



European Association of Urology



Letter to the Editor

Re: Paul C.M.S. Verhagen, Egbert R. Boevé. The European Association of Urology Guideline on Renal Cell Carcinoma (RCC) is Not Concise in its Recommendation to Perform Partial Nephrectomy in T1b RCC. Eur Urol 2019;76:136–7

With concern we read the letter from Verhagen and Boevé [1], in which the unfavourable postoperative course of a young female patient is used to argue that the European Association of Urology Guidelines should not recommend partial nephrectomy (PN) for T1b tumours. The patient developed early perirenal, intraperitoneal, and abdominal wall recurrences after robotic PN for a 4.6-cm papillary type 2 renal cell carcinoma and a positive margin.

We strongly disagree with the authors. It is hazardous to suggest changing guideline recommendations on the basis of a single case description. The PN recommendation is developed using a transparent and structured process that is based on a randomised controlled trial (RCT) [2] and multiple retrospective comparative studies. Importantly, the RCT included tumours of up to 5 cm, which clearly extends the indication for PN to the cT1b stage. In addition, the difference in survival observed in the RCT involves too few patients to be statistically meaningful using a noninferiority test.

The mechanism of recurrence in this case was most likely seeding of an aggressive papillary type 2 tumour with invaded margins. This might also happen in tumours of <4 cm (T1a) or following radical nephrectomy (RN). Port-site and intra-abdominal metastases have been described after laparoscopic and robotic procedures, including PN and RN [3]. Of the 16 cases in the largest series, 12 occurred after RN and four after PN. Technical and biological factors such as high tumour grade were reported in these cases. The young age of the patient and the papillary type 2 subtype suggest that tumour biology drove this dramatic development and warrants testing for hereditary tumours such as hereditary leiomyomatosis and renal cell carcinoma syndrome, which has an aggressive course [4]. Given the range of alternative explanations for this development, it is inappropriate to insinuate that the recommendation to perform PN for cT1b tumours implies that an unfavourable

oncologic outcome is acceptable in some individual cases who could have been cured by RN. The authors use the element of hindsight to make their point. We caution against this argument.

The authors challenge the strength rating of our recommendation. However, we use the GRADE approach [5] to rate not only the quality of the evidence and magnitude of effect but also the balance between benefits and harms, as well as patient values and preferences. Guidelines are not intended to be a substitute for sound clinical reasoning and judicious judgement. Clinical practice recommendations cannot be individualised for each clinical scenario and have to be based on broad acceptance and applicability and not single cases. In this particular case, young age and the potential of harbouring hereditary disease with a likelihood of developing recurrences in the remaining kidney strongly support the use of PN, if technically feasible.

This case illustrates that the achievement and maintenance of technically high surgical standards are likely to be more important than the type of surgical approach, and there is no evidence to associate this dramatic event to T stage. Instead of modifying the guidelines, we believe that these cases should be analysed in registries to better understand underlying factors and improve recommendations based on stronger evidence.

Conflicts of interest: The authors have nothing to disclose.

References

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