PHILIPPINE SOCIETY OF MEDICAL ONCOLOGY (PSMO)
CONSENSUS RECOMMENDATIONS IN THE MANAGEMENT OF KIDNEY CANCER DURING COVID-19 PANDEMIC IN THE CORONAVIRUS DISEASE 2019 (COVID-19) ERA

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I. General Recommendations

A. Prioritization

Q: In general, how should renal cancer patients be prioritized during the COVID-19 pandemic?

A: The tiered approach of ESMO for cancer patients during the COVID-19 pandemic is designed across three levels of priorities, namely: tier 1 (high priority), 2 (medium priority) and 3 (low priority) as follows (1):

- High Priority: Patient's condition is immediately life threatening, clinically unstable, and/or the magnitude of benefit qualifies the intervention as high priority (e.g. significant overall survival [OS] gain and/or substantial improvement in quality of life [QoL]) (1)
- Medium Priority: Patient's situation is non-critical but delay beyond 6 weeks could potentially impact overall outcome and/or the magnitude of benefit qualifies for intermediate priority (1)
- Low Priority: Patient's condition is stable enough that services can be delayed for the duration of the COVID-19 pandemic and/or the intervention is non-priority based on the magnitude of benefit (e.g. no survival gain with no change nor reduced QoL) (1)

B. Screening for COVID-19

Q: Who should get SARS-CoV-2 Testing?

A:

1. High Priority: Patients with COVID symptoms

Patients with cancer, especially those who are undergoing chemotherapy, are in an immunocompromised state. If they have symptoms of fever with cough, colds, dyspnea or diarrhea, they should undergo SARS-CoV testing. Patients with exposure to SARS-CoV are also advised testing. They are considered to be at highest priority based on local DOH guidelines (7).

2. Medium Priority: Hospitalized patients

More hospitals are adapting SARS-CoV-2 testing even in non-cancer patients. Testing of all cancer patients admitted to the hospital is being supported by the NCCN guidelines, depending on availability of testing kits in the area (8).

3. Low priority: Asymptomatic patients who are receiving immunosuppresive therapy are at low priority for SARS-Cov. The response of various institutions to this is variable. However, the Infectious Disease Society of America strongly recommends (but with very low certainty of evidence) that patients with cancer who are undergoing immunosuppressive therapy should undergo SARS-CoV-2 testing 48-72 hours prior to treatment.

There are no recommendations for SARS-CoV-2 testing in asymptomatic patients undergoing non-immunosuppressive treatment such as tyrosine kinase inhibitors or immunotherapy.

C. Outpatient Visits

Q: Among renal cancer patients, who should be prioritized for outpatient visits?
A:
Patients may be prioritized as High, Medium, or Low Priority for outpatient visits.

1. High Priority: Those deemed at High Priority for clinic visits are 1) first time consults of renal cancer patients presenting with advanced disease, 2) those on immunotherapy with significant immune-mediated adverse effects, 3) patients with large renal masses causing local symptoms (hematuria, severe pain, renal failure), 4) patients with suspected oncologic emergencies (symptomatic brain metastasis, spinal cord compression), 5) post-operative complications such as infection, hematoma. (2)
2. Medium Priority: Patients on Medium Priority are those 1) good-risk patients (IMDC) for initiation of systemic treatment, 2) patients ongoing VEGF-therapy where tolerance has been ensured, 3) routine post-operative follow-up. (2)
3. Low Priority: Low priority are those patients already on systemic therapy for at least 1-2 years, and post-operative follow up of more than 6 months. (2)

D. Telemedicine

Q: Among renal cancer patients, who can be attended to via telemedicine?
A: Renal patients on anti-VEGF TKI therapy for at least 1 year with excellent tolerance to treatment may be attended to via telemedicine. Post-operative patients of at least 6 months duration may also be attended to via telemedicine. (2)

II. Specific Recommendations

A. Diagnosis and Staging

Q: How do we prioritize imaging/image-guided biopsies among patients with renal cancers?
A:

1. High Priority: Patients who are for initiation of systemic therapy for advanced/metastatic disease or for preoperative evaluation are considered High priority for imaging and image-guided biopsies. Patients with suspected immune-

mediated toxicities or presenting with acute symptoms (neurologic, bleeding, fracture) are also considered as High priority. (2,11)

