I'M A TESTICULAR CANCER SURVIVOR

TEST ME

Testicular cancer survivors are at risk of developing testosterone deficiency, which can result in metabolic syndrome and poor cardiac health.¹⁻⁵

The European Society for Medical Oncology recommends measurement of testosterone levels during follow-up.⁶

References:

Adverse events should be reported. Reporting forms and information can be found at:
www.mhra.gov.uk/download or search for NPSA Yellow Card or NPSA Yellow Card. Adverse events should also be reported to Besins Healthcare (UK).
Email: pharmacy@besinshealthcare.com

Besins Healthcare
Innovating for Well-being

PreScri ption Information TESTosterone Replacement Therapy (R) 2018-01-01

For full prescribing information, including side effects, precautions and contraindications, please consult the Summary of Product Characteristics (SPC).
Renal oncocytoma: landscape of diagnosis and management

Renal oncocytoma represents between 6% and 12% of T1 renal tumours in surgical series [1–2]. Contemporary imaging cannot differentiate oncocytoma from malignant renal cell carcinoma (RCC). Uptake of renal tumour biopsy in clinical practice has been variable [3] and surgery with partial or radical nephrectomy is the first line in the management of RCC [4,5]. Many patients with renal masses therefore undergo empirical surgery for presumed RCC but have a postoperative histological diagnosis of benign oncocytoma.

While nephron-sparing and minimally invasive surgical techniques have undoubtedly improved surgical outcomes and reduced morbidity, there remains substantial risk associated with surgical resection. Recent national data for the surgical management of oncocytoma showed that 20% of patients experienced inpatient complications, and there was a 60-day mortality rate of 0.4% [6].

To understand the landscape of current oncocytoma diagnosis and management, we conducted a clinician survey to establish clinical practice. Sixty-eight clinicians from six countries took part in an online questionnaire openly distributed via social media. Just over half of respondents were UK-based, one-third were from North America, and the remainder were from across Europe, Africa and Australasia. The majority of respondents were consultants (72%), and more than half (54%) were involved in over 40 radical or partial nephrectomy cases per year. The majority (54%) saw six or more patients a year with renal oncocytoma in their practice. Renal tumour biopsy of small renal masses (≤4 cm) was routine practice for only 29% of respondents, 20% offered it ‘often (20–50% of the time)’, 26% ‘occasionally (10–20% of the time)’, and 25% offered it ‘rarely’ or ‘almost never’ (<10% of the time). Barriers to biopsy were identified as high non-diagnostic rate, concern regarding hybrid tumours, diagnostic accuracy and it not being standard practice in the department.

An initial conservative management strategy with active surveillance or watchful waiting was associated with smaller tumours (P < 0.001), and older (P < 0.001) and more comorbid patients (P < 0.001), with the majority of respondents usually adopting a conservative strategy for small tumours in elderly or comorbid patients. However, there was a lack of consensus for the management of younger patients and larger tumours. For example, a 3-cm oncocytoma diagnosed in a fit 50-year-old patient would usually be managed with active surveillance or watchful waiting by 52% of respondents, and surgery or ablation by 33%, while the remaining 15% would usually adopt either strategy according to patient preference. Similarly, for a fit 60-year-old patient with a 6-cm oncocytoma, 47% would usually treat with surgery or ablation, and 44% with active surveillance, with 9% adopting either strategy according to patient preference.

There was also variation in preferred imaging method for surveillance of biopsy-confirmed oncocytoma, with 49% favouring CT, 36% ultrasonography and 15% MRI. For frequency of surveillance imaging, two-thirds of respondents favoured imaging at 6 months and annually thereafter across each imaging method. The majority of respondents agreed that a change in imaging characteristics (87%), development of symptoms (61%) and an increase in size >25% in 1 year (61%) would warrant a change in management strategy.

The survey also demonstrated variation in follow-up regimens for patients with completely surgically excised oncocytoma. After complete surgical resection of an oncocytoma with no aggressive features on histology, 54% would discharge the patient after the first postoperative review, while 22% would continue surveillance imaging for up to 5 years. If surgical pathology demonstrated either fat or vascular invasion, however, only 14% chose to discharge after the first postoperative review, with 49% favouring surveillance imaging for up to 5 years.

Strengths of the present study include the snapshot of international practice from a large number of high-volume surgeons. Limitations include the fact that the survey was not distributed to all practising urologists, and there may be bias introduced by recruiting clinicians via social media networks. Additionally, patient factors but not surgeon factors influencing diagnostics and management strategy were evaluated.

