RM Partners
West London Cancer Alliance

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NHS

Standards of Care: Urology Cancer Multidisciplinary Meetings

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RM Partners Document Control

Document History

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Quality Control and Sign off

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Contents

1 Introduction

This Standard of Care (SOC) document concerns details of how patients should be streamlined within the framework of Urology MDM/SMDMs for all Trusts within the RM Partners Cancer Alliance.

It is envisioned that 'streamlining' will maximise MDM/SMDM management discussions 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 guidelines e.g. (EAU, NICE & AUA) are sufficient for decision-making.

Furthermore, the streamlining of MDM's/SMDM's is expected to encourage and foster a learning environment for all clinicians and students involved in the MDM process. This document will be reviewed on an annual basis.

2 Risk stratification

2.1 Risk stratification of prostate patients for MDM discussion

Patients will be risk stratified according to their serum PSA, clinical stage, and Gleason score in alignment with NICE Guidelines. Patients will be further characterised according to life expectancy.

Criteria for discussion at MDM are:

- All high risk prostate cancer cases need to be discussed at MDM
- Metastatic, low risk and intermediate risk prostate cancer cases will be protocolised according to their potential treatment options and not formally discussed at the MDM - rather the MDM chair will ratify the standard

Patients that do not fit the criteria in Table 1 can be discussed in full at the MDM following clinician request.

Finally, Appendix 1 set out the data items (minimum clinical dataset) that must be provided when a patient is added to the MDM irrespective of whether the patients' case is protocoled or formally discussed.

2.1.1 Table 1; Predetermined Standards of Care for Prostate

Risk Group	Standard of Care Guidelines
Cambridge Prognostic Group 1: *Low risk prostate cancer cases* • Gleason score 6 (grade group 1) *AND* • PSA < 10 ng/ml *AND* • Stages T1–T2	**Standard of care** Recommend active surveillance as first choice. Active surveillance to involve serial PSA testing (6 monthly), repeat MRI Scan at 1 year, and consider repeat prostate biopsy in conjunction with PSA and MRI. Consider treatment defined by the MDT, if patient rejects active surveillance following multidisciplinary counselling or if patient life expectancy >20 years although this should be discouraged as benefits of surveillance maybe most in younger men. Bulky disease on MRI likely to have been undersampled should be re-evaluated with early MRI at 6-12 months followed by biopsy.
Cambridge Prognostic Group 2: *Low - intermediate risk prostate cancer cases* • Gleason score 3 + 4 = 7 (grade group 2) *OR* • PSA 10–20 ng/ml *AND* • Stages T1–T2	**Standard of care** Active surveillance Active surveillance to involve serial PSA testing (6 monthly), repeat MRI scan at 1 year and consider repeat prostate biopsy in conjunction with PSA and MRI Consider treatment defined by the MDT, if life expectancy >10 years Active surveillance if patient rejects treatment defined by the MDT, providing they are fully informed that they have a slightly higher risk of metastasis over next 10-15 years
Cambridge Prognostic Group 3: *Intermediate risk prostate cancer cases* • Gleason score 3 + 4 = 7 (grade group 2) *AND* • PSA 10–20 ng/ml	**Standard of care** Recommend treatment defined by the MDT, if life expectancy >10 years Active surveillance if patient has low volume disease (Gleason score 3+4) on MRI and prostate biopsy if patient rejects radical therapy, providing they are fully informed that they have a higher risk of metastasis over next 10-15 years

AND • Stages T1–T2 *OR* • Gleason score 4 + 3 = 7 (grade group 3) *AND* • Stages T1–T2	
Cambridge Prognostic Group 4: High risk prostate cancer cases One of the following: • Gleason score 8 (grade group 4) *OR* • PSA > 20 ng/ml *OR* • Stage T3	**Discuss all cases at LMDM and/or SMDM** Recommend treatment defined by the MDT.
Cambridge Prognostic Group 5: High risk prostate cancer cases • Any combination of Gleason score 8 (grade group 4), PSA > 20 ng/ml OR Stage T3 *OR* • Gleason score 9–10 (grade group 5) *OR* • Stage T4	**Discuss all cases a LMDM and/or SMDM**

