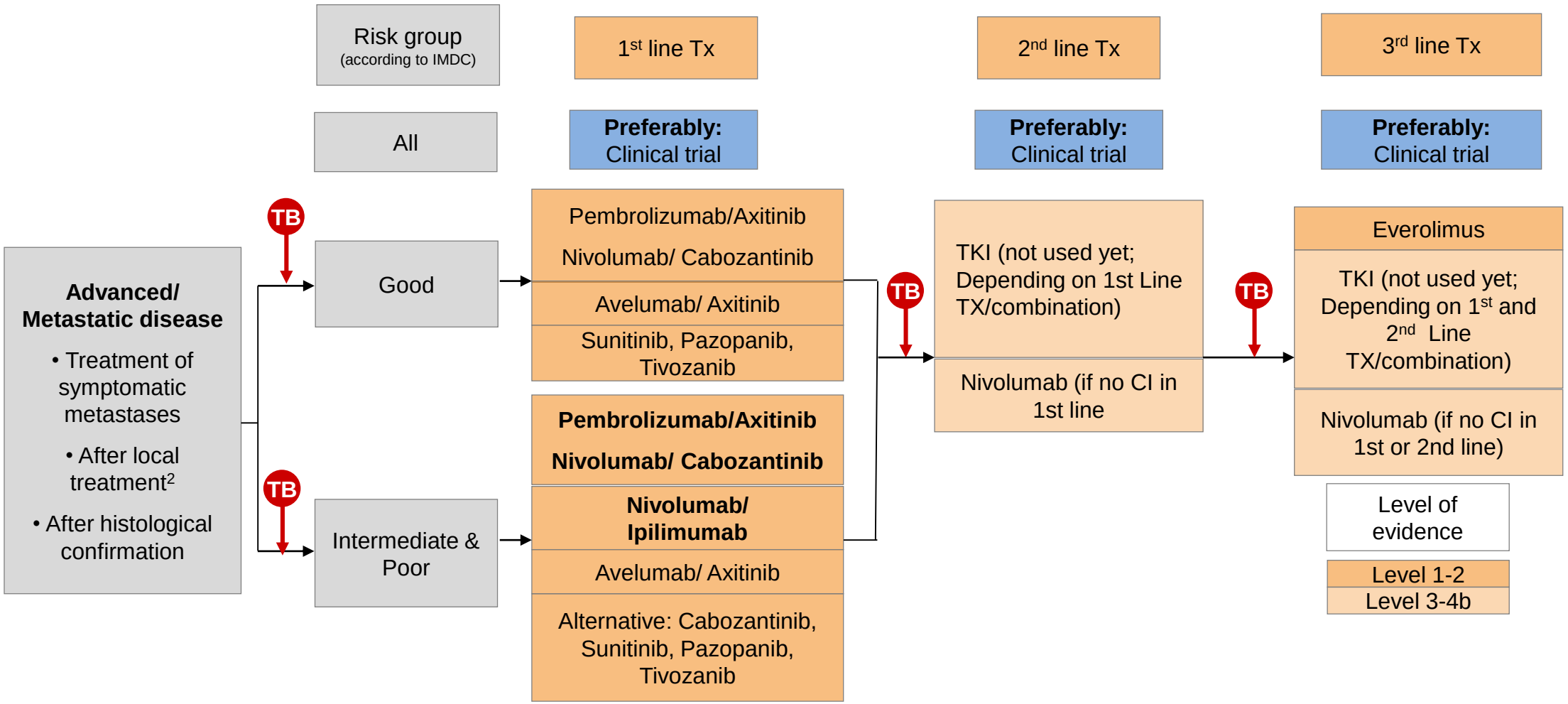
PD Progressive Disease

Pathway page 5: Metastatic disease (potentially resectable)



