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EAU Calling for Treatment of All Renal Cell Carcinomas

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MILAN, Italy — Patients with small renal cell carcinomas should be treated, despite recommendations by some groups for active surveillance, the European Association of Urology (EAU) announced at a news conference here at the EAU 28th Annual Congress.

"Those who advocate active surveillance must be very careful because you never know how malignant a tumor is," Hein Van Poppel, MD, adjunct secretary general and executive member of education for the EAU, told *Medscape Medical News*. "You are never sure that what you are watching is not going to kill the patient. Even if you're following 100 patients and there's only 1 patient who dies, that is 1 patient too many."

There is no consensus in the field over the management of small renal cell carcinomas, and controversy exists over the risks and benefits of active surveillance and treatment, said Sandra Steffens, MD, who is from the Hannover University Medical School in Germany.

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"Approximately 5% of patients with a localized tumor measuring 4 cm or smaller die in the first 5 years, even though they had localized disease," Dr. Steffens told *Medscape Medical News*. However, "95% of these patients live. Do you really want to subject them to follow-up routinely?"

The multicenter study by Dr. Steffens and colleagues involved 2197 patients from 6 German tertiary care centers who underwent surgical resection of histologically confirmed renal cell carcinomas. The median follow-up was 56.2 months.

German Study

The researchers found that 8.0% of the patients had advanced tumor stage (pT3a or larger), 6.2% had poor differentiation, and 3.5% already had tumor metastasis at the time of diagnosis, Dr. Steffens reported.

The 5-year cancer-specific survival was significantly higher in patients with pT1 tumors than in those with tumors that were pT3a or higher (93.8% vs 79.4%). The 5-year cancer-specific mortality rate for patients with localized cancers was 5.8%.

"So 5.8% of these patients died within the first 5 years, even though they had localized disease at the time of diagnosis," Dr. Steffens pointed out.

Although most patients with small renal cell cancers have pT1a tumors and a good prognosis, "there is a small subgroup of patients who already have locally advanced disease or poor differentiation and, as we have found, there's a small group of patients with synchronous or even metachronous disease," she noted.

Small-cell renal cell carcinomas cannot generally be considered harmless, and they require a standardized follow-up, Dr. Steffens explained. "To say don't do any active surveillance is difficult.... It depends on how old the patient is, the comorbidities, and what the patient wants," she said during an interview. However, "you're subjecting patients to radiation with CT [computed tomography] scans."

During the question period after the presentation, Dr. Steffens was challenged. "I don't see how these data can aid in clinical decision making," said Sabine Brookman-May, a PhD specialist in renal cell carcinoma from the Ludwig Maximilian University of Munich in Germany, who is currently working in prostate cancer for Janssen Pharmaceuticals. "What the [researchers] should have done is an analysis to define the parameters predicting metastasis," she told *Medscape Medical News*.

In Dr. Brookman-May's experience, there is no correlation between advanced stage and tumor size, "but I think we should answer this question of how to stratify patients to active surveillance or treatment," she said. "We already know, based on several publications, that about 4% to 7% of patients will have metastasis, so the final conclusion would be that most patients don't have metastasis and should be followed with active surveillance. But we don't have defined risk parameters to identify which patients should be treated actively and which should not," Dr. Brookman-May explained.

There are very few reasons not to take good care of renal masses.

Despite this lack of clarity, Dr. Van Poppel, speaking on behalf of the EAU, said there is little dilemma over the management of these tumors. "As doctors, we are often blamed because we are jumping on tumors and trying to resect them, but there are very few reasons not to take good care of renal masses," he said.

Mortality is higher in kidney cancer (38%) than in other urologic cancers (23% in bladder cancer, 13% in prostate cancer, and 7% in testicular cancer). "We now have new techniques that are not very invasive, so older patients can have a radiofrequency ablation or a cryoablation," Dr. Van Poppel said.

Active surveillance of renal tumors is not easy, given the lack of distinct radiologic findings and the fact that there is no difference in the growth rate of these and benign tumors. Dr. Van Poppel pointed out that "85% of tumors less than 1 cm can be malignant," Also, CT-guided biopsy can lead to complications such as bleeding, fibrosis, arteriovenous fistula, seeding, pneumothorax, and sampling errors.

"There are very few excuses to mandate observation," he explained. However, "observation should be allowed when the patient and the urologist take an accepted and calculated risk to not do anything.

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