

Clinicians Consider Identification, Management of RCC Through the Patient's Eyes

James Zoeller was diagnosed with renal cell carcinoma (RCC) in April 2024 after already having stage II testicular cancer following a diagnosis in 1995. He spoke with members of his care team, including Hannah Dzimitrowicz McManus, MD, assistant professor of medicine at Duke Cancer Center Genitourinary Clinic in Durham, North Carolina, and Allison Brown, BSN, RN, RN-BC, a nurse coordinator at the Duke Cancer Center, about his experience being treated for RCC.

The conversation took place during a CancerNetwork *From All Angles* program, and Zoeller shared what it was like working with McManus to choose what type of treatment to take while also working with Brown to understand what types of adverse effects (AEs) he would experience during treatment.

Diagnosing and Treating RCC

McManus / Can you please share your experience of being diagnosed with clear cell RCC?

Zoeller / I had 2 big symptoms that I ignored. Early on, I was getting up and going to the bathroom once a night, and that quickly changed to going 3 times a night; that was a red flag that should have told me something was wrong. I also discovered I had a low-grade fever in the evenings [but not] during the day. [Those are] 2 quick things that somebody might be able to catch on to... a little sooner than I did.

I was getting tired. I was having a lot of fatigue... Then I started losing weight and lost my appetite. Then I caught [COVID-19], so that made [diagnosing myself more difficult]. I got far down the path before I realized something was going wrong. It wasn't until I got blood work done and a basic [complete blood count] panel showed that I was anemic [that it] raised the first red flag that I was having some type of issue with my

body. We also did a couple [of] other blood tests; the sedimentation rate and C-reactive protein [levels] indicated I had some type of inflammation going on inside [my body].

With that information, my wife and I pushed to get a CT scan done, a full-body, pelvic, abdomen, and chest scan, with and without contrast, [which] showed I had a tumor on my kidney.... My urologist said he wanted to go straight to surgery, and we were going to do the surgery and remove the tumor and the kidney, but because of my past cancer, I had surgical clips inside that made him hesitant to do surgery. He referred me to the Duke Cancer Center, [and it] was there that we ran another CT scan with and without contrast. It identified that the cancer had spread into my lymph nodes and my bones.

That's when I got my stage IV cancer diagnosis. After we got the diagnosis there, we did a needle biopsy and confirmed that it was clear cell RCC.

[I'm also a cancer survivor already; I was diagnosed with stage II testicular cancer back in 1995, and here I am, taking on another cancer challenge].

McManus / We often describe kidney cancer as the great imitator because it can cause these vague symptoms—things like low-grade fevers or weight loss—[that] you wouldn't necessarily [assume] are coming from kidney cancer. While you've astutely



**Hannah Dzimitrowicz
McManus, MD**



**Allison Brown, BSN,
RN, RN-BC**



James Zoeller

said, “Yeah, there’s something going wrong in my body,” I don’t think anyone—even me as a kidney cancer doctor—[jumps to] that as the first thing. Sometimes there is a little bit of a delay, even when we’re thoroughly working things up to totally understand what’s going on.

Allison, what’s your perspective on this? What is the multidisciplinary team’s role in supporting patients through an RCC diagnosis?

Brown / The first thing [we do] is make an effort to introduce [the patient] to different members of our team [who] work within the clinic. Typically, someone like Dr McManus is the first person a patient talks to and discusses the diagnosis and treatment options with. As a nurse coordinator assigned to a specific provider, I touch base with all her [new patients] to introduce myself and my role as their point person through their treatment journey. I make sure they feel comfortable knowing how to reach out to us when they leave the clinic.

