



Letter to the Editor

Re: Philip S. Macklin, Mark E. Sullivan, Charles R. Tapping, et al. Tumour Seeding in the Tract of Percutaneous Renal Tumour Biopsy: A Report on Seven Cases from a UK Tertiary Referral Centre. Eur Urol 2019;75:861–7

We read with interest and concern the article by Macklin et al. [1] on tumour seeding in percutaneous renal tumour biopsy (RTB) tracts. The authors report on seven cases, although only six underwent RTB using the recommended coaxial technique. The number of cases reported (1.2% in their own institution) is at odds with a meta-analysis [2] and the European Association of Urology (EAU) guidelines [3], suggesting potential under-reporting in the literature. It is interesting that six of the seven cases had papillary subtypes, which may be related to differences in biological behaviour and a less distinct peritumoural pseudocapsule.

We disagree with the authors that their case series provides evidence that patients appear to be at risk of local recurrence, given that six out of the seven cases were recurrence-free at last follow-up (median 11.5 mo). The single case with a local recurrence had an open partial nephrectomy for a high-grade 5-cm central tumour in a solitary kidney. An alternative likely explanation for recurrence could be intraoperative implantation or tumour spillage, a plausible scenario given that there was a positive margin at initial surgery.

While the clinical significance of tumour seeding of a RTB tract is not yet known, the clinical significance and harm of not performing RTB is well documented. Partial or radical nephrectomy is associated with a 5% risk of a Clavien ≥ 3 complication and a 0.5% mortality rate [3]. Unfortunately, patients who undergo potentially avoidable surgery for benign tumours are exposed to the same risks. In a recent analysis of >18 000 partial nephrectomies performed over a period of 7 yr for seemingly malignant disease on imaging, benign tumour removal was consistent with year-on-year rates exceeding 30% [4]. Analysis of the British Association of Urological Surgeons nephrectomy audit over a 4-yr period showed that of 1200 patients who had surgery for

oncocytomas, almost half of them were >70 yr or had tumours of <4 cm [5]. Only 2.9% had a prior RTB; the postoperative Clavien Dindo grade ≥ 3 complication rate was 4%, including five surgery-related deaths. RTB can help patients and surgeons avoid unnecessary interventions and the accompanying real risks associated with surgery and anaesthesia, which by far exceed the number of cases and percentage rates of needle tract seeding reported.

We are concerned that this article will further deter clinicians from using RTB, for which adoption is already uniformly poor [4,5] despite the tangible benefits. The incidence of small renal masses is increasing and is likely to accelerate because of the growing use of imaging. In the absence of effective biomarkers, RTB is currently the only tool available to help in determining which tumours should be actively treated and which are suitable for surveillance. Until more research is conducted and follow-up data mature, we advocate providing patients with advice according to the best available evidence. To that end, we recommend adherence to the EAU guidelines and use of RTB whenever it may change a patient's management pathway.

Conflicts of interest: The authors have nothing to disclose.

References

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