

Early Stage Kidney Cancer



My cancer is only in the kidney: what treatments could I take?



Active surveillance

It may seem strange, but for some people with small (stage 1) kidney cancers, the first best treatment is often observation, or “**active surveillance**”.

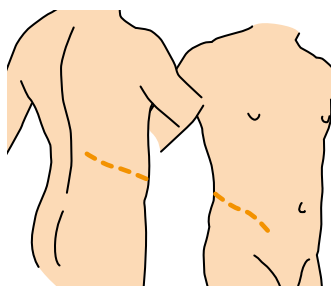
If you are older, or have significant medical problems, it may be safer to first carefully watch the cancer, with multiple scans and multiple visits to the cancer specialist. Because many kidney cancers are discovered by accident on scans that were recommended for other reasons, a number of small kidney lumps are now being detected. Kidney cancers that are smaller than 3 cm are very unlikely to spread elsewhere, and sometimes the risks of an operation outweigh the benefits of surgery. People who choose active surveillance with their doctors must continue to have regular follow-up care, in case the cancer starts to grow.



Surgical approaches

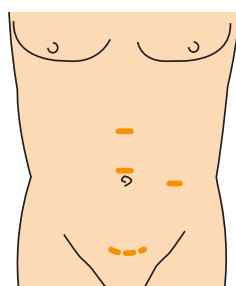
If you have a larger cancer in the kidney, surgery is usually the first best treatment. Surgery to remove kidney cancers is performed by a specialist surgeon called a Urologist or Uro-oncologist (a Urologist who specialises in cancer). Surgery may either remove just a part of the kidney (called a “partial nephrectomy”) or the entire kidney, which is called a “radical nephrectomy”.

Surgery might need to be done with a large incision (an “open” nephrectomy) or might be able to be done by keyhole surgery (a “laparoscopic” nephrectomy) which results in a shorter hospital stay and quicker recovery.



Open Surgery: Flank section

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Laparoscopic surgery

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If the cancer is small (stage 1, <7cm) a “partial” nephrectomy may be possible, where the remaining normal kidney can be spared. If the cancer is larger (stage 2), or has started to spread near the kidney (stage 3) then the whole kidney is removed.

Non-surgical approaches

In some people an operation is not possible due to their age or other medical problems. It may be still possible to treat a localised kidney cancer without surgery, using other treatments.

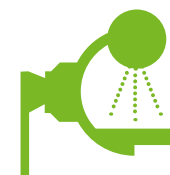
These include:

- **Radiofrequency ablation (RFA):** where a needle containing a microwave antenna is inserted into the cancer under local anaesthetic, and the cancer is “cooked” from the inside.



- **Cryoablation:** where a series of probes are inserted into the cancer, and then cooled with liquid nitrogen to freeze the cancer cells. This has a similar effect as RFA but may require a general anaesthetic.

- **Stereotactic body radiation therapy (SBRT):** this newer, computer-controlled radiation has been tested in kidney cancer and many other cancers. SBRT gives lots of very small doses of radiation from a lot of different angles, such that a therapeutic dose of radiation lands on the cancer, but the normal organs and tissues around the cancer are only slightly affected.



Approaches to rare kidney cancers

If you have one of the inherited types of kidney cancer, it is possible you may get more kidney tumours in the future. Because of this, your surgeon might suggest a different approach for you. Patients with inherited types of kidney cancer need a long-term strategy and so should be seen by an expert in kidney cancer whenever possible.

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Is there any treatment I can take to help ensure that the cancer won't come back?

In many cancers, people can take additional “insurance policy” treatments to reduce the chance of the cancer coming back. You may have heard of chemotherapy, hormone therapy or radiotherapy as additional (“adjuvant”) treatments for cancer. In the past, these treatments have not seemed to work for patients with kidney cancer.

There is however a lot of interest in clinical trials testing adjuvant treatments for kidney cancer. Ask your doctor if adjuvant therapy or a clinical trial is appropriate for you.

Follow-up after treatment?

All cancer survivors should have follow-up care. Once you have finished your cancer treatment, you will establish a follow-up cancer care plan with your treatment team, which may include seeing a range of health professionals.

In general, kidney cancer survivors usually return to their specialist every three to four months during the first few years after treatment, and once or twice a year after that. At these visits, your doctor will look for side effects from treatment and will check to ensure you cancer has not returned (recurred) or spread (metastasised) to another part of your body.

The type of tests will depend upon your stage and grade of kidney cancer. Like most cancers, the chance of the cancer returning is highest soon after treatment. The longer away from the treatment, the more chance the cancer will not recur. However, your treatment team will want to follow you for some time. In some countries, kidney cancer patients are followed for 5 years following initial surgery. Your patient organisation can refer you to guidelines for follow-up that are specific to kidney cancer in your country or other countries.



Good to know!

Adjuvant

The use of other therapies after performing surgery for cancer. Adjuvant therapies are given when there are no obvious cancer cells remaining but a patient is determined to have a higher risk of having a recurrence. It is given in order to delay or reduce the risk of a cancer recurrence.

Nephrectomy

The removal of the kidney by surgery.

Radical nephrectomy: The surgical removal of the whole kidney and the fat surrounding the kidney.

Partial nephrectomy: The surgical removal of the portion of the kidney containing the tumour along with a small amount of normal (cancer-free) kidney that is surrounding the tumour.

Localised

Restricted to the primary (original) site, without evidence of spread. A localised kidney cancer is confined to the kidney.

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