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EDITORIAL

Approach of the patient with renal cancer: Is there a collaboration between urology and oncology?☆

Abordaje del paciente con cáncer renal: ¿existe la colaboración entre urología y oncología?

Introduction

Kidney cancer accounts for 80–90% of tumors affecting the kidney, accounting for 2–4% of all existing tumors; it is more frequent in men than in women and its incidence is increasing in many parts of the world.[1] Its correct approach and management requires the collaboration of many health professionals. However, despite the recognition of multidisciplinary teams, these are still not fully implemented in many health centers. Because of this, a group of urologists and oncologists from Galicia gathered to share their personal experience, describing their management of patients with renal cancer and exposing the characteristics that a multidisciplinary committee should have, the importance of having reference centers and specialization in urology, the need to protocolize the treatment and follow-up of these patients, as well as the need to establish training programs and mechanisms to control the results obtained.

Multidisciplinary committees

Multidisciplinary tumor committees are defined as 'periodic multidisciplinary meetings for the individual prospective approach of cancer patients in which management proposals are formulated based on the best available evidence'.[2]

The functions of a committee include: discussing the diagnosis and treatment of each case individually, contributing to proper care of the patient, improving their satisfaction, contributing to innovation and development of knowledge of participating professionals, and promoting the relationships between centers.

Thanks to all these functions, compliance with the clinical practice guidelines is facilitated by homogenizing the treatments, reducing biases and, thus, achieving an improvement in the quality of care of patients.[2,3] Although there are studies that show that multidisciplinary committees improve patient care and provide greater coordination among services, there is still not enough evidence that they improve the results in clinical practice.[3,4] In Spain, the presence of multidisciplinary committees was recognized as a health priority in 2006 by the National Health System.[5]

The structure that a multidisciplinary committee should have, and how it should be organized, has been published on different occasions.[2,6,7] It must be formed by the professionals involved in the oncological approach, so a uro-oncology committee should have urologists, medical oncologists, radiation oncologists, radiologists, pathologists, nuclear medicine personnel, and palliative care personnel, as well as members of the nursing staff responsible for managing cases, with the presence of other professionals being optional depending on the characteristics and complexity of the case.

It is recommended that the president of the multidisciplinary committee is a specialist with communication skills, able to promote, improve, and encourage the committee. The secretary may be a non-health professional, whose functions are to organize the calendar, create and distribute the list of clinical cases, and record the decisions taken at meetings. The figure of the case manager (or nurse manager) is one of the most important. The strategy for addressing the chronicity that the Ministry of Health published in 2012 describes the need to enhance the actions of nursing professionals in the care of chronic processes, guiding their

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responsibility to the role of educators and/or coaches in self-care, in case management in patients with especially complex conditions and as liaison professionals to improve the transition between areas and care units.[8]

However, within this structure that seems already organized and implemented internationally, it remains unclear which patients are likely to be presented in a multidisciplinary tumor committee. The ideal situation would be the existence of action protocols for each tumor and specific to each center or health area. Those cases with localized disease subsidiary of other therapies that are not surgical, those that require active monitoring, radiotherapy or chemotherapy, and any case with metastatic disease should be presented.

Reference and specialization centers in urology

The specialization in medicine and surgery makes new graduates specialists in a medical and/or surgical discipline. Although this is usually sufficient in small centers, in centers with a high volume of pathologies, the tendency is toward subspecialization, since it implies an improvement in the management of specific pathologies and, especially, in some complex surgical procedures. In fact, it has been proven that the risk of mortality decreases significantly in hospitals with a high volume of surgeries.[9,10] It has also been found that when a surgeon performs a certain surgical procedure more frequently, the mortality related to this procedure for that surgeon decreases.[11] Therefore, it seems reasonable to conclude that complex oncological surgeries should be performed in specialized centers with a minimum number of surgeries of this type per year and with surgeons specialized in some pathology. In this way, the patient would be offered a lower rate of complications and morbidity and mortality associated with the process.

Protocolization of treatment and follow-up in renal cancer

Both the functional unit of urooncology and the committee of urological tumors must have protocolized in writing the different therapeutic and follow-up alternatives for each stage of renal cancer according to the most recent scientific evidence. Their objective is to homogenize the treatments between the centers and thus optimize the resources. It would be interesting to be able to agree on these protocols with the pharmacy services and the center's management to discuss cost–benefit aspects, facilitate the flow of information, and reduce bureaucratic times.

Table 1 Protocol for the treatment and follow-up of patients with renal cancer.

Progression risk	Postoperative months											
	3	6	9	12	15	18	21	24	30	36	48	60
Low (pT1)												
MH, PE, Bt	X	X		X		X	X	X				
Thorax		CT		XR		CT	XR	CT				
Abdomen	US/CT	CT/US		CT/US		CT/US		CT/US				
Discharge in 3–6 years. For PN, CT every 3 months (according to AUA, CUA)												
Intermediate (pT2)												
MH, PE, Bt	X	X	X	X	X	X	X	X	X			
Thorax		XR	CT	XR	CT	XR	CT	XR	CT			
Abdomen	CT	US	CT	US	CT	US	CT	US	CT			
Discharge in 10 years. For PN/RN/RFA/CRYO, XR/US alternate every 2 years												
(pT3–T4 or N+)												
MH, PE, Bt	X	X	X	X	X	X	X	X	X			
Thorax		XR	CT	XR	CT	XR	CT	XR	CT			
Abdomen	CT	CT	CT	CT	CT	CT	CT	CT	CT			
Undefined discharge. For PN/RN/RFA/CRYO, XR/CT alternate every 2 days												
Stage IV (adrenal M1)												
MH, PE	X	X	X	X	X	X	X	X	X	X	X	X
Bt		X		X		X		X	X	X	X	X
Thorax	CT		CT		CT		CT					
Abdomen		CT		CT		CT		CT		CT	CT	CT
From the sixth year, HC, PE, Bt and CT every year												
Stage IV in active treatment												
Follow-up according to treatment												
CT every 3 months, except when there are analytical alterations or according to symptoms												

Bt: blood test; AUA: American Urological Association; CRYO: cryoablation; CUA: Canadian Urological Association; PE: physical examination; MH: medical history; PN: partial nephrectomy; RN: radical nephrectomy; RFA: radiofrequency ablation; XR: X-ray; CT: computed tomography; US: ultrasound; x: evaluation is done that month.