

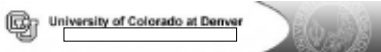
Point-Counterpoint: Small Renal Masses

Best to Remove ~ *Paul D. Maroni, MD*

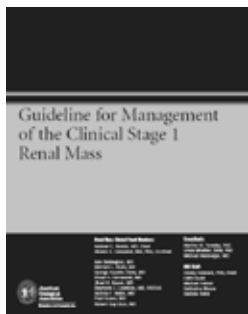
Best to Watch ~ *Donald L. Lamm, MD*

Point-Counterpoint: Small Renal Masses Best to Remove

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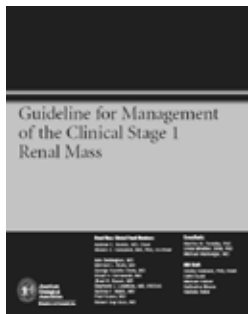
AUA Clinical Guidelines 2009



Index 1 patient: SRM
and healthy

- **Standard** – Partial nephrectomy if able
- If PN not feasible, then radical nx
- Cryo, RFA, and surveillance are **options**

AUA Clinical Guidelines 2009



Index 1 patient: SRM
and not healthy

- **Standard** – Partial nx or radical nx
- Cryo, RFA, and surveillance are **recommendations**

**Small renal mass
Best to remove**

- Definition – enhancing renal mass ≤ 4 cm (clinical T1a)

SRMs - Best to remove

Why?

- Minimal risk
- Effective treatment
- A real medical threat
- Improvements in peri-operative care

Risk of partial nephrectomy



	# Pts	Size	Compl.	Medical	Leak
Open	2756	3.2	21.3%	10%	3.9%
Lap	1062	2.7	21.4%	9.6%	4.2%

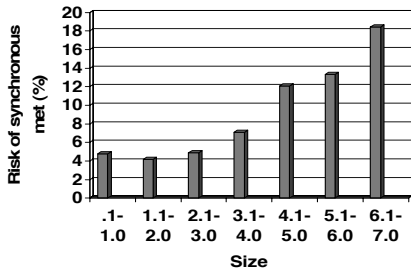
Adapted from Porpiglia et al Eur Urol 2008

Contemporary reality

- 1-3 day hospital stay (even with open surgery)
- 3-4 weeks of convalescence
- 98% 10-yr cancer specific survival
 - 100% with smaller tumors?
- ~4% local recurrence

***Exceptionally low-risk in
healthy patients with excellent
cancer control***

Cancer risk



Adapted from Lughezzani et al J Urol 2009

Cancer Risk

- Crispin et al Cancer 2009
 - 173 patients with enhancing renal mass on AS
 - 24 month median f/u
 - 1.3% developed metastasis
 - 15% exhibiting growth still had benign tumors
- Development of metastasis in 2-yrs as high as 10-yr CSS for PN.***
Growth a poor indicator of cancer.

Cancer Risk

Growth Kinetics of Renal Tumors/Crispen et al

low risk of disease progression, the excellent oncologic outcomes obtained with prompt surgical intervention continue to indicate that extirpative therapy in acceptable candidates should remain standard. Identification of clinical, radiographic, pathologic, and molecular correlates of a tumor's biologic potential is essential to avoid potential overtreatment of otherwise indolent asymptomatic tumors.

Real-life case

- 1987 – 63 yo male with abnormality on IVP in upper pole of right kidney
- 2004 – 81 yo male has 3-4cm mass identified in upper pole of right kidney. Cardiologist told him his cardiac risk was too high. Urologist told him his heart would kill him first.
- 2005 – 4cm – continue to watch
- 2006 – 5cm – continue to watch

Real-life case

- 2007 – 7cm, losing weight. Thinking more seriously about surgery. Saw cardiologist, PCP – all said not to operate.

UROLOGY **64**: 909–913, 2004.

MANAGEMENT OF RENAL MASSES IN PATIENTS
MEDICALLY UNSUITABLE FOR NEPHRECTOMY—NATURAL
HISTORY, COMPLICATIONS, AND OUTCOME

GAVIN W. A. LAMB, EMMA J. BRONWICK, PAUL VASEY, AND MICHAEL ARCHISON

- 36 patients with renal masses 3.5-20cm in size (median 6)
- 23 had biopsy confirming RCC
- No deaths from cancer progression
- Generally slow growth (0.4cm/year)

Real-life case

- 2007 – 7cm, losing weight. Thinking more seriously about surgery. Saw cardiologist, PCP – all said not to operate.
- 2008 – 10 cm, flank pain. Local spread to liver and lung.
- August 2008 – dead from kidney cancer.

Acceptable candidates?

- How old is too old?
- How ill is too ill?

Example: elective abdominal aortic aneurysm repair in people over 80 years old

- Mortality 5.6% at one year

Example: Hypertrophic cardiomyopathy

- In hospital death – 6.7%

Ballotta et al Minerva Med 2009; Hreybe et al Clin Cardio 2006

Advice to patients (and practitioners)

- Do not discount surgery with the "eye-ball" test.
- Consultation with cardiologist and anesthesiologist.
- Balance surgical risks and cancer risks.
- Growth not indicative of cancer, but probably of malignant potential.
