Early Detection, Diagnosis, and Staging

Detection and Diagnosis

Catching cancer early often allows for more treatment options. Some early cancers may have signs and symptoms that can be noticed, but that is not always the case.

- Can Kidney Cancer Be Found Early?
- Signs and Symptoms of Kidney Cancer
- How Is Kidney Cancer Diagnosed?

Stages and Outlook (Prognosis)

After a cancer diagnosis, staging provides important information about the extent of cancer in the body and anticipated response to treatment.

- How Is Kidney Cancer Staged?
- Survival Rates for Kidney Cancer by Stage

Questions to Ask About Kidney Cancer

Here are some questions you can ask your cancer care team to help you better understand your cancer diagnosis and treatment options.

- What Should You Ask Your Doctor About Kidney Cancer?

Can Kidney Cancer Be Found Early?

Many kidney cancers are found fairly early, while they are still confined to the kidney, but others are found at a more advanced stage. There are a few reasons for this:

- These cancers can sometimes grow quite large without causing any pain or other
problems.
- Because the kidneys are deep inside the body, small kidney tumors cannot be seen or felt during a physical exam.
- There are no recommended screening tests for kidney cancer in people who are not at increased risk. This is because no test has been shown to lower the overall risk of dying from kidney cancer.

Some tests can find some kidney cancers early, but none of these is recommended to screen for kidney cancer in people at average risk.

A routine urine test (urinalysis), which is sometimes part of a complete medical checkup, may find small amounts of blood in the urine of some people with early kidney cancer. But many things other than kidney cancer cause blood in the urine, including urinary tract infections, bladder infections, bladder cancer, and benign (non-cancerous) kidney conditions such as kidney stones. And some people with kidney cancer do not have blood in their urine until the cancer is quite large and might have spread to other parts of the body.

Imaging tests such as computed tomography (CT) scans and magnetic resonance imaging (MRI) scans can often find small kidney cancers, but these tests are expensive. Ultrasound is less expensive and can also detect some early kidney cancers. One problem with these tests is that they can’t always tell benign tumors from small renal cell carcinomas.

Often, kidney cancers are found incidentally (by accident) during imaging tests for some other illness such as gallbladder disease. These cancers usually are causing no pain or other symptoms when they are found. The survival rate for these kidney cancers is very high because they are usually found at a very early stage.

For people at increased risk of kidney cancer

People who have certain inherited conditions, such as von Hippel-Lindau disease, have a higher risk of kidney cancer. Doctors often recommend that these people get regular imaging tests such as CT, MRI, or ultrasound scans to look for kidney tumors. Kidney cancers that are found early with these tests can often be cured.

It is important to tell your doctor if any of your family members (blood relatives) has or had kidney cancer, especially at a younger age, or if they have been diagnosed with an inherited condition linked to this cancer, such as von Hippel-Lindau disease. Your doctor may recommend that you consider genetic counseling and testing to see if you have the condition.
Before having genetic tests, it’s important to talk with a genetic counselor so that you understand what the tests can and can’t tell you, and what any results would mean. Genetic tests look for the gene mutations that cause these conditions in your DNA. They are used to diagnose these inherited conditions, not kidney cancer itself. Your risk may be increased if you have one of these conditions, but it does not mean that you have (or definitely will get) kidney cancer. For more information on genetic testing, see Genetic Testing: What You Need to Know.

Some doctors also recommend that people with kidney diseases treated by long-term dialysis have regular tests to look for kidney cancer.

- References

See all references for Kidney Cancer

Signs and Symptoms of Kidney Cancer

Early kidney cancers do not usually cause any signs or symptoms, but larger ones might. Some possible signs and symptoms of kidney cancer include:

- Blood in the urine (hematuria)
- Low back pain on one side (not caused by injury)
- A mass (lump) on the side or lower back
- Fatigue (tiredness)
- Loss of appetite
- Weight loss not caused by dieting
- Fever that is not caused by an infection and that doesn’t go away
- Anemia (low red blood cell counts)

These signs and symptoms can be caused by kidney cancer (or another type of cancer), but more often they are caused by other, benign, diseases. For example, blood in the urine is most often caused by a bladder or urinary tract infection or a kidney stone. Still, if you have any of these symptoms, see a doctor so that the cause can be found and treated, if needed.
How Is Kidney Cancer Diagnosed?

