West Midlands cancer alliance

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Kidney Standards of Care

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West Midlands Cancer Alliance

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Document Purpose	The aim of this document is to provide recommendations for streamlining the kidney cancer MDT and does not represent clinical guidelines.	
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Version Control

Version	Date	Amendments
0.1	June 2025	Created by The Royal Wolverhampton NHS Trust (RWT) led by Mr David Mak.
0.2	August 2025	Encompasses comments from the Urology EAG on the 3rd of June 2025.
0.3	October 2025	Encompasses comments from the Urology EAG on the 9th September 2025.
1.0	November 2025	Ratified by WMCA Urology EAG and WMCA Clinical Cabinet

Contents

1.Introduction

The multi-disciplinary team (MDT) has been the cornerstone of cancer care delivery since the Calman-Hine report in 1995 and National Cancer Plan in 2000. Although it was originally mandated that all patients with cancer would be discussed by an MDT, the cancer landscape has changed with the demand for more personalised treatments to a higher volume of patients with more case complexity.

With the ever-increasing burden and workload on MDTs, there is a need to optimise case discussions to derive the full benefit of MDT meetings and provide input where it is needed. In line with guidance published from NHS England and NHS Improvement on streamlining MDT meetings, Standards of Care (SoC) have been introduced in various institutions to good effect with up to 25% of pelvic uro-oncology cases being streamlined and MDT discussion avoided.

There is a requirement for SoCs to be introduced as a routine part of the Urology MDT meetings to stratify patients into those that require full multidisciplinary discussion and those that can be listed but not discussed in the MDT meeting when the patient needs are met by a SoC.

Implementation of SoCs will require more work outside of the MDT meeting, including after the MDT for audit purposes, as well as support from and increased responsibility and input of all clinicians (benign or malignant) whether involved in MDT meeting discussions or not.

A regional SoC is required to decrease the variability in patient management. The West Midlands Cancer Alliance (WMCA) Urology Expert Advisory Group (EAG) had the task to review and agree the proposed SoC document. This was based on the MDT streamlining document by Mr David Mak, Consultant Urologist at RWT based on multiple sources, which are referenced below. A summary of the recommendations made during the EAG is included in the post-EAG meeting minutes document, which can be obtained on request from the WMCA.

This document outlines the various processes around the Urology MDT to facilitate streamlining with the objective of maximising MDT management discussion for patients with complex urological cancer disease that requires a full multidisciplinary approach while protocolising the management of patients with less complex disease for which national guidance (EAU and NICE) is sufficient for decision making.

This document is not intended as a comprehensive guideline for the management of kidney cancer. Instead it is an advisory document on how discussion at MDT can be streamlined in a standardised manner. This can be adapted by individual units as required for their local or regional MDT model.

2. Listing for Cases for MDT

The primary responsibility of listing of patients for formal discussion at MDT lies with the responsible clinician.

Requests for formal discussion at MDT must include a valid clinical question. The role of the MDT is to provide recommendations for treatment, in addition to oversight of clinical governance of cancer patient management. The responsibility of the final treatment choice lies with both the patient and responsible clinician.

When cases are listed for MDT, it must be indicated whether histology review, radiology review or both are required.

As outlined in this document, each of the organ site specific standards of care should be adhered to and guides whether patients are to be formally discussed at MDT or protocoled.

New diagnoses of urological malignancy will be listed on MDT, but not all will be formally discussed in line with the standards of care. Those cases that conform to a SoC will be protocoled.

Patients with benign histopathology will not be formally discussed at MDT unless the responsible clinician detects discrepancies. The responsible clinician must review these results and request MDT discussion if warranted. Benign kidney biopsies do not routinely require discussion.

All tertiary referrals will be formally discussed at MDT. It is essential that all investigations have been received at the tertiary centre before listing and review. The referring clinical team must ensure all relevant information is provided and indicate the investigations that require review. If tertiary referrals are incomplete and further information is required, the case will not be listed at MDT and sent back to the referring clinical team.

Surveillance scans and investigations will not be routinely discussed at MDT. The responsible clinician must review the result of investigations of those patients following a surveillance protocol to determine if formal MDT discussion is required. Post-operative scans reported as no evidence of disease prior to adjuvant therapy also do not require routine MDT discussion.

All patients who may be eligible for a clinical trial will be listed and discussed at the MDT.

Re-discussion of patients who are already being managed under an agreed MDT plan can be warranted if they are complex or if new pertinent information arises that requires discussion by more than one discipline.