Any risk (excluding metastatic) prostate cancer cases with marked comorbidity making ineligible for radical therapy	**Standard of care** Recommend watchful waiting Watchful Waiting to include serial PSA testing and symptom review (6 monthly) either in primary or secondary care.
Metastatic prostate cancer	**Standard of care** Recommend Systemic treatment (chemotherapy or AR targeted therapy) For low volume metastatic disease advise Radiotherapy to the prostate For patients with marked co-morbidity making them not suitability for chemotherapy, recommend hormone monotherapy. If symptomatic, consider oncology referral

2.1.2 Appendix 1; Minimum clinical dataset for prostate patients discussed at MDM/SMDM

	Required minimum clinical dataset	Complete
1.	Patient Age	
2.	Is patient aware of diagnosis	
3.	Comorbidity - listed in words	
4.	Performance status (as per NPCA – National Prostate Cancer Audit)	
5.	PSA at diagnosis	
6.	TNM staging:	
	– Local T stage (T1-T4)	
	– Nodal status (N0-N2)	
	– Metastatic status (M0-M2)	
7.	Number of positive biopsy cores / Number of total cores	
8.	Imaging performed to date:	
	– MRI	
	– Bone Scan	
	– PET Scan	
	– CT	
9.	Is the patient eligible for a clinical trial?	
10.	Family history	
11.	Ethnicity	
12.	Lower urinary tract symptoms	
13.	Type of MDT Discussion held: Standards of Care or Full MDT Discussion	
14.	Recommendations/Management Plan	

2.2 Risk stratification of prostate patients for Diagnostic Clinical Review

Patients will be risk stratified according to their PIRADs /Likert score, in alignment with European Association of Urology (EAU) Guidelines.

Risk Group	Standard of Care Guidelines
PI-RADS or Likert 1–2 with PSA density < 0.12	**Standard of care** No biopsy required Discharge to Primary care, recommending PSA follow up. Ensure an ad personum PSA is given to Primary Care for re-referral, based patient's prostate volume and PSAD 0.12.
PI-RADS or Likert 1–2 with PSA density ≥ 0.12	**Diagnostic Clinical Review** No biopsy required usually. Trans-perineal Biopsy can be advised if there are other risk factors e.g., family history or ethnicity risk. Ensure an ad personum PSA is given to Primary Care for re-referral based on a 20% rise from baseline PSA level.
PI-RADS or Likert 3	**Diagnostic Clinical Review** If PSA density <0.12, then no biopsy usually required. Ensure an ad personum PSA is given to Primary Care for re-referral based on patient's prostate volume and PSAD 0.12. If PSA density >0.12, suggest trans-perineal biopsy
PI-RADS or Likert 4-5	**Standard of care** Recommend trans-perineal biopsy

2.2 Risk stratification of bladder patients for MDM discussion

If a core member of the Urology MDT agrees with radiology and pathology findings, patients will be risk stratified according to their tumour histological subtype and grade, size, focality and history of previous bladder or upper tract disease, in alignment with European Association of Urology Guidelines.

Patients will be further characterised according to life expectancy.

All patients should be considered for clinical trials.

Criteria for discussion at MDM/SMDM are:

- all intermediate and high-risk bladder cancer cases and new diagnosis of metastatic bladder cancer cases must be discussed at MDM/SMDM;
- low risk disease will be protocoled according to their potential follow-up options and not formally discussed at the MDM/SMDM-rather the MDM chair will ratify the standard.

Patients that do not fit the criteria in Table 2 can be discussed in full at the MDM/SMDM following clinician request.

Finally, Appendix 2 sets out the data items (minimum clinical dataset) that must be provided when a patient is added to the MDM/SMDM irrespective of whether the patients' case is protocoled or formally discussed. Appendix 3 shows a bladder map.

