

**COVID-19 Strategy for the Interim Management of Kidney Cancer  
Prepared by the BAUS Section of Oncology**

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This document consists of two sections. The first section concerns specific guidance and recommendations for the management of suspected and proven kidney cancer during a period of limited resources caused by the current COVID-19 outbreak. Section 2 provides detail on the rationale for the policy, its associated risks and likely impact.

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**PRINCIPLES OF CARE**

- Limit outpatient attendance at time of high COVID-19 virus prevalence to reduce risks to patients and hospital staff.
  - Minimise the risk of missing significant new kidney cancer and the risk of disease progression in those with proven disease.
  - Rationalise imaging requests to reduce pressure on radiology services.
  - Consider delaying administration of immunosuppressant drugs to those with metastatic kidney cancer to avoid exacerbation of host susceptibility.
  - Communicate effectively to explain the potential trade-offs that will result from introducing risk-stratification guidelines with respect survival and quality of life.
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**SECTION 1: GUIDANCE AND RECOMMENDATIONS**

**Wherever possible, patients with suspected or proven kidney cancer should be managed according to currently accepted investigative and treatment strategies, until such point that resources become so limited that severe risk stratification is required.**

Suggested risk stratification measures are shown below.

We recognise, however, that individual hospital circumstances will differ, and not all measures will be required in every unit.

## **1. Patients with suspected kidney cancer**

- Perform urgent assessment for patients 45 years and older who have unexplained visible haematuria without urinary tract infection, or who have visible haematuria that persists or recurs after successful treatment of urinary tract infection (NICE 2015).
- Perform urgent assessment for patients with symptoms and signs of metastatic kidney cancer (hypercalcaemia, cord compression, bone pain, haemoptysis).
- Do not perform urgent assessment for patients with non-visible haematuria. Recommend repeat urine dipstick testing after an interval period of 6 months.
- Do not perform renal mass biopsy.
- Do not perform kidney characterisation/staging for patients with likely kidney tumours and complex cysts less than 4cm (T1a). Instead organise imaging and appropriate secondary care follow-up in 6 to 9 months.
- Do not perform kidney characterisation/staging for patients with likely kidney tumours and complex cysts between 4 & 7cm (T1b). Instead organise imaging and appropriate secondary care follow-up in 3 to 6 months.

## **2. Patients with newly diagnosed, non-metastatic kidney cancer**

- Commence surveillance for patients with newly diagnosed T1a/T1b tumours. There should be no role for the use of partial nephrectomy, ablation or stereotactic radiotherapy in the management of T1 patients during this period.
- Perform kidney characterisation/staging for patients with likely kidney tumours and complex cysts more than 7cm (T2+).
- Non metastatic patients with T2 disease should be offered urgent surgery as per current departmental protocols, although patients

should be warned that their surgery may be delayed depending on hospital resources.

- Non-metastatic patients with T3 disease, particularly those with significant extension into the renal vein or IVC, have the highest priority for urgent surgical intervention and should not be delayed unless absolutely necessary.

### **3. Patients with newly diagnosed, metastatic kidney cancer**

- Do not offer cytoreductive nephrectomy.
- Do not perform renal mass biopsy.
- All patients with metastatic kidney cancer should be considered for systemic therapy, subject to oncological assessment. The systemic treatment agent of choice will be the responsibility of the treating oncologist, but there is little evidence against the use of TKIs (except for the possible exception of *Sorafenib*) in this group.
- Immunotherapy may not be an appropriate treatment modality in this group due to immunomodulation. A proportion may be eligible for surveillance alone.

### **4. Follow-up of patients with kidney cancer after definitive treatment**

- In view of the potential decreased scanning resource and limited robust evidence for post treatment follow up, defer surveillance CT scanning in patients with low/intermediate risk kidney cancer after definitive treatment, for a period of 6 months.
- Defer surveillance CT scanning in patients with high risk kidney cancer, after definitive treatment, for a period of 3 months.

### **5. Patients currently on the waiting list for kidney surgery**

- Patients currently on the waiting list for kidney surgery should be reassessed according to the above guidelines. It is important to communicate clearly with these patients as it will be an extremely anxious time.

## **6. Recruitment into clinical trials**

There will be no recruitment into clinical trials.

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## **SECTION 2: IMPACT OF POLICY RECOMMENDATIONS, RATIONALE FOR THE POLICY AND RISK ASSOCIATED WITH THE POLICY**

### **1. New patient diagnosis**

#### ***a. Patient population***

Patients referred with a suspicion of harbouring kidney cancer

#### ***b. Rationale for the policy***

To maximise hospital capacity to enable ~COVID-19 patients to be managed, whilst minimising any potential compromise in patient safety

#### ***c. Risks associated with the policy***

Patients undergoing urgent haematuria clinic evaluation increase the risk of staff contamination.

Patients with small kidney cancers will have a delay in their diagnosis with the anxiety that this causes in patients, their families and treating staff. There is a low chance that kidney cancers less than 3cm in diameter will metastasise (less than 1%). The growth rate of small kidney masses is documented and shows a slow progression in the majority of cases.

Patients with emergency symptoms and signs of metastatic kidney cancer should be prioritised to avoid a sudden and severe loss in quality of life. The biggest divergence from standard practice is in patients with metastatic disease. There is strong evidence for debulking nephrectomy in this group. In view of the resource implications, there is evidence that these patients could be offered systemic therapy with delayed nephrectomy.

### **2. Post-treatment follow-up**

#### ***a. Patient population***

Patients who have undergone therapy in the form of surgery for kidney cancer.

***b. Rationale for the policy***

To maximise hospital capacity to enable COVID-19 patients to be managed.

***c. Risks associated with the policy***

There is a small risk there will be a delay in detecting recurrent kidney cancer following kidney cancer surgery. The risk of a patient experiencing a significantly worse oncological outcome due to a delay in detecting recurrence, and subsequently being denied curative second-line therapy, is thought to be very low.

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