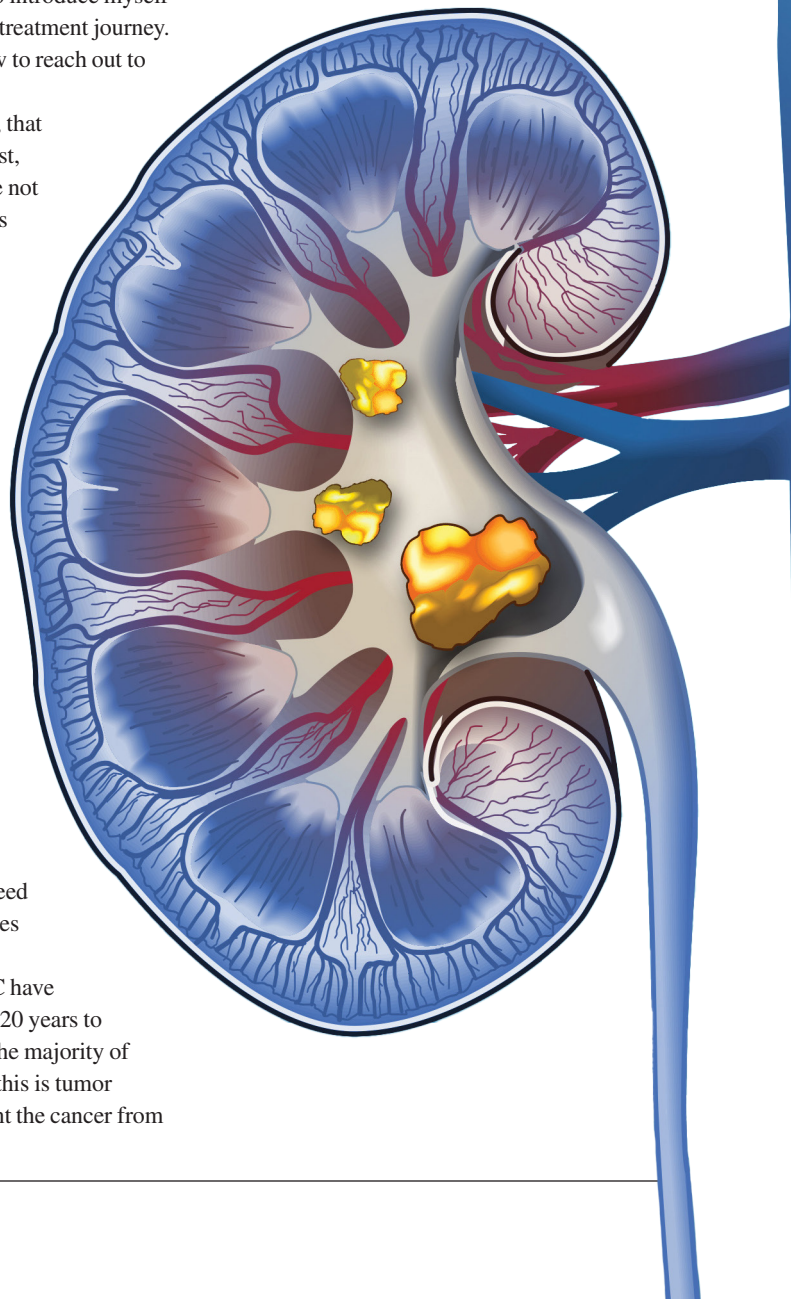
Once we’ve decided on a treatment regimen, that patient will [typically] meet with our pharmacist, who specializes in genitourinary oncology. She not only provides the medication but also facilitates access to the medication. A lot of these drugs can be expensive, and we have to navigate manufacturer programs and grants to make sure patients can afford and access their medication—she’s super helpful with that. If a patient comes in having issues with weight loss related to their cancer, our dietitian...meets with them. We also have a counselor through our support services who meets with patients who need some extra support to process the diagnosis.

It’s important to individualize the way we’re supporting [the patients]. Some patients...[had] their cancer found incidentally, and they’re not feeling that sick. It can be challenging for them to understand why treatment is so important at that level. It’s good to provide that extra education at that point. Then [for] other patients who have already been feeling sick because their disease has already progressed and metastasized, we need to prioritize connecting them to certain resources more quickly.

McManus / Our treatment options for RCC have evolved and, importantly, improved in the past 20 years to where our treatments now deliver benefits for the majority of patients who receive them. For many patients, this is tumor shrinkage or stable disease, meaning we prevent the cancer from

growing; for a [smaller] percentage of patients, it’s complete remission. Shrinking or delaying cancer growth can prolong patients’ lives and help maintain quality of life by preventing symptoms [associated with] growing cancer.