[1] Individual decision based on carefull patient selection

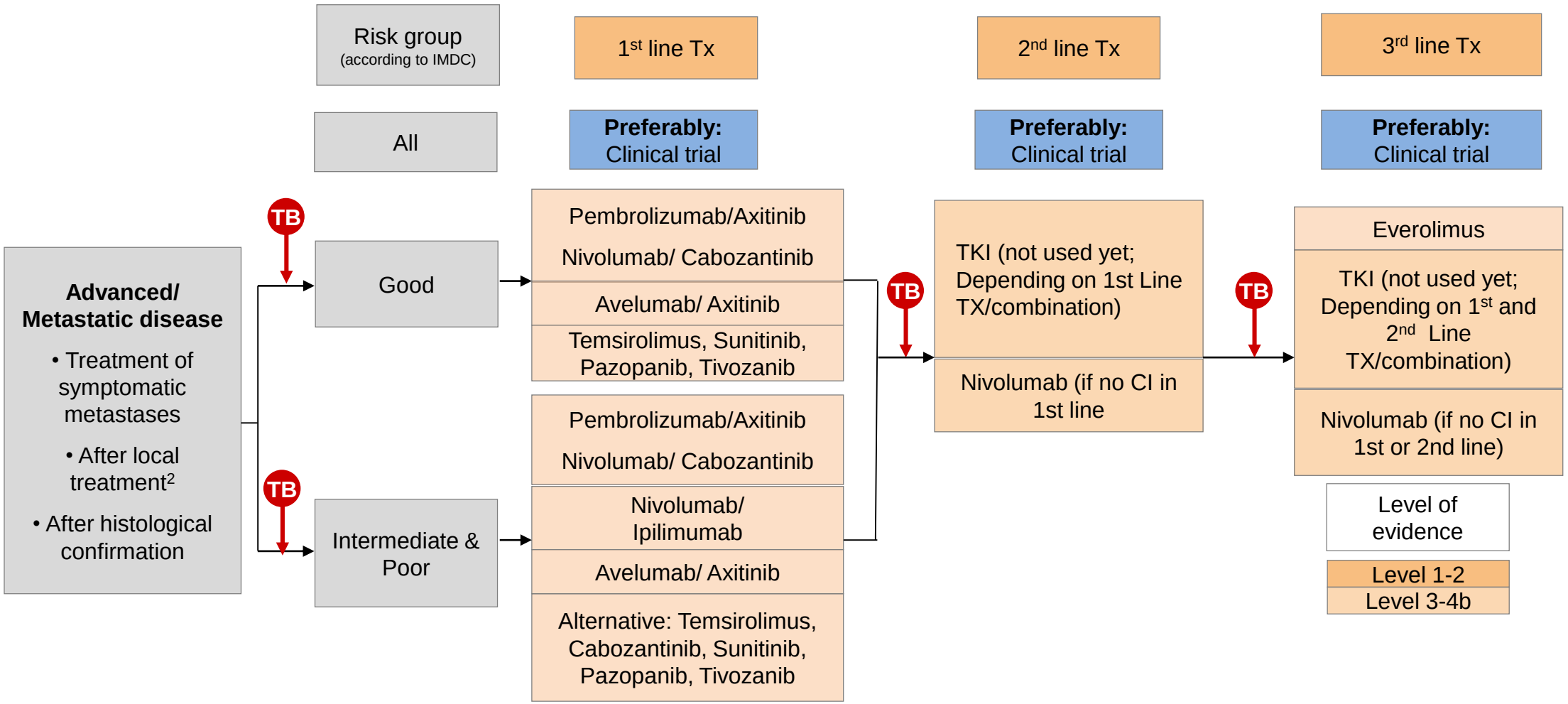
Pathway page 6.1: Advanced / metastatic disease (systemic treatment) of clear cell histology renal carcinoma



TKI Tyrosinekinase inhibitor, CI contraindication

[2] Nephrectomy only after careful patient selection in intermediate and poor risk patients

