Survivorship – Kidney Cancer

Disclaimer: This algorithm has been developed for MD Anderson using a multidisciplinary approach considering circumstances particular to MD Anderson’s specific patient population, services and structure, and clinical information. This is not intended to replace the independent medical or professional judgment of physicians or other health care providers in the context of individual clinical circumstances to determine a patient’s care. This algorithm should not be used to treat pregnant women.

ELIGIBILITY

- After completion of treatment and NED

CONCURRENT COMPONENTS OF VISIT

- Follow-up visit at 48 months, 60 months, between 72-84 months and another between 96-120 months. Follow-up visits beyond 120 months are at the discretion of the patient and clinical team:
  - History and physical exam
  - BUN, creatinine, alkaline phosphatase, CBC with differential, ALT, AST, and total bilirubin
  - Chest x-ray
  - CT or MRI abdomen with contrast or ultrasound abdomen

SURVEILLANCE

- High Risk and Very High Risk

MONITORING FOR LATE EFFECTS

- CT chest with contrast (chest x-ray may be utilized instead)
- CT or MRI of abdomen with contrast or ultrasound abdomen

Risk Reduction/Early Detection

- See Page 2

Psychosocial Functioning

PSYCHOSOCIAL FUNCTIONING

- Continue survivorship monitoring

Suspected new primary or recurrent disease?

- Yes
- No

Department of Clinical Effectiveness V9
Approved by the Executive Committee of the Medical Staff on 04/16/2024

NED = no evidence of disease

1 Patients with suspected or confirmed high-risk genetic syndromes with predisposition to kidney cancer are excluded
2 Low Risk (LR): pT1 and Grade 1 or 2
3 Intermediate Risk (IR): pT1 and Grade 3 or 4; pT2 and any Grade
4 Primary team may initiate referral for the survivorship clinic when patient meets criteria to transfer after the 24 months visit for LR, after the 36 months visit for IR, and after the 60 months visit for High Risk (HR) and Very High Risk (VHR)
5 HR: pT3 and any Grade
6 VHR: pT4 or pN1, or sarcomatoid/rhabdoid dedifferentiation or macroscopic positive margin
7 GCC should be initiated by the Primary Oncologist. If Primary Oncologist is unavailable, Primary Team/Attending Physician to initiate GCC discussion and notify Primary Oncologist. Patients, or if clinically indicated, the Patient Representative should be informed of therapeutic and/or palliative options. GCC discussion should be consistent, timely, and re-evaluated as clinically indicated. The Advance Care Planning (ACP) note should be used to document GCC discussion. Refer to GCC home page (for internal use only).

Follow-up visit at 72-84 months and another between 96-120 months. Follow-up visits beyond 120 months are at the discretion of the patient and clinical team:
- History and physical exam
- BUN, creatinine, alkaline phosphatase, CBC with differential, ALT, AST, and total bilirubin
- CT chest with contrast (chest x-ray may be utilized instead)
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ELIGIBILITY

Kidney cancer after completion of treatment and NED\(^1\)

CONCURRENT COMPONENTS OF VISIT

MONITORING FOR LATE EFFECTS

Assess for renal insufficiency\(^2\)

Patient education, counseling, and screening:
- Lifestyle risk assessment\(^3\)
- Cancer screening\(^4\)
- HPV vaccination as clinically indicated (see HPV Vaccination algorithm)
- Screening for Hepatitis B and C as clinically indicated (see Hepatitis B Virus (HBV) Screening and Management, and Hepatitis C Virus (HCV) Screening algorithms)
- Consider cardiovascular risk reduction\(^5\)
- Vaccinations\(^6\) as appropriate

RISK REDUCTION/EARLY DETECTION

Assess for:
- Distress management (see Distress Screening and Psychosocial Management algorithm)
- Body image
- Financial stressors
- Social support

PSYCHOSOCIAL FUNCTIONING

DISPOSITION

Refer or consult as indicated

1 Patients with suspected or confirmed high-risk genetic syndromes with predisposition to kidney cancer are excluded

2 Consider Nephrology referral or consult for patients with eGFR < 45 mL/minute/1.73 m\(^2\)

3 See Physical Activity, Nutrition, and Tobacco Cessation Treatment algorithms; ongoing reassessment of lifestyle risks should be a part of routine clinical practice

4 Includes breast, cervical (if appropriate), colorectal, liver, lung, pancreatic, prostate (if appropriate), and skin cancer screening

5 Consider use of Vanderbilt’s ABCDE’s approach to cardiovascular health

6 Based on Centers for Disease Control and Prevention (CDC) guidelines
SUGGESTED READINGS


SUGGESTED READINGS - continued


MD Anderson Institutional Policy #CLN1202 - Advance Care Planning Policy. Advance Care Planning (ACP) Conversation Workflow (ATT1925)


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DEVELOPMENT CREDITS

This survivorship algorithm is based on majority expert opinion of the Genitourinary Survivorship workgroup at The University of Texas MD Anderson Cancer Center. It was developed using a multidisciplinary approach that included input from the following:

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