2. Medium Priority: Any imaging for purposes of changing treatment are considered Medium priority. Imaging for renal tumors between 4-7cm may be done within 3 months and are considered Medium priority.
3. Low Priority: Cross-sectional imaging/image-guided biopsies for small renal masses < 4cm may be deferred for 6 months therefore considered Low priority. Patients on long-term follow up for advanced disease, or post-operative patients for re-staging are considered Low priority for imaging. (2,11)

B. Treatment: Localized Disease

a. Surgery/Ablation

Q: How do we prioritize surgery among patients with localized renal cancers?
A:

1. High Priority: Nephrectomy is advised for cT3+ patients including patients with documented renal vein/IVC thrombus (High priority).
2. Medium Priority: For cT1-2 renal masses, including asymptomatic renal cancer patients, planned partial/radical nephrectomy may be delayed by 3 months thus considered Medium priority.
3. Low Priority: Surgery or ablation of small renal masses < 4cm are classified at Low priority. (3,11)

C. Treatment: Relapsed/Metastatic Disease

a. Systemic Therapy

Q: Among patients ongoing anti-VEGF TKI therapy, how often can monitoring be done?
A: For patients ongoing anti-VEGF therapy, consultation may be done every after 2 cycles (12 weeks) as long as response and tolerance to therapy has been ensured. (2)

Q: Among patients ongoing anti-VEGF TKI therapy, can we offer treatment breaks/delays?
A: Renal cancer patients on anti-VEGF TKI therapy for at least 2 years without clinical progression may be given breaks/delays during treatment. (2,10,11) However, more data is needed as to the maximum duration of treatment breaks that may be allowed to the patient.

Q: Among patients on anti-VEGF TKI therapy who progressed, what other treatment options can be offered?
A: For patients who progress on anti-VEGF TKI therapy, switching to a second-line anti-VEGF therapy may be considered over an immune checkpoint inhibitor/VEGF combination since anti-VEGF TKI therapy is orally administered. Patients with poor risk status, poor performance scores may be offered best supportive care (especially for patients who progress after second or third line therapy). (2)

Q: Among patients on immunotherapy, what is the longest duration of treatment cycles and follow up that can be done?
A: For patients on immunotherapy, nivolumab may be administered every 4 weeks, whereas pembrolizumab may be administered every 6 weeks. (2)

b. Surgery

Q: Among metastatic renal cancer patients, which patients are candidates for cytoreductive nephrectomies?
A: All cytoreductive nephrectomies should be postponed whenever feasible. Avoid surgery for metastatic disease. (2)

c. Radiation

Q: Among metastatic renal cancer patients, who should be prioritized for radiation?
A: Patients with symptomatic brain metastases are considered as high priority for radiation, particularly stereotactic radiation (SRS). (2)

D. Supportive and Palliative Care

Q: Is there a role for surgery as palliative treatment of symptomatic renal cancer?
A: As mentioned earlier, generally it is recommended that we avoid surgery in metastatic disease. (2) Most symptomatic patients are in advanced stages of renal cancers. This type of renal tumors may progress rapidly, eventually making delayed surgeries more difficult. Delayed treatment may also worsen patients' symptoms and decrease their survival and quality of life. Surgery is also an option if there are strong contraindications to local treatment, such as palliative radiation therapy, and palliative systemic therapy.

Q: Is there a role for palliative chemotherapy or palliative radiation therapy?
A: Since delaying treatment in a symptomatic patient with advanced cancer may cause more morbidity or decrease quality of life, immediate palliative radiation therapy in symptomatic metastatic sites or palliative chemotherapy should be prioritized (2). Treatment should be initiated for frontline symptomatic IMDC intermediate- and poor risk metastatic disease (9).

E. Surveillance and Follow-Up

Q: How do we prioritize follow-up of renal cancer patients?

A:

1. High Priority: Asymptomatic metastatic renal cancer patients are still considered High priority for follow-up. However, as previously mentioned, monitoring may be done after every 2 cycles (12 weeks).
2. Medium Priority: Non-metastatic high-risk renal cancer patients following radical or partial nephrectomy are considered Medium priority for follow up. Patients on systemic therapy for at least 1 year are also considered Medium priority.
3. Low Priority: Non-metastatic low- and intermediate- risk renal cancer patients following radical/partial nephrectomy, ablative procedures or those on active surveillance are considered Low priority for follow up.

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