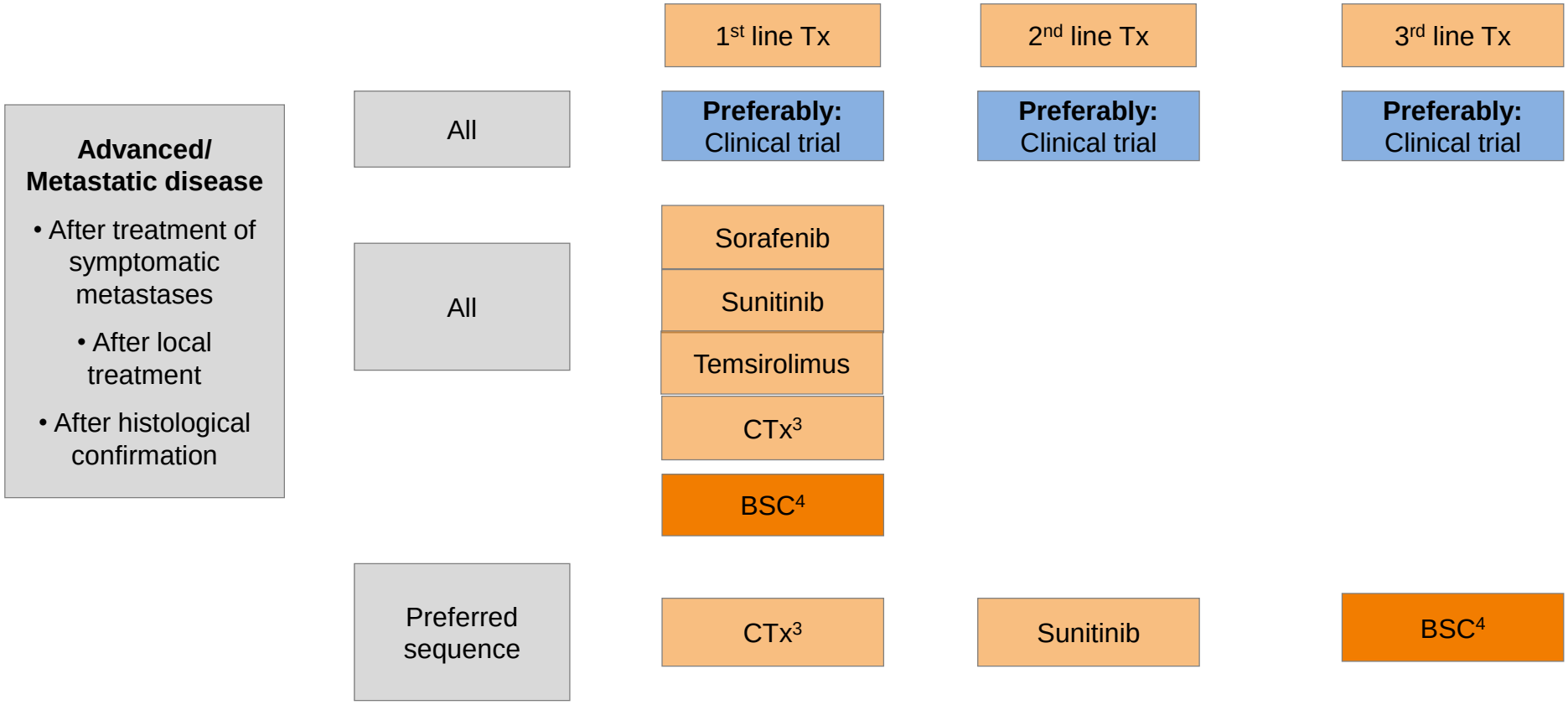
Pathway page 6.2: Advanced / metastatic disease (systemic treatment) of non-clear cell histology renal carcinoma



TKI Tyrosinekinase inhibitor, CI contraindication

[2] Nephrectomy only after careful patient selection in intermediate and poor risk patients

Pathway page 6.3: Advanced / metastatic disease (systemic treatment) of Ductus Bellini renal carcinoma



[3] CTx Chemotherapie: Gemcitabine / Cisplatin
[4] BSC best supportive care: See palliative care screening tool on page 12

Pathway page 9: Follow up

(Minimal recommendations for outpatient Follow up performed by a Specialist for Uro-Oncology, not evidence based)

1.) For patients after RFA or under active surveillance:

