AUA 2013 - Session Highlights: AUA Guideline Presentation: Follow-up care for renal cancer

Published on 09 May 2013

SAN DIEGO, CA USA (UroToday.com) - Dr. Sherri Donat presented the new AUA guideline for the follow-up of clinically localized renal neoplasms during a much-anticipated plenary session. The goal of the panel was to create evidence-based guidelines for the follow-up and surveillance of clinically localized renal cancers treated with surgery or renal ablative procedures, biopsy-proven untreated clinically localized renal cancers followed on surveillance, and radiographically suspicious but biopsy-unproven renal neoplasms. An extensive literature review from January 1999 to 2011 was performed, and statements were presented as standards, recommendations, or options, with evidence rated as A (high), B (moderate), or C (low).

Notably, only one of the 27 statements in the guideline was considered a standard. Patients with a history of renal neoplasm presenting with acute neurological signs or symptoms must undergo prompt neurologic cross-sectional CT or MRI scanning of the head or spine based on localization of symptomatology (Standard; Grade A). Bone scan can be performed in patients with an elevated alkaline phosphatase or clinical symptoms such as bone pain and/or radiographic findings suggestive of a bony neoplasm (*Recommendation; Grade C*).

For patients with a history of low risk (pT1, N0, Mx) RCC managed surgically, chest X-ray (CXR) should be performed annually for 3 years and then only as clinically indicated to assess for pulmonary metastases (*Recommendation; Grade C*). A baseline abdominal CT or MRI should be performed within 3 to 12 months following renal surgery (Expert Opinion), and if the baseline image is negative, abdominal imaging (US, CT, or MRI) may be performed yearly for 3 years following partial nephrectomy (*Option; Grade C*).

For moderate- to high-risk patients managed surgically (pT2-4, N0, Nx or any N+), the panel recommends baseline abdominal imaging (CT or MRI) within 3 to 6 months following surgery, with continued imaging every 6 months for at least 3 years and annually thereafter to year 5 (*Recommendation; Grade C*). Site- specific imaging should be performed as warranted by clinical symptoms suggestive of recurrence or metastatic spread (*Recommendation; Grade C*), while the routine use of FDG-PET for follow-up is not indicated (*Expert Opinion*).

For patients on active surveillance (AS), the panel recommends that patients undergo abdominal imaging (CT or MRI) within 6 months of AS initiation to establish a growth rate, and then annually thereafter (*Recommendation; Grade C*). Percutaneous biopsy may be considered prior to initiating AS (*Option; Grade C*), and for those patients with biopsy proven RCC on AS, annual CXR should be performed to assess for pulmonary metastases (*Recommendation; Grade C*). The panel recommends urologist involvement in all patients undergoing ablative procedures (*Expert Opinion*), and pretreatment diagnostic biopsy (*Recommendation; Grade C*). Following ablation, cross-sectional CT or MRI, with and without IV contrast, should be performed at 3 and 6 months to assess treatment success, and annually thereafter for 5 years (*Recommendation; Grade C*). Patients with biopsy proven RCC, non-diagnostic biopsies, or no prior biopsies should undergo annual CXR for 5 years (*Expert Opinion*) following ablation, whereas patients with pathological confirmation of benign histology and radiographic confirmation of treatment success require no further radiologic scanning (*Recommendation; Grade C*). If there is radiographic evidence of ablation failure within 6 months, observation, repeat treatment, and surgical intervention should be discussed (*Expert Opinion*).

Finally, the panel recommends against the routine use of molecular markers (Ki-67, p-53, and VEGF), as "benefits remain unproven at this time" (*Recommendation; Grade C*). While the guidelines present an excellent step forward in standardizing follow-up of clinically localized RCC, they also highlight the lack of available high-quality evidence to guide clinicians in the appropriate follow-up of clinically localized renal cell carcinoma.

Presented by ***Sherri Machele Donat, MD*** at the American Urological Association (AUA) Annual Meeting - May 4 - 8, 2013 - San Diego Convention Center - San Diego, California USA

CONFERENCES MENU

Conferences Home Page
AUA 2013
EAU 2013
SES AUA 2013
SUFU Winter 2013
Cancers Symposium 2013
2012 Conferences
2011 Conferences

Memorial Sloan-Kettering Cancer Center, New York, NY USA

Reporte ay.com by **Jeffrey J. Tomaszewski, MD**

View F Coverage

2

Share

URO

Tags:

Topics on Urology Health, Urinary Leakage, Treating Prostate Cancer, Prostate Cancer Diagnosis, Urology News, Symptoms For Bladder Infection In Men