Kidney cancer might be found because of signs or symptoms a person is having, or it might be found because of lab tests or imaging tests a person is getting for another reason. If cancer is suspected, tests will be needed to confirm the diagnosis.

Medical history and physical exam

If you have any signs or symptoms that suggest you might have kidney cancer, your doctor will want to take a complete medical history to check for risk factors and to learn more about your symptoms.

A physical exam can provide information about signs of kidney cancer and other health problems. For example, the doctor may be able to feel an abnormal mass when he or she examines your abdomen.

If symptoms or the results of the physical exam suggest you might have kidney cancer, more tests will probably be done. These might include lab tests and imaging tests.

Lab tests

Lab tests cannot show for sure if a person has kidney cancer, but they can sometimes give the first hint that there may be a kidney problem. If cancer has already been diagnosed, they are also done to get a sense of a person’s overall health and to help tell if the cancer might have spread to other areas. They also can help show if a person is healthy enough to have an operation.

Urinalysis
Urinalysis (urine testing) is sometimes part of a complete physical exam, but it may not be done as a part of more routine physicals. This test may be done if your doctor suspects a kidney problem.

Microscopic and chemical tests are done on a urine sample to look for small amounts of blood and other substances not seen with the naked eye. About half of all patients with renal cell cancer will have blood in their urine. If the patient has transitional cell carcinoma (in the renal pelvis, the ureter, or the bladder), sometimes a special microscopic exam of the urine sample (called *urine cytology*) will show actual cancer cells in the urine.

**Complete blood count**

The complete blood count (CBC) is a test that measures the amounts of different cells in the blood, such as red blood cells, white blood cells, and platelets. This test result is often abnormal in people with renal cell cancer. Anemia (having too few red blood cells) is very common. Less often, a person may have too many red blood cells (called *polycythemia*) because the kidney cancer cells make a hormone (erythropoietin) that causes the bone marrow to make more red blood cells.

Blood counts are also important to make sure a person is healthy enough for surgery.

**Blood chemistry tests**

Blood chemistry tests are usually done in people who might have kidney cancer, because the cancer can affect the levels of certain chemicals in the blood. For example, high levels of liver enzymes are sometimes found. High blood calcium levels may indicate that cancer has spread to the bones, and may therefore prompt a doctor to order a bone scan. Blood chemistry tests also look at kidney function, which is especially important if certain imaging tests or if surgery is planned.

**Imaging tests**

Imaging tests use x-rays, magnetic fields, sound waves, or radioactive substances to create pictures of the inside of your body. Imaging tests can be done for a number of reasons:

- To help find out whether a suspicious area might be cancer
- To learn how far cancer has spread
- To help determine if treatment has been effective
• To look for signs of the cancer coming back

Unlike most other cancers, doctors can often diagnose kidney cancer fairly certainly based on imaging tests without doing a biopsy (removing a sample of the tumor to be looked at under a microscope). In some patients, however, a biopsy may be needed to be sure.

Computed tomography (CT) scans, magnetic resonance imaging (MRI) scans, and ultrasound can be very helpful in diagnosing most kinds of kidney tumors, although patients rarely need all of these tests. Other tests described here, such as chest x-rays and bone scans, are more often used to help determine if the cancer has spread (metastasized) to other parts of the body.

**Computed tomography (CT) scan**

The CT scan uses x-rays to produce detailed cross-sectional images of your body. It is one of the most useful tests for finding and looking at a tumor in your kidney. It can provide precise information about the size, shape, and position of a tumor. It is also useful in checking to see if a cancer has spread to nearby lymph nodes or to organs and tissues outside the kidney. If a kidney biopsy is needed, this test can also be used to guide a biopsy needle into the mass to obtain a sample.