2.2.1 Table 2; Predetermined Standards of Care for Bladder

Risk Group	SWL Feedback - Standard of Care Guidelines
High risk bladder cancer cases • *Non-Urothelial:* Squamous Cell Carcinoma • *Non-Urothelial*: Adenocarcinoma • Non-Urothelial: Small Cell Carcinoma • *Non-Urothelial:* Unusual Histological Subtypes (Lymphoma etc) • *Urothelial:* pTaG3 • *Urothelial:* pT1G2 • *Urothelial*: pT1G3 • *Urothelial:* pTis (Cis) • Aggressive variants of urothelial carcinoma, for example micropapillary or nested variants • Muscle invasive pT2 and above • Non-muscle invasive cancers who fail BCG treatment	**Discuss all cases at MDM and/or SMDM.** All patients who have a muscle invasive bladder cancer should also be fast tracked to SMDM (ideally from flexible cystoscopy)
Intermediate risk bladder cancer cases (Urothelial) • Solitary pTaG1 with a diameter of more than 3 cm • multifocal pTaG1 • Solitary pTaG2 (low grade) with a diameter of more than 3 cm • Multifocal pTaG2 (low grade) • Any pTaG2 (grade not further specified) • Any low-risk non-muscle-invasive bladder cancer recurring within 12 months of last tumour occurrence	**Standard of care** For intravesical mitomycin C treatment (active [EMDA] or passive) once a week for 6 weeks And Surveillance cystoscopy in line with EAU guidelines, with initial cystoscopy surveillance in 3 months. OR Symptomatic Control - if marked co-morbidity or poor performance status (Intervention with Cystoscopy +- TURBT/TULA if patient exhibits symptoms including haematuria, lower urinary tract symptoms or deteriorating renal function if obstruction suspected) can be considered. This can also be considered if patient rejects cystoscopic surveillance or if patient life expectancy <5 years although benefits of surveillance may be in favour of younger men).

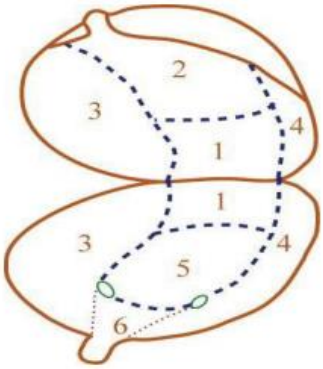
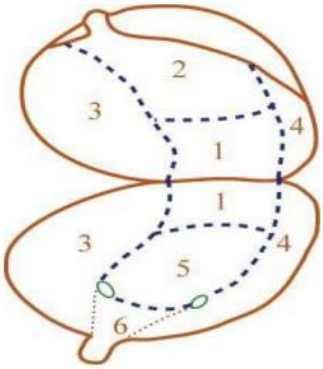
Intermediate risk bladder cancer cases • Urothelial: Recurrent pTaG2 (high grade)	**Discuss all cases at LMDM.** Recommend BCG
Low risk bladder cancer cases • Solitary pTaG1 with a diameter of less than 3 cm • Solitary pTaG2 (low grade) with a diameter of less than 3 cm. Any papillary urothelial neoplasm of low malignant potential	**Standard of care** Recommend surveillance cystoscopy as first choice, in line with EAU guidelines, with initial cystoscopy surveillance in 3 months. Symptomatic Control - if marked co-morbidity or poor performance status (Intervention with Cystoscopy +- TURBT/TULA if patient exhibits symptoms including haematuria, lower urinary tract symptoms or deteriorating renal function if obstruction suspected) can be considered. This can also be considered if patient rejects cystoscopic surveillance or if patient life expectancy *<5 years* although benefits of surveillance may be in favour of younger men.
Metastatic bladder cancer cases Definition of metastatic disease: Pelvic or Non-Pelvic Lymph Node/Bone/Soft tissue harbouring bladder cancer in addition to local bladder cancer on imaging	**Discuss all cases at MDM and/or SMDM.**
Metastatic bladder cancer with marked co-morbidity making unsuitable for chemotherapy or immunotherapy	**Standard of care** Symptomatic Control Only. Referral to Community Palliative Care Team.

2.2.2 Appendix 2; Minimum clinical dataset for bladder patients discussed at MDM/SMDM

	Required minimum clinical dataset	Complete
1.	Patient Age	
2.	Is patient aware of diagnosis	
3.	Comorbidity - listed in words	
4.	Smoking History	
5.	ASA grade	
6.	Performance status	
7.	Bladder Map Containing	
	– Size of Tumour	
	– No. of Lesions	
	– Description of Lesion (Solid/Papillary)	
	– Tumour Cleared or Residual Remaining	
	– Urethral biopsies	
8.	TNM staging:	
	– Local T stage (T1-T4)	
	– Nodal status (N1-N2)	
	– Metastatic status (M1-M2)	
9.	Histological: – Grade: High/Low and G1/2/3 – Muscle:	
10.	Any previous history of bladder cancer and treatment received to date	
11.	Is patient on fast-track pathway for likely muscle invasive bladder cancer and fit for radical treatment	Histology and imaging not required
12.	Imaging performed to date:	
	MRI	

	Bone Scan	
	PET Scan	
	CT CAP/UROGRAM	
13.	Kidney function to date: (tick if completed) GFR bloods	
14.	Symptoms e.g., haematuria	
15.	Is the patient eligible for a clinical trial?	
16.	Type of MDT Discussion held: Standards of Care or Full MDT Discussion	
17.	Recommendations/Management Plan	

2.2.3 Appendix 3; Bladder map

CYSTOSCOPY - Bladder Map	
Bladder Map at Initial Diagnosis	Latest Bladder Map (At Last Cystoscopy – If Applicable)
	

2.3 Risk stratification of renal patients for MDM discussion

Patients that do not fit the criteria in Table 3 can be discussed in full at the MDM/SMDM following clinician request.