Clinicians can request formal discussion of cases if the criteria outlined in the SoC guidance are not fulfilled and if formal MDT discussion is warranted.

When patients are listed for formal MDT discussion, the relevant minimum datasets must be provided by the referring clinician as outlined in the specific organ site guidance detailed below. This will facilitate detailed and accurate discussion of cases. If minimum datasets are not complete, the responsible clinician will be requested to provide the necessary information before listing on MDT.

Whenever possible, all relevant investigations (particularly radiological investigations) should be completed before listing at the MDT.

Note that for review of imported radiological investigations from other Trusts, the image reports must be available for MDT discussion. Cases from other Trusts will not be listed when the image reports are not available.

Table 1 – Summary of criteria for listing at MDT

New diagnosis of urological malignancy	Listed for MDT • Protocoled if standard of care can be applied, • Formally discussed as per SoC guidance,
Tertiary referrals	All cases listed and formally discussed at MDT
Benign histology	Not listed for MDT Responsible clinician to request MDT discussion if warranted after clinical review.
Surveillance investigations	Not listed for MDT Responsible clinician to request MDT discussion if warranted after clinical review.
Eligible for clinical trial	All cases to be listed and formally discussed at MDT
Renal cysts	Only Bosniak 3/4 renal cysts will be listed and formally discussed at MDT The responsible clinician will review Bosniak 2 and 2F renal cysts and can either discuss directly with radiology or at a local uro-radiology meeting if warranted.

3. Renal Cancer

3.1 Risk stratification of renal cancer patients for MDT discussion

Patients that do not fit the criteria in Table 10 can be discussed in full at the MDT or specialist multi-disciplinary team (SMDT) following clinician request.

Note that for patients with new findings of a small renal mass(es), a pre and post contrast CT will be required for review at MDT. Such cases will only be formally discussed at the MDT where there is post contrast enhancement of >15 Hounsfield Units or where CT with contrast is contraindicated. It will be the duty of the responsible clinician to ensure that an appropriate CT has been performed.

Table 2 - Predetermined Standards of Care for Renal Cancer

Risk Group	Standard of Care Guidelines
All patients referred with a suspected new diagnosis of renal cell cancer or upper tract urothelial cancer	**Discuss all cases at MDT** [For small renal masses, cases will only be discussed if a pre and post contrast CT has been performed and there is evidence of >15 Hounsfield Unit enhancement on post contrast scans].
All patients with recurrent renal cell cancer or recurrent upper tract urothelial cancer	**Discuss all cases at MDT**
All patients with metastatic renal cell cancer (mRCC) or metastatic upper tract urothelial cancer	**Discuss all cases at MDT** Patients with mRCC (with primary in-situ) who have had significant response to systemic therapy for whom cytoreductive nephrectomy may be an option. Progressive metastatic disease after first line systemic therapy.
Tertiary referrals for consideration of focal therapy for confirmed renal cell carcinoma	**Discuss all cases at MDT** Review of histology (kidney biopsy) and radiological investigations with representation from interventional radiology department is required.
All patients on active surveillance for small renal masses who are being considered for a change to active treatment.	**Re-discuss case at MDT if the treatment option differs from those previously considered reasonable**
All patients with Bosniak 3 or 4 renal cysts	**Discuss all cases at MDT** *Note – Bosniak 2F renal cysts do not need to be discussed at the MDT. They can be assessed by the*

	responsible clinician and if required discussed with radiology.
All patients after radical or partial nephrectomy with intermediate or high-risk renal cell cancer on histology (Leibovich score >2 or equivalent for non-ccRCC) or positive surgical margins	**Discuss all cases at MDT** Consider referral to oncology for adjuvant therapy in accordance with guidelines. High risk cases post nephrectomy must be seen by oncology within 12 weeks of surgery with a post operative CT scan (to meet funding criteria for adjuvant therapy)
All patients after nephroureterectomy with invasive urothelial cancer (pT2-pT4) on histology	**Discuss all cases at MDT** For consideration of adjuvant therapy as per POUT study.
Patients after radical or partial nephrectomy with low-risk renal cell cancer on final histology • Leibovich score 0-2 for clear cell RCC (or equivalent for non-clear cell RCC) • Clear surgical margins • No evidence of nodal or metastatic disease (normal preoperative staging)	**Standard of care** Recommend surveillance in accordance with local policy. *[Follow up – Telephone OP with kidney team – Priority 2]*
Patients after nephroureterectomy with non-invasive urothelial cancer on final histology • pTa or pT1 • Clear surgical margins • No evidence of nodal or metastatic disease (normal preoperative staging)	**Standard of care** Recommend low risk surveillance in accordance with local policy. *[Follow up – Telephone OP with kidney team– Priority 2]*
Patients post focal therapy (cryotherapy / radiofrequency ablation)	**Standard of care** Recommend surveillance in accordance with local policy as defined by interventional radiology team. *[Follow up – OP review with interventional radiology or kidney team]*
Patients having had a renal mass biopsy who already have been discussed in the MDT and an agreed post-biopsy plan	**Standard of care** Follow agreed post-biopsy plan. Discuss variant or unexpected histology**,** *[Follow up – Inform responsible clinician of result]*

