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European Association of Urology

Letter to the Editor

Reply to Lorenzo Marconi, Karim Bensalah, and Axel Bex's 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

We appreciate the opportunity to respond to the comments by Marconi et al., who suggest that we propose to change the guideline on renal cell carcinoma (RCC) on the basis of a single patient experience; however, this is not what we have argued [1]. The case was presented as a reason to review the evidence underlying the recommendations of the guideline. We came to the conclusion that to date there is not a single study to substantiate the recommendation in the current European Association of Urology guideline on RCC to perform partial nephrectomy in T1b RCC.

Unfortunately, Marconi et al. cannot produce any evidence to substantiate their recommendation. They point to the only randomised trial on this topic by van Poppel et al. [2], which showed inferior survival following partial nephrectomy for tumours <5 cm. It is inappropriate to translate the results of this important trial into a recommendation that is not in line with the primary outcome and to apply this to patients that were not included in this trial.

We agree with Marconi et al. that the unfavourable outcome in the case we presented is probably due to biological factors that are uncommon in RCC and could also be present in smaller tumours. The chance that a suspicious lesion is actually malignant increases from 77% in T1a to 91% in T1b. Results published following treatment of T1a lesions can therefore not be extrapolated to T1b [3].

We would like to ask Marconi et al. to clarify the use of the GRADE approach, and to show how the guideline committee on RCC could reach a “strong” recommendation in the absence of any available evidence.

As we have stated, results for partial nephrectomy in RCC are generally excellent for both T1a and T1b tumours. We point to the fact that for a patient with suspected T1b RCC and a normal contralateral kidney, the urologist has two options: radical nephrectomy or partial nephrectomy. In absence of evidence in the literature, we expect that a balanced guideline would mention both options, one with a slightly better oncological outcome and the other with a slightly better outcome in terms of kidney function. In our opinion it is up to the urologist and the informed patient to decide which alternative is appropriate.

Conflicts of interest: The authors have nothing to disclose.

References

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March 13, 2019

DOIs of original articles: <https://doi.org/10.1016/j.eururo.2019.01.020>, <https://doi.org/10.1016/j.eururo.2019.03.017>

<https://doi.org/10.1016/j.eururo.2019.03.017>

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