Instead of taking one picture, like a regular x-ray, a CT scanner takes many pictures as it rotates around you. A computer then combines these pictures into images of slices of the part of your body being studied.

A CT scanner has been described as a large donut, with a narrow table that slides in and out of the middle opening. You will need to lie still on the table while the scan is being done. CT scans take longer than regular x-rays, and you might feel a bit confined by the ring while the pictures are being taken.

Before the test, you might be asked to drink 1 to 2 pints of a liquid called *oral contrast*. This helps outline the intestine so that certain areas are not mistaken for tumors. You might also receive an IV (intravenous) line through which a different kind of contrast dye (IV contrast) is injected. This helps better outline structures in your body. The injection may cause some flushing (a feeling of warmth, especially in the face). Some people are allergic and get hives. Rarely, more serious reactions like trouble breathing or low blood pressure can occur. Be sure to tell the doctor if you have any allergies or if you have ever had a reaction to any contrast material used for x-rays.

CT contrast can damage the kidneys. This happens more often in patients whose kidneys are not working well in the first place. Because of this, your kidney function will
be checked with a blood test before you get IV contrast.

**Magnetic resonance imaging (MRI) scan**

Like CT scans, MRI scans provide detailed images of soft tissues in the body. But MRI scans use radio waves and strong magnets instead of x-rays. The energy from the radio waves is absorbed and then released in a pattern formed by the type of body tissue and by certain diseases. A computer translates the pattern into a very detailed image of parts of the body.

A contrast material called *gadolinium* is often injected into a vein before the scan to better see details. This contrast material isn’t used in people on dialysis, because in those people it can rarely cause a severe side effect called *nephrogenic systemic fibrosis*.

MRI scans take longer than CT scans — often up to an hour — and are a little more uncomfortable. You have to lie inside a narrow tube, which is confining and can upset people with claustrophobia (a fear of enclosed spaces). Special, open MRI machines can sometimes help with this if needed, but the drawback is that the pictures may not be as clear. MRI machines also make buzzing and clicking noises that many people find disturbing. Some centers provide headphones with music to block this noise out.

MRI scans are used less often than CT scans in people with kidney cancer. They may be done in cases where CT scans aren’t practical, such as if a person can’t have the CT contrast dye because they have an allergy to it or they don’t have good kidney function. MRI scans may also be done if there’s a chance that the cancer has grown into major blood vessels in the abdomen (like the inferior vena cava), because they provide a better picture of blood vessels than CT scans. Finally, they may be used to look for possible spread of cancer to the brain or spinal cord if a person has symptoms that suggest this might be the case.

**Ultrasound**

Ultrasound uses sound waves to create images of internal organs. For this test, a small, microphone-like instrument called a *transducer* is placed on the skin near the kidney after a gel is applied. The transducer gives off sound waves and picks up the echoes as they bounce off the tissues in the kidney. The echoes are converted by a computer into a black and white image that is displayed on a computer screen. This test is painless and does not expose you to radiation.

Ultrasound can help find a kidney mass and show if it is solid or filled with fluid (kidney
tumors are more likely to be solid). Different echo patterns also can help doctors tell some types of benign and malignant kidney tumors from one another.

If a kidney biopsy is needed, this test can also be used to guide a biopsy needle into the mass to obtain a sample.

**Positron emission tomography (PET) scan**

In a PET scan, a form of radioactive sugar (known as fluorodeoxyglucose or FDG) is injected into the blood. The amount of radioactivity used is very low and will pass out of the body over the next day or so. Because cancer cells in the body are growing quickly, they absorb more of the radioactive sugar. After about an hour, you will be moved onto a table in the PET scanner. You lie on the table for about 30 minutes while a special camera creates a picture of areas of radioactivity in the body. The picture is not finely detailed like a CT or MRI scan, but it provides helpful information about your body.

This test can help spot small collections of cancer cells and can be useful in seeing if the cancer has spread to lymph nodes near the kidney. PET scans can also be useful if your doctor thinks the cancer may have spread but doesn’t know where. PET scans can be used instead of doing multiple x-rays because they scan your whole body.