The poor uptake of renal tumour biopsy highlights the need for improved diagnostics of benign renal tumours that are
accurate and acceptable to patients and clinicians alike. Technetium (99mTc)-sestamibi single-photon emission CT (SPECT)/CT has shown promise in small trials in the USA and Sweden in distinguishing benign oncocytoma from RCC [7–9]. 99mTc-sestamibi is a radiotracer preferentially taken up by cells with abundant mitochondria such as oncocytoma, and actively transported out of cells in RCCs. Oncocytomas therefore light up brightly on SPECT/CT, appearing ‘hot’, while RCCs are devoid of tracer and appear ‘cold’. A prospective study of 50 patients reported sensitivity and specificity of 87.5% and 95.2%, respectively, for 99mTc-Sestamibi SPECT/CT in diagnosing oncocytomas and indolent hybrid oncocytic/chromophobe tumours [7]. In our clinician survey a majority of respondents expressed interest in recruiting patients to a trial assessing the utility of 99mTc-Sestamibi SPECT/CT in the evaluation of renal masses, with 76% responding ‘yes’ and 21% responding ‘potentially – need more information’. A prospective single-centre trial has recently opened in the UK to assess the acceptability and feasibility in the NHS setting (ISRCTN23705289).

The survey demonstrates that the majority of participating clinicians support management of renal oncocytomas with surveillance in select clinical scenarios; however, it also demonstrated variable practice, which highlights research gaps in the field.

Key evidence gaps highlighted by this survey are underpinned by the lack of understanding of the natural history of oncocytomas and the dearth of randomized controlled trials to inform best practice. Our own group has reported the safety of oncocytoma active surveillance in just under 100 patients over a median follow-up of 2 years [10], consistent with smaller longitudinal cohort studies [11,12]. However, reporting of outcomes over the longer term is needed to increase confidence in managing these tumours conservatively in patients with long life expectancy. Research into tumour behaviour stratified by size at presentation may also help select patients for surveillance. Further, tumour recurrence rates for surgically excised oncocytoma both with and without invasive features on pathology are required to inform appropriate surveillance strategies after operative management. Finally, well-designed randomized controlled trials are required to provide high-level evidence for guideline recommendations and to standardize practice for each stage of the patient pathway (diagnosis, management and follow-up).

**Acknowledgements**

We would like to thank all of the clinicians who kindly participated and shared the survey with their networks.

**Disclosure of Interest**

None declared.

Hannah Warren¹, Joana B. Neves²,³ and Maxine G. B. Tran²,³

¹Department of Urology, King’s College Hospital NHS Foundation Trust, ²Division of Surgery and Interventional Science, University College London, and ³Specialist Centre for Kidney Cancer, Royal Free London NHS Foundation Trust, London, UK
References

1 Lane BR, Babineau D, Kattan MW et al. A preoperative prognostic nomogram for solid enhancing renal tumors 7 cm or less amenable to partial nephrectomy. J Urol 2007; 178(2): 429–34

Correspondence: Maxine G. B. Tran, UCL Division of Surgery and Interventional Science, Royal Free Hospital, Pond street, 9th Floor, London NW3 2QG, UK.
e-mail: m.tran@ucl.ac.uk
Abbreviation: 99mTc, technetium; RCC, renal cell carcinoma; SPECT, single-photon emission CT.
PROSTATE CANCER QUESTION HOUR

RCT to RWE: The evolution of non-metastatic castration-resistant prostate cancer treatment

Thursday 2 December 2021
18:00-19:00 GMT

REGISTER HERE FOR THIS PROMOTIONAL WEBINAR

Please join us for what promises to be a highly informative event, featuring a faculty of top international experts:

Professor Heather Payne,
Consultant Clinical Oncologist,
University College Hospital, London, UK

Dr Thirivyam Elumalai,
Consultant Clinical Oncologist,
Addenbrooke’s Hospital, Cambridge University Hospitals NHS Foundation Trust, Cambridge, UK

Professor Karim Fizazi,
Medical Oncologist,
Head of the Department of Cancer Medicine,
Gustave Roussy Institute, Villejuif, France

Mr William Cross,
Consultant Urological Surgeon,
St James’s University Hospital, Leeds Teaching Hospitals NHS Trust, Leeds, UK

NUEGA® (Daranatumab) 300 mg film-coated tablets
Prescribing Information (Refer to full Summary of Product Characteristics (SmPC) before prescribing)

