

Use of Surveillance versus Active Treatment for Renal Masses ≤ 7 cm: Results from the MUSIC KIDNEY regional collaborative

Brian Lane*, Grand Rapids, MI, Alon Weizer, Tae Kim, Ji Qi, Ann Arbor, MI, Sanjeev Kaul, Royal Oak, MI, Edward Schervish, Troy, MI, Benjamin Stockton, St. Joseph, MI, Craig Rogers, Detroit, MI, for the Michigan Urological Surgery Improvement Collaborative, Ann Arbor, MI

INTRODUCTION AND OBJECTIVES: Regional quality improvement collaboratives are an effective way to analyze the patterns of care that are in place across multiple practices. The Michigan Urological Surgery Improvement Collaborative (MUSIC) has established the infrastructure to examine prostate cancer outcomes in Michigan. We describe the initial pattern of usage of active surveillance in a regional quality improvement collaborative for kidney cancer.

METHODS: MUSIC Kidney mass: Identifying and Defining Necessary Evaluation and therapy (KIDNEY) was proposed in September 2015, approved in December 2015, and underwent beta testing in 2016-2017. Case entry for 8 Michigan practices began in September 2017. Clinical, radiographic, pathologic, and short-term follow-up data were entered into the registry by data abstractors at a single point in time (120 days after initial office visit).

RESULTS: During the initial 2 months of data entry, 62 patients with newly diagnosed renal masses ≤ 7 cm in size were evaluated. Seven diverse pilot practices contributed data from visits to 16 physicians. Of these patients, 31 initially chose definitive treatment and 22 pursued active surveillance (AS). Nine patients had a renal biopsy to help make their treatment decision, after which 3 chose AS, 5 chose definitive treatment, and 1 was lost to follow-up. Final treatment decisions demonstrated variation across practices, with 24 (39%) patients choosing AS, 36 (58%) patients choosing definitive treatment, and 2 (3%) patients lost to follow-up. Patients choosing AS versus definitive treatment demonstrated a significant difference in comorbidities (Charlson comorbidity score ≥ 2 in 63% vs. 26%, $p=0.017$) and tumor size (median: 2.7 vs. 4.0 cm, $p=0.110$). Age, gender, race, insurance status, BMI, and GFR were not significantly associated with treatment decision ($p>0.05$ for each). AS use among pilot practices varied from 0-69% (Figure 1).

CONCLUSIONS: In our initial assessment of treatment patterns for patients with localized SRM ≤ 7 cm, a surprisingly high proportion of patients (39%) were managed (at least initially) with surveillance. Further information regarding the factors leading to surveillance and the heterogeneity of practice patterns across the state will be collected.

Source of Funding: Blue Cross Blue Shield of Michigan

Figure 1: MUSIC KIDNEY Pilot practice level variation in SRM surveillance