Special machines can perform both a PET and CT scan at the same time (PET/CT scan). This lets the doctor compare areas of higher radioactivity (suggesting an area of cancer) on the PET with the more detailed image from the CT. Still, PET and PET/CT scans are not a standard part of the work-up for kidney cancers.

**Intravenous pyelogram**

An intravenous pyelogram (IVP) is an x-ray of the urinary system taken after a special dye is injected into a vein. The kidneys remove the dye from the bloodstream and it then concentrates in the ureters and bladder. An IVP can help find abnormalities of the renal pelvis and ureter, such as cancer, but this test is not often used when kidney cancer is suspected.

**Angiography**

This type of x-ray also uses a contrast dye, although not the same as the one used for an IVP. A catheter is usually threaded up a large artery in your leg into the artery leading to your kidney (renal artery). The dye is then injected into the artery, and x-rays are taken to identify and map the blood vessels that supply a kidney tumor.
This test can help in planning surgery for some patients. Angiography can also help diagnose renal cancers since the blood vessels usually have a special appearance with this test.

Angiography can often be done as a part of a CT or MRI scan, instead of as a separate x-ray test. This means less contrast dye is used, which is helpful since the dye can damage kidney function further if it is given to people whose kidneys aren’t working well.

**Chest x-ray**

If kidney cancer has been diagnosed (or is suspected), your chest may be x-rayed to see if cancer has metastasized (spread) to your lungs. The lungs are a common site of kidney cancer metastasis, but this is not very likely unless the cancer is far advanced.

This x-ray can be done in any outpatient setting. If the results are normal, you probably don’t have cancer in your lungs. Still, if your doctor has reason to suspect lung metastasis (based on symptoms like shortness of breath or a cough), you may have a chest CT scan instead of a regular chest x-ray, because it can show more detail.

**Bone scan**

A bone scan can help show if a cancer has spread to your bones. It might be done if there is reason to think the cancer might have spread to the bones (because of symptoms such as bone pain or blood test results showing an increased calcium level). PET scans can usually show the spread of cancer to bones as well, so if you’ve had a PET scan you might not need a bone scan.

For this test, a small amount of low-level radioactive material is injected into a vein (intravenously, or IV). The substance settles in areas of damaged bone throughout the entire skeleton in a couple of hours. You then lie on a table for about 30 minutes while a special camera detects the radioactivity and creates a picture of your skeleton.

Areas of active bone changes attract the radioactivity and show up as “hot spots” on your skeleton. These areas might suggest cancer spread, but arthritis or other bone diseases can also cause the same pattern. To distinguish between these conditions, your cancer care team may use other imaging tests such as simple x-rays or MRI scans to get a better look at the areas that light up, or they may even take biopsy samples of the bone.

**Fine needle aspiration and needle core biopsy**
Unlike with most other types of cancer, biopsies are not often used to diagnose kidney tumors. Imaging tests usually provide enough information for a surgeon to decide if an operation is needed. The diagnosis is then confirmed when part of the kidney that was removed is looked at under a microscope.

However, a biopsy is sometimes used to get a small sample of cells from an area that may be cancer when the results of imaging tests are not clear enough to warrant surgery. Biopsy may also be done to confirm a cancer diagnosis if a person might not be treated with surgery, such as with small tumors that will be watched and not treated, or when other treatments are being considered.

Fine needle aspiration (FNA) and needle core biopsy are 2 types of kidney biopsies that may be done. For these types of biopsies a needle is put through the skin to take a sample of cells (called a percutaneous biopsy).

For either type of biopsy, the skin where the needle is to be inserted is first numbed with local anesthesia. The doctor directs the biopsy needle into the area while looking at your kidney with either ultrasound or CT scans. Unlike ultrasound, CT doesn’t provide a continuous picture, so the needle is inserted in the direction of the mass, a CT image is taken, and the direction of the needle is guided based on the image. This is repeated a few times until the needle is within the mass.