Every 3 to 6 months until year two

- Clinical exam
- Laboratory exam
- CT / MRI retroperitoneum after 3 to 6 months, afterwards every 6 months
- Offer contact to self help group and psychooncological support whenever necessary

2.) For patients with low risk profile (pT1a, G1 and G2 degree of differentiation):

Every six months until year one, afterwards yearly until year five

- Clinical exam
- Laboratory exam
- Ultrasound abdomen after six months, CT thorax and CT /MRI abdomen after one year
- Offer contact to self help group and psychooncological support whenever necessary

3.) For patients with intermediate risk profile (pT1b and pT2):

Every three months until year two, afterwards every six months until year five

- Clinical exam
- Laboratory exam
- CT thorax and CT / MRI abdomen every 6 months until year two, afterwards yearly until year five
- Offer contact to self help group and psychooncological support whenever necessary

4.) For patients with high risk profile (pT3 and pT4):

Every three months until year two, afterwards every six months until year five

- Clinical exam
- Laboratory exam
- CT thorax and CT / MRI abdomen every three months until year two, afterwards every six months until year 5
- Offer contact to self help group and psychooncological support whenever necessary

Prognostic criteria according to Motzer*

- ECOG: PS ≥ 2
- Hb: Lower limit of laboratory´s reference range
- Corrected serum calcium: > 10 mg/dl
- LDH: higher 1.5 fold of laboratory´s reference range
- Time from initial RCC diagnosis to start of therapy < 1 year

Risk score

- Low: no risk factor
- Intermediate: 1-2 risk factors
- High: more than two risk factors

IMDC criteria (Heng score)

- Neutrophiles > upper limit of laboratory´s reference range
- Platelets > upper limit of laboratory´s reference range
- Calcium (corrected) > upper limit of laboratory´s reference range
- Hb < lower limit of laboratory´s reference range
- Karnofsky-Index < 80%
- Time from initial RCC diagnosis to initiation of systemic therapy < 1 year

Risk score

- Low: no risk factor
- Intermediate: 1-2 risk factors
- High: more than two risk factors

*Motzer RJ, Bacik J, Schwartz LH et al. Prognostic factors for survival in previously treated patients with metastatic renal cell carcinoma. J Clin Oncol 2004. 22(3): p. 454–63.

Pathway page 11:
Best supportive care

- Consider nutrition counseling, psychological counseling
- Blood transfusion in case of anemia (Hb ≤ 8 g/dl)
- Supportive care: hematopoietic growth factors (e.g. erythropoietin)
- Embolization
- Radiation of brain or bone metastases as well as other localisations causing symptoms or threatening the patient
- Bisphosphonates in case of bone metastases
- Consider to contact palliative care team

Tumor associated pain

- Analgetics (according to WHO pain relief ladder for cancer pain)
- Radiation of symptomatic metastases
- Consider to contact palliative care team

Pathway page 12: Palliative care screening tool

			Screening items	Points
1.		•	Presence of metastatic or locally advanced cancer	**2**
2.		•	ECOG score (functional status score, performance status)	**0-4**
3.		•	Presence of one or more serious complications of advanced cancer usually associated with a prognosis of < 12 months (e.g. brain metastases, hypercalcemia, delirium, spinal cord compression, cachexia)	**1**
4.		•	Presence of one or more serious comorbid diseases also associated with poor prognosis (e.g. moderate-severe COPD or CHF, dementia, AIDS, end stage renal failure end stage liver cirrhosis)	**1**
5.		•	Presence of palliative care problems	**1**
	a.	•	Symptoms uncontrolled by standard approaches	**1**
	b.	•	Moderate to severe distress in patient or family, related to cancer diagnosis or therapy (personal targets and expectations, educational and informational requirements, cultural factors)	**1**
	c.	•	Patient/family requests palliative care consult	**1**
	d.	•	Team needs assistance with complex decision making or determing goals of care (benefit/side effects of treatment)	**1**
	e.	•	Instable or deficient network especially for emergency situation or 24-h care	**1**

A total of > 5 points signalizes need for supportive palliative care

According to Glare et al. (2011); NCCN Clinical Practice guidelines in Oncology 2015