Finally, Appendix 4 sets out the data items (minimum clinical dataset) that must be provided when a patient is added to the MDM/SMDM irrespective of whether the patients' case is protocoled or formally discussed.

2.3.1 Table 3; Predetermined Standards of Care for Renal

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 LMDM** For discussion at **SMDM** if bilateral tumours, solitary kidney, poor renal function
All patients with recurrent renal cell cancer or recurrent upper tract urothelial cancer	**Discuss all cases at LMDM** For discussion at **SMDM** if metachronous lesion in solitary kidney, post cryotherapy and post partial Recurrent upper tract urothelial cancer to be discussed at Bladder/Urothelial SMDM.
All patients with metastatic renal cell cancer or metastatic upper tract urothelial cancer	**Discuss all cases at LMDM** For discussion at LMDM with initial metastatic presentation **For discussion at SMDM:** Large tumours considered for CRN Patients with mRCC (with primary in-situ) who have had significant response to systemic therapy with metastases for whom CRN may be an option. Progressive metastatic disease after first line systemic therapy Metastatic upper tract urothelial cancer needs to be discussed in Bladder/Urothelial SMDM.
All patients with small renal masses on active surveillance who are being considered for a change in management to active treatment	**Discuss all cases at LMDM**

All patients with Bosniak 2F, 3 or 4 renal cysts	**For discussion at LMDM**
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	For discussion at **SMDM** and consider adjuvant trial
All patients after nephroureterectomy with invasive urothelial cancer (pT2-pT4) on histology	**Discuss all cases at Bladder/Urothelial SMDM.** For discussion at Bladder/Urothelial SMDM for consideration of chemo as per POUT eGFR <50 carboplatin, >50 cisplatin.
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 pre-operative staging)	**Standard of care** Recommend EAU CT TAP at 6,18, and 36 months, and then at year 5. Follow AUA Guidelines: • For Partial Nephrectomy recommend CT AP at 6, 18 and, 30mths, with Chest X-Ray yearly for 3 years. • For Radical Nephrectomy recommend CT in year 1 and if clear at Clinicians' discretion. Chest X-Ray yearly for 3 years U&E's blood tests for all patients prior to each CT scan
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 pre-operative staging)	**Standard of care** For discussion at LMDM. For low-risk tumours, recommend cystoscopy at three months. If negative, perform subsequent cystoscopy nine months later and then yearly, for 5 years. Perform computed tomography urography every year, for 5 years.
Patients post Cryotherapy	**Standard of care**

	Follow AUA Guidelines (no EAU guideline on F/U): • CT AP at 3,6 and 12 months and then yearly for 5 years • CT Chest scan yearly U&E's blood tests for all patients prior to each CT scan
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

2.3.2 Appendix 4; Minimum clinical dataset for renal patients discussed at MDM/SMDM

	Required minimum clinical dataset	Complete
1.	Patient Age	
2.	Is patient aware of diagnosis	
3.	Comorbidity - listed in words	
4.	Performance status	
5.	TNM staging:	
	– Local T stage (T1-T4)	
	– Nodal status (N1-N2)	
	– Metastatic status (M1-M2)	
6.	Fuhrman grade	
7.	Histological type	
8.	Risk category (primary or metastatic disease)	
9.	Life expectancy	
10.	Renal function	
11.	Symptoms	
12.	Family history of cancer/renal cancer?	
13.	Type of MDT Discussion held: Standards of Care or Full MDT Discussion	
14.	Recommendations/Management Plan	

2.4 Management of MDM discussion for testicular and penile patients

In line with the current clinical guidelines on the management of testicular and penile cancer, SoC pathways are not required. All patients with a confirmed testicular or penile cancer and/or those patients where a clinician makes a request MDM review, will have a full MDM discussion undertaken.