For FNA, a small sample of the target area is sucked (aspirated) through the needle into a syringe. The needle used for FNA biopsy is thinner than the ones used for routine blood tests. The needle used in core biopsies is larger than that used in FNA biopsy. It removes a small cylinder of tissue. Either type of sample is checked under the microscope to see if cancer cells are present.

In cases where the doctors think kidney cancer might have spread to other sites, they may take a sample of the metastatic site instead of the kidney.

**Fuhrman grade**

The Fuhrman grade is found by looking at kidney cancer cells (taken during a biopsy or during surgery) under a microscope. Many doctors use it to describe how quickly the cancer is likely to grow and spread. The grade is based on how closely the cancer cells’ nuclei (the part of the cell in which DNA is stored) look like those of normal kidney cells.

Renal cell cancers are usually graded on a scale of 1 through 4. Grade 1 renal cell cancers have cell nuclei that look a lot like normal kidney cell nuclei. These cancers usually grow and spread slowly and tend to have a good prognosis (outcome). At the
other extreme, grade 4 renal cell cancer nuclei look quite different from normal kidney cell nuclei. These cancers have a worse prognosis.

Although the cell type and grade can sometimes help predict prognosis (outlook), the cancer’s stage is by far the best predictor of survival. The stage describes the cancer’s size and how far it has spread beyond the kidney. Staging is explained in “How is kidney cancer staged?”

- References

See all references for Kidney Cancer

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**How Is Kidney Cancer Staged?**

The stage of a cancer describes how far it has spread. Your treatment and prognosis (outlook) depend, to a large extent, on the cancer’s stage.

The stage is based on the results of the physical exam, biopsies, and imaging tests (CT scan, chest x-ray, PET scan, etc.), which are described in “How is kidney cancer diagnosed?”

There are actually 2 types of staging for kidney cancer:

- The *clinical stage* is your doctor’s best estimate of the extent of your disease, based on the results of the physical exam, lab tests, and any imaging tests you have had.
- If you have surgery, your doctors can also determine the *pathologic stage*, which is based on the same factors as the clinical stage, plus what is found during surgery and examination of the removed tissue.

If you have surgery, the stage of your cancer might actually change afterward (if cancer were found to have spread further than was suspected, for example). Pathologic staging is likely to be more accurate than clinical staging, because it gives your doctor a firsthand impression of the extent of your disease.
AJCC (TNM) staging system

Astaging systemis a standard way for the cancer care team to describe the extent of the cancer. The most common staging system for kidney cancer is that of the American Joint Committee on Cancer (AJCC), sometimes known as the TNM system. (Cancers that start in the renal pelvis have a different AJCC staging system, which is not described here.)

The TNM system describes 3 key pieces of information:

- **T** indicates the size of the main (primary) tumor and whether it has grown into nearby areas.
- **N** describes the extent of spread to nearby (regional) lymph nodes. Lymph nodes are small bean-sized collections of immune system cells to which cancers often spread first.
- **M** indicates whether the cancer has spread (metastasized) to other parts of the body. (The most common sites of spread are to the lungs, bones, liver, brain, and distant lymph nodes.)

Numbers or letters appear after T, N, and M to provide more details about each of these factors. The numbers 0 through 4 indicate increasing severity. The letter X means “cannot be assessed because the information is not available.”

**T categories for kidney cancer**

**TX:** The primary tumor cannot be assessed (information not available).

**T0:** No evidence of a primary tumor.

**T1:** The tumor is only in the kidney and is no larger than 7 centimeters (cm), or a little less than 3 inches, across

- **T1a:** The tumor is 4 cm (about 1½ inches) across or smaller and is only in the kidney.
- **T1b:** The tumor is larger than 4 cm but not larger than 7 cm across and is only in the kidney.

