Survivorship – Kidney Cancer

ELIGIBILITY

Kidney cancer after completion of treatment and NED[1]

CONCURRENT COMPONENTS OF VISIT

SURVEILLANCE

Low Risk[2] and Intermediate Risk[3]

Follow-up visit at 48 months[4], 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

High Risk[5] and Very High Risk[6]

Follow-up visit at 72-84 months[4] 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)
- CT or MRI of abdomen with contrast or ultrasound abdomen

MONITORING FOR LATE EFFECTS

RISK REDUCTION/ EARLY DETECTION

PSYCHOSOCIAL FUNCTIONING

See Page 2

Suspected new primary or recurrent disease?

Yes

- For new primary refer to the appropriate clinic per disease site
- For metastatic disease refer to Medical Oncology
- For recurrent disease or renal mass return to primary treating physician
  - **Primary Oncologist** to discuss Goal Concordant Care (GCC) with patient, or if clinically indicated, with Patient Representative[7]

DISPOSITION

No

Continue survivorship monitoring

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).

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Approved by the Executive Committee of the Medical Staff on 04/16/2024

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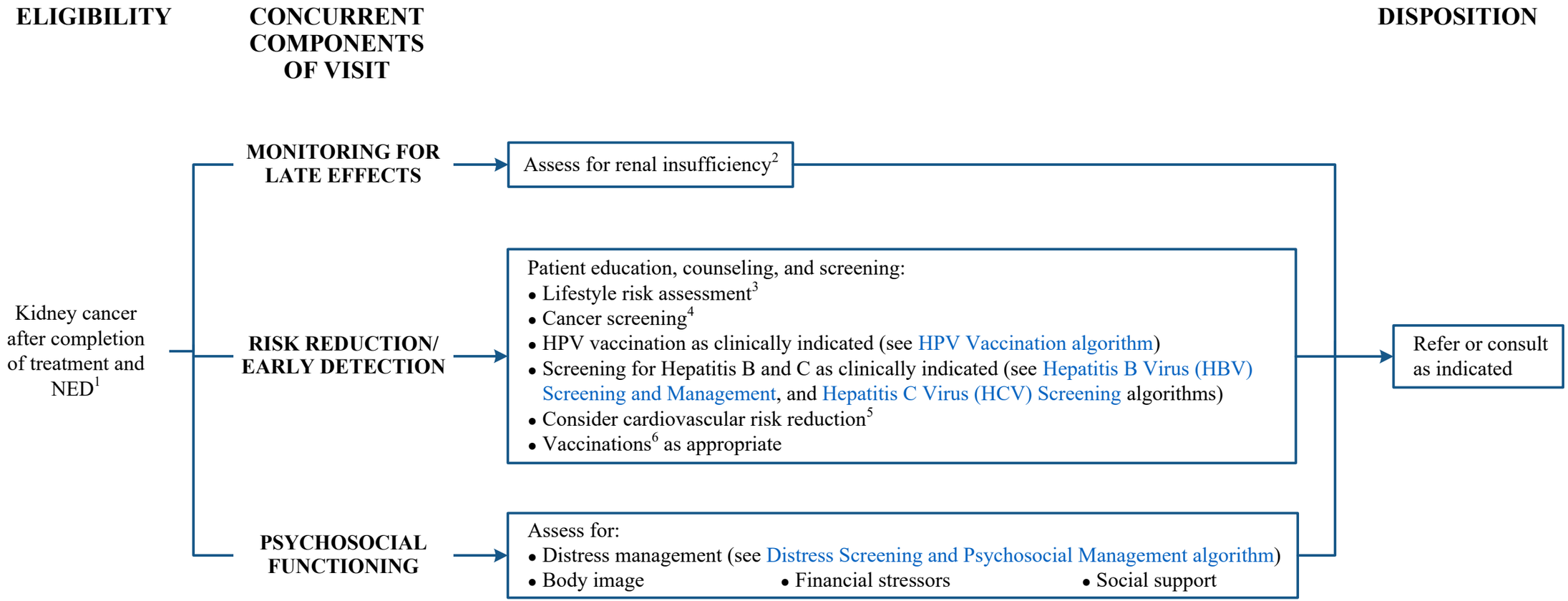

[1] Patients with suspected or confirmed high-risk genetic syndromes with predisposition to kidney cancer are excluded
[2] Consider Nephrology referral or consult for patients with eGFR < 45 mL/minute/1.73 m^2
[3] See Physical Activity, Nutrition, and Tobacco Cessation Treatment algorithms; ongoing reassessment 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

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SUGGESTED READINGS

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DEVELOPMENT CREDITS

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