Our standard of care—fast forwarding to the [past] 5-plus years—is to use a combination treatment approach in the first line for patients who can safely receive these medications. Here we have multiple options to choose from, which have all been shown to be effective in clinical trials, but they’ve never been compared head-to-head. These options include either the immunotherapy drug combination



ipilimumab [Yervoy] plus nivolumab [Opdivo] or an immunotherapy tyrosine kinase inhibitor [TKI] combination, of which there are several options, including, and in no particular order, lenvatinib [Lenvima], pembrolizumab [Keytruda], cabozantinib [Cometriq], nivolumab, and axitinib [Inlyta]. All these are [NCCN] category 1 options and have shown meaningful benefits over prior therapies.

When I'm meeting with a patient and discussing their treatment options [with them], I like to give an overview of the availability of these options but not overload them with the facts about different options. What was that process [of] making a treatment plan and making shared decisions with your team [like, Mr Zoeller]?

Once you get to a point where everything is stable, you feel more in control; you feel more like you're able to tolerate the medications. It's [important to] be aware of what you [have] to look for.

– James Zoeller

Zoeller / I wanted the surgery; I wanted to get that tumor out. I remember having quite a few conversations and talking about the downsides of having to wait for surgery and then waiting to recover from the surgery before starting the treatment plan. It took a little convincing on your part, [Dr McManus], to convince me that [the better option] was to just get into the treatment plan. You're exactly right. It's a lot of information for patients trying to process all [of it]. You did well by me [choosing] to focus on what you felt was the best treatment plan for me. If I had all the information, it would have been very hard for me to decide between different treatment plans.

For me, I need to understand what you're doing and what your plan is. I bugged you with a bunch of questions early on. You were so patient with me and answered all my questions, but I wanted to make sure I was comfortable with what we were doing. The process works well when the patient is engaged and not just receiving the news. It's important that the patient listens to the doctor as well as the doctor listens to the patient. You explained the benefits of starting treatments and how that was going to benefit me in the long run. You talked about [how treatment was a] marathon vs a sprint, and I was not on board. I wanted to sprint. I always wanted to sprint—take the maximum doses that [were allowed]. It took me a while to embrace the idea that it is the marathon, but it was a good process for us. ... I've always been curious: Based on my condition and the stage of my cancer, what factors guided you in recommending the pembrolizumab and lenvatinib for my treatments?

McManus / Your diagnosis with clear cell RCC was rapidly changing [to the point where], over months, we thought it was localized disease and then we knew it was metastatic disease. It was quite symptomatic as well. You were having the fevers and the weight loss; you were starting to have bone pain from the bone metastases.... Those were the real triggers [that got] me to [decide that although] we had all those options available... an immunotherapy/TKI inhibitor approach, like lenvatinib and pembrolizumab, was a good option for you because that class of drugs has higher objective response rates.

We needed to get a response [immediately] because [the disease] was causing you problems. There are multiple immunotherapy/TKI options for RCC, and we're essentially choosing between equivalent options. Even though we can look at the numbers from each trial and try to compare them, they're not compared head-to-head. We can't say one is better than the other. When we're choosing [and] using equivalent options, I like the response rate numbers from the phase 3 CLEAR trial [NCT02811861], which was the study of lenvatinib and pembrolizumab [vs sunitinib (Sutent)]. Allison, what patient education is essential when initiating these combination regimens?

Brown / For the combination of immunotherapy and TKI, the main overlapping AEs that we educate on are skin rash and diarrhea. The skin rash caused by immunotherapy is often presented as a full-body rash, whereas the TKI drugs can cause a condition called hand-foot syndrome, which is generally localized to the palms and bottoms of the feet. This matters because we will treat them differently based on whether it's one or the other. We know that if it's immune induced, we would use palpable or oral steroids to target inflammation.

McManus / James, what information do you think is essential for patients to understand when receiving pembrolizumab and lenvatinib?

Zoeller / Education is important so we can be on the lookout for what we're looking for. My biggest AE from the get-go was my blood pressure, and we had to monitor that quite regularly and get medication to get that under control. I wanted to sprint, so I was dead set on taking the maximum doses of everything, and I was trying to tolerate everything as long as I could. I eventually had to concede because the AEs were getting to a point where [they] were affecting my ability to have a [good] quality of life. I was getting those calluses on the bottom of my feet, and I was having difficulty walking around the house without pain. We did have to pull back on the amount [of medication] I was taking. Once you get to a point where everything is stable, you feel more in control; you feel more like you're able to tolerate the medications. It's [important to] be aware of what you [have] to look for. ■