**T2:** The tumor is larger than 7 cm across but is still only in the kidney.

- **T2a:** The tumor is more than 7 cm but not more than 10 cm (about 4 inches) across and is only in the kidney
• **T2b**: The tumor is more than 10 cm across and is only in the kidney

**T3**: The tumor is growing into a major vein or into tissue around the kidney, but it is not growing into the adrenal gland (on top of the kidney) or beyond Gerota’s fascia (the fibrous layer that surrounds the kidney and nearby fatty tissue).

• **T3a**: The tumor is growing into the main vein leading out of the kidney (renal vein) or into fatty tissue around the kidney
• **T3b**: The tumor is growing into the part of the large vein leading into the heart (vena cava) that is within the abdomen.
• **T3c**: The tumor has grown into the part of the vena cava that is within the chest or it is growing into the wall of the vena cava.

**T4**: The tumor has spread beyond Gerota’s fascia (the fibrous layer that surrounds the kidney and nearby fatty tissue). The tumor may have grown into the adrenal gland (on top of the kidney).

**N categories for kidney cancer**

**NX**: Regional (nearby) lymph nodes cannot be assessed (information not available).

**N0**: No spread to nearby lymph nodes.

**N1**: Tumor has spread to nearby lymph nodes.

**M categories for kidney cancer**

**M0**: There is no spread to distant lymph nodes or other organs.

**M1**: Distant metastasis is present; includes spread to distant lymph nodes and/or to other organs. Kidney cancer most often spreads to the lungs, bones, liver, or brain.

**Stage grouping**

Once the T, N, and M categories have been assigned, this information is combined to assign an overall stage of I, II, III, or IV. The stages identify cancers that have a similar prognosis (outlook) and thus are treated in a similar way. Patients with lower stage numbers tend to have a better prognosis.

**Stage I**: T1, N0, M0
The tumor is 7 cm across or smaller and is only in the kidney (T1). There is no spread to lymph nodes (N0) or distant organs (M0).

**Stage II: T2, N0, M0**

The tumor is larger than 7 cm across but is still only in the kidney (T2). There is no spread to lymph nodes (N0) or distant organs (M0).

**Stage III:** Either of the following:

**T3, N0, M0:** The tumor is growing into a major vein (like the renal vein or the vena cava) or into tissue around the kidney, but it is not growing into the adrenal gland or beyond Gerota’s fascia (T3). There is no spread to lymph nodes (N0) or distant organs (M0).

**T1 to T3, N1, M0:** The main tumor can be any size and may be outside the kidney, but it has not spread beyond Gerota’s fascia. The cancer has spread to nearby lymph nodes (N1) but has not spread to distant lymph nodes or other organs (M0).

**Stage IV:** Either of the following:

**T4, any N, M0:** The main tumor is growing beyond Gerota’s fascia and may be growing into the adrenal gland on top of the kidney (T4). It may or may not have spread to nearby lymph nodes (any N). It has not spread to distant lymph nodes or other organs (M0).

**Any T, Any N, M1:** The main tumor can be any size and may have grown outside the kidney (any T). It may or may not have spread to nearby lymph nodes (any N). It has spread to distant lymph nodes and/or other organs (M1).

**Other staging and prognostic systems**

The TNM staging system is useful, but some doctors have pointed out that there are factors other than the extent of the cancer that should be considered when determining prognosis and treatment.

**University of California Los Angeles (UCLA) Integrated Staging System**

This is a more complex system that came out in 2001. It was meant to improve upon the AJCC staging that was then in place. Along with the stage of the cancer, it takes into
account a person’s overall health and the Fuhrman grade of the tumor. These factors are combined to divide people into low-, intermediate-, and high-risk groups. Ask your doctor if he or she uses this system and how it might apply to you.

**Survival predictors**

The stage of the cancer is an important predictor of survival, but other factors are also important. For example, researchers have linked certain factors with shorter survival times in people with kidney cancer that has spread outside the kidney. These include:

- High blood lactate dehydrogenase (LDH) level
- High blood calcium level
- Anemia (low red blood cell count)
- Cancer spread to 2 or more distant sites
- Less than a year from diagnosis to the need for systemic treatment (targeted therapy, immunotherapy, or chemotherapy)
- Poor performance status (a measure of how well a person can do normal daily activities)

People with none of the above factors are considered to have a good prognosis; 1 or 2 factors are considered intermediate prognosis, and 3 or more of these factors are considered to have a poor prognosis and may be more or less likely to benefit from certain treatments.

