Renal Cell Carcinoma

Cancer Centre of Southeastern Ontario
Standard Management Guidelines

Intended for use by Clinicians and Health Care Providers involved in the Management or Referral of adult patients with Renal Cell Carcinoma

Section	Activity	Activity Description	Details	Reference(s)
AA	Cancer Centre Referrals		• Not routine pre-op referral indicated for localized disease at diagnosis • Medical oncology referral when metastatic disease at presentation or during follow up • Radiation oncology referral for palliative management	
A	Diagnosis		• Cross-sectional abdominal imaging with and without contrast • Imaging alone makes probable diagnosis in most cases • Biopsy not routine – but may be indicated for small renal mass in which outcome of biopsy might change management	
B	History and Physical exam		• Routine • Family History – refer to genetic counselling if positive family history • Be wary of numerous paraneoplastic sydromes	
C	Investigations		**Staging** • Chest X-Ray or CT • Bone scan if clinically indicated or elevated alkaline phosphatase (ALP) • Brain only if high clinical suspicion **Bloodwork** • CBC, lytes, renal function, liver function, ALP, PTT/INR, calcium, magnesium, phosphate, albumin. extended lytes	

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D	Primary Management	Curative Intent	1. Surgery: • Surgical resection indicated in most settings in medically fit patients o Partial nephrectomy as default for small masses if feasible o Laparoscopic or open procedure based on surgeon choice o Clinically uninvolved regional nodes do not require routine resection o Clinically uninvolved adrenal gland does not require routine resection 2. Non-surgical Treatment: (i.e. Radiofrequency Thermal Ablation (RFA) in this center) • Indicated for small masses in selected populations in whom surgery is not indicated or safe 3. Active surveillance: • Indicated for patients in whom surgery or thermal ablation is not feasible due to age/comorbidity/anatomy of mass	AUA Guidelines 1
E	Primary Management	Neo-Adjuvant Treatment	• No routine neo-adjuvant/adjuvant treatment indicated	
F	Metastatic Disease, Late diagnosis, or During Follow-up	Palliative Intent	• Referral to medical oncology indicated o For patients in whom systemic treatment indicated, Sunitinib first line agent o Other agents or clinical trial participation may	Cancer Care Ontario Drug Formulary

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			be considered ○ Temsirolimus as typical first line agent in poor prognosis patients ○ Interferon remains an option in selected patients Cytoreductive nephrectomy for patients presenting with metastatic disease • Evidence supports this in fit patients in whom a majority of the cancer can be resected safely through nephrectomy and where post-op systemic treatment planned	
H	Follow up with no evidence of disease		Post-nephrectomy according to Canadian Urological Association follow-up Guidelines	2
I	Recurrent Disease (Low Volume and/or Locally Recurrent)		• Repeat resection can be considered for isolated, resectable regional recurrence • Small volume metastatic disease to lung or liver may be considered for resection with appropriate referral	
J	Controversies		• Numerous systemic treatment options in first, second and third lines settings • Cytoreductive nephrectomy not universally accepted • Management of Clear cell vs. other types in metastatic disease	
K	Clinical Trials		• Patients should always be considered for clinical trial eligibility	

References

1. Kassouf W et al. Can Urol Assoc J 2009; 3:73-76
2. Canadian Kidney Cancer Forum 2011 Can Urol Assoc J 2012;6(1):16-22

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Revisions

- 2014/02/13: Draft created
- 2014/04/02: Revisions to text, addition of links and references
- 2014/04/09: Revisions to text
- 2014/06/09: Revisions to text, addition of links and references