Presentation: Each film-coated tablet contains 300 mg of daratumumab. Indications: NUEGA is indicated for the treatment of adult men with non-metastatic castration-resistant prostate cancer (nmCRPC) who are at high risk of developing metastatic disease. Pathology & method of administration: Treatment should be initiated and supervised by a specialist physician experienced in the treatment of prostate cancer. Medical castration with a luteinising hormone-releasing hormone (LHRH) analogue should be continued during treatment of patients not surgically castrated. For oral use. The tablets should be taken whole with food. Adult: 300 mg daratumumab tablets 3 tablets 300 mg twice daily, equivalent to a total daily dose of 1200 mg. Children & adolescents: No relevant use of daratumumab in the paediatric population for the indication of treatment of nmCRPC. Efficacy: No dose adjustment is necessary. Renal impairment: No dose adjustment is necessary for patients with mild or moderate renal impairment. For patients with severe renal impairment (GFR 15-20 mL/min/1.73 m2), not receiving haemodialysis, the recommended starting dose is 300 mg twice daily. Hepatic impairment: No dose adjustment is necessary for patients with mild hepatic impairment. This available data on daratumumab pharmacokinetics in moderate hepatic impairment is limited. Daratumumab has not been studied in patients with severe hepatic impairment. For patients with moderate and severe hepatic impairment (Child-Pugh Classes B and C), the recommended starting dose is 300 mg twice daily. Contra-Indications: Hypersensitivity to the active substance or to any of the excipients. Women who are or may become pregnant. Warnings & precautions: The available data in patients with severe renal impairment are limited. As exposure might be increased those patients should be closely monitored for adverse reactions. The available data in patients with moderate hepatic impairment are limited, and daratumumab has not been studied in patients with severe hepatic impairment. As exposure might be increased those patients should be closely monitored for adverse reactions. Patients with clinically significant cardiovascular disease in the past 6 months including stroke, myocardial infarction, severuncontrollable angina, pectoris, coronary/peripheral artery bypass graft, and symptomatic congestive heart failure were excluded from the clinical studies. However, the safety of daratumumab in these patients has not been established. Use of strong CYP3A4 and P-gp inhibitors during treatment with daratumumab may decrease the plasma concentration of daratumumab and is not recommended, unless there is no therapeutic alternative. Selection of an alternate co-administrated medicinal product with less potential to induce CYP3A4 or P-gp should be considered. Patients should be monitored for adverse reactions of BCRP, OATP1B1 and OATP1B3 substrates as co-administration with daratumumab may increase the plasma concentrations of these substrates. Co-administration with cyclosporin should be avoided unless there is no therapeutic alternative. In patients with a history of risk factors for QT prolongation and in patients receiving concomitant medicinal products that might prolong the QT interval, physicians should assess the benefit-risk ratio including the potential for tachycardia de points prior to initiating NUEGA. NUEGA 300mg film-coated tablets contains lactose. Patients with rare hereditary problems of glucose/galactose intolerance, total lactase deficiency or glucose/galactose malabsorption should not take the medicinal product. Interactions: For the effect of other medicinal products on the action daratumumab in CYP3A4, P-gp inducers and CYP3A4, P-gp and BCRP substrates and UGT1A1 inhibitors and the action of daratumumab on other medicinal products (BCRP, OATP1B1, OATP1B3 substrates, P-gp substrates, CYP3A4 substrates and other medicinal products that prolong the QT interval) refer to the SmPC. Pregnancy & lactation: Daratumumab is not indicated in women of childbearing potential, and it is not to be used in women who are, or may be, pregnant or breastfeeding. Unknown whether daratumumab or its metabolites are present in semen. If the patient is engaged in sexual activity with a woman of childbearing potential, a highly effective contraceptive method (<1% failure rate per year) should be used during and for 1 week after completion of treatment. Unknown whether daratumumab or its metabolites are excreted in human milk. No studies in animals have been conducted to evaluate the secretion of daratumumab or its metabolites into milk. A risk to the breast-fed child cannot be excluded. There are no human data on the effect of daratumumab on fertility. Based on animal studies, daratumumab may impair fertility in males of reproductive potential. Effects on ability to drive and use machines: Daratumumab has no or negligible influence on the ability to drive and use machines. Undesirable effects: Very common: Glucometabolic conditions (incl. fatigue and flushing); lidocaine, melphalan, neutrophil granulocyte, thrombocytosis, AST; increased. Common: Myocardial heart disease (including arrhythmias); coronary artery disease; coronary artery occlusion; coronary artery stenosis; acute coronary syndrome; acute myocardial infarction; angina pectoris; angina unstable, myocardial infarction; myocardial ischemia); heart failure (including cardiac failure; cardiac failure acute; cardiac failure chronic; cardiac failure congestive; cardiogenic shock; rash, pain in extremities, musclekeletal pain, fractures). Prescriptions should consult the SmPC in relation to side effects. Overdose: In the event of intake of a higher than recommended dose, treatment with daratumumab can be continued with the next dose as scheduled. There is no specific antidote for daratumumab and symptoms of overdose are not established. Legal Category: POM. Package Quantities & Basic NHS Costs: Pack of 112 film-coated tablets, 54 (60). MA Number(s): EMA/23143/2001 Further information available from: Bayer plc, 409 South Park Way, Reading RG2 6GD United Kingdom. Telephone: 0118 206 5000. Date of preparation: March 2020

NUEGA® is a trademark of the Bayer Group

nmCRPC, non-metastatic castration-resistant prostate cancer; RCT, randomised controlled trial; RWE, real-world evidence. This promotional meeting has been organised and funded by Bayer and is for healthcare professionals only.