- References

See all references for Kidney Cancer

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**Survival Rates for Kidney Cancer by Stage**

Survival rates are often used by doctors as a standard way of discussing a person’s prognosis (outlook). Some people with cancer may want to know the survival statistics
for people in similar situations, while others may not find the numbers helpful, or may even not want to know them. If you decide that you don’t want to know them, stop reading here and skip to the next section.

The 5-year survival rate refers to the percentage of patients who live at least 5 years after their cancer is diagnosed. Of course, many people live much longer than 5 years (and many are cured). Also, some people die from causes other than their cancer.

In order to get 5-year survival rates, doctors have to look at people who were treated at least 5 years ago. Treatments for kidney cancer have changed in recent years, which may result in a better outlook for people now being diagnosed with kidney cancer.

Survival rates are often based on previous outcomes of large numbers of people who had the disease, but they cannot predict what will happen in any person’s case. Many other factors can affect a person’s outlook, such as the grade of the cancer, the treatment received, and the patient’s age and overall health. Your doctor can tell you how the numbers below may apply to you, as he or she is familiar with your situation.

**Survival rates by AJCC TNM stage**

The numbers below come from the National Cancer Data Base and are based on patients first diagnosed in the years 2001 and 2002. These are observed survival rates. They include people diagnosed with kidney cancer who may have later died from other causes, such as heart disease. People with kidney cancer tend to be older and may have other serious health conditions. Therefore, the percentage of people surviving the cancer itself is likely to be higher.

<table>
<thead>
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<th>5-Year Survival Rate</th>
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<td>I</td>
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<tr>
<td>II</td>
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<td>III</td>
<td>53%</td>
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<td>IV</td>
<td>8%</td>
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**Survival rates in the UCLA Integrated Staging System**

Researchers at UCLA have published a study evaluating their system in patients treated there from 1989 to 2005, looking at survival rates of the low-, intermediate- and high-risk groups. All of these patients at least had surgery to remove the tumor in the kidney. These numbers are disease-specific survival rates, meaning they only take into account people who died from their kidney cancer (and not other causes).

For patients with localized kidney cancer (cancer that had not spread to the lymph
nodes or distant organs), 5-year survival rates were 97% for the low-risk group, 81% for intermediate-risk group, and 62% for the high-risk group.

For patients with kidney cancer that had spread to the lymph nodes or distant organs when it was first found, 5-year survival rates were 41% for the low-risk group, 18% for intermediate-risk group, and 8% for the high-risk group.

- References
See all references for Kidney Cancer

What Should You Ask Your Doctor About Kidney Cancer?

It’s important to have frank, open discussions with your cancer care team. Feel free to ask any question, no matter how small it might seem. For instance, consider asking these questions:

- What kind of kidney cancer do I have?
- What is the stage of my cancer and what does that mean?
- Do I need other tests before we can decide on treatment?
- Do I need to see other doctors?
- How much experience do you have treating this type of cancer?
- What treatment choices do I have? What do you recommend? Why?
- Should I get a second opinion? Can you recommend a doctor or cancer center?
- How soon do I need to start treatment?
- What should I do to be ready for treatment?
- How long will treatment last? What will it be like? Where will it be done?
- What risks or side effects are there to the treatments you suggest?
- How long will it take me to recover from treatment?
- What are the chances of my cancer coming back after treatment? What will we do if that happens?
• What type of follow-up will I need after treatment?
• Are there any clinical trials I should think about?

Along with these sample questions, be sure to write down some of your own. Keep in mind, too, that doctors are not the only ones who can give you information. Other health care professionals, such as nurses and social workers, may have the answers to your questions. You can find more information about communicating with your health care team in Talking With Your Doctor.

• References
See all references for Kidney Cancer

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