3.2 Renal cancer patients established on surveillance protocols

Renal cancer patients that are under surveillance following treatment or on active surveillance (for small renal mass) will not routinely be discussed at MDT. Scans reporting no recurrent or residual disease prior to adjuvant therapy will not routinely be discussed at MDT.

Investigations undertaken as part of surveillance will be reviewed by the responsible clinician. If findings on surveillance require a change in treatment options from those originally considered reasonable by MDT, the responsible clinician can request formal discussion at MDT.

3.3 Renal cyst patients

Renal cysts identified on radiological imaging (e.g. CT, MRI) should be characterised according to the Bosniak classification.

As outlined in table 10, only Bosniak 3 and 4 renal cysts will be formally discussed at MDT.

Bosniak 2 and 2F renal cysts will not be discussed at MDT. Patients with Bosniak 2 and 2F renal cysts will be reviewed by the responsible clinician and can be discussed directly with radiology or reviewed at the local uro-radiology meeting if required. The responsible clinician can then request formal discussion at MDT if deemed necessary.

The responsible clinician must ensure that all necessary radiological imaging is undertaken to characterise cases of renal cysts before referring to the MDT for discussion if required (e.g. patients with a renal cyst identified on ultrasound should have a CT or MRI before consideration of referral to the MDT).

Surveillance scans of patients with renal cysts will not be discussed at MDT. If there is a need for a change in treatment strategy based on the surveillance scan, the responsible clinician will request formal discussion at MDT.

3.4 Chest CT

If the results of a CT chest will affect the management of a renal mass, it should ideally be available to review at the time of MDT discussion. If a staging chest CT has not been performed, the MDT should decide whether a chest CT not showing evidence of metastatic disease should also be reviewed at the MDT once done, or if it is appropriate to simply accept a negative report. All lung nodules on staging CT should be discussed in MDT.

3.5 Adrenal lesions

Patients who are found to have adrenal lesions on radiological imaging, in the absence of other suspected or known urological pathology/malignancy, will not be discussed at MDT. These cases should be referred to the adrenal MDT directly for formal review.

3.6 Minimum clinical dataset for kidney patients discussed at MDT

When a patient is added to the MDT irrespective of whether the patient's case is protocoled or formally discussed, the data items outlined in Table 11 (the minimum clinical dataset) must be provided.

Table 11 - Minimum clinical dataset for kidney patients discussed at MDT

Required minimum clinical dataset
Patient age
Is patient aware of diagnosis
Co-morbidities – including diabetic state, cardiovascular status & previous surgery
BMI
Performance status (WHO)
TNM staging
Fuhrman grade
Histological type
Imaging performed to date [MRI, Bone Scan, CT, PET Scan]
Serum creatinine/eGFR and haemoglobin
Status of contralateral kidney
Symptoms – e.g. haematuria
Type of MDT Discussion held – Standard of Care or Full MDT Discussion
Documentation of discussion
Recommendation / Management Plan

3.7 Glossary of Acronyms

Acronym	Definition
BMI	Body mass index
ccRCC	Clear cell renal cell carcinoma
CT	Computerised tomography
EAG	Expert Advisory Group
EAU	Expert Advisory Group
eGFR	Estimated glomerular filtration rate
MDT	Multi-disciplinary team
mRCC	Metastatic renal cell carcinoma
MRIU	magnetic resonance imaging
NICE	National Institute for Health and Care Excellence
OP	Outpatient
PET	Positron emission topography
POUT	Peri-Operative chemotherapy versus Surveillance in Upper Tract Urothelial Cancer
RCC	Renal cell carcinoma
RWT	Royal Wolverhampton NHS Foundation Trust
TNM	Tumour Nodes Metastases
SMDT	Specialist multi-disciplinary team
SOC	Standards of care
WHO	World Health Organization
WMCA	West Midlands Cancer Alliance