	A	N	S	4	8	1	2	B	Dispatch: 2.12.08	Journal: ANS	CE: Viji R.
Journal Name				Manuscript No.					Author Received:	No. of pages:	ME: Bala

LETTER TO THE EDITOR

ANZJSurg.com

Dear Editor,

Re: Dilemma of small renal masses

We feel that Vivian's 'Perspectives' article requires a response.[1] To imply that partial nephrectomy (PN) does not preserve renal function better than radical nephrectomy (RN) because there is no '…significant difference in rates of end stage renal function…' is untenable. End-stage renal disease and chronic kidney disease (CKD) should not be confused with each other, as the former is the final stage of the latter.[2] Many urologists continue to mistakenly believe that as long as a patient with a small renal mass (SRM) has a 'normal' opposite kidney and 'normal' serum creatinine preoperatively, radical nephrectomy can be carried out without future risk of CKD. *Not true!* Of patients with a single ≤4 cm kidney tumour, 'normal' contralateral kidney and 'normal' serum creatinine, 26% have stage 3 CKD (glomerular filtration rate, GFR <60) at presentation.[2]

Data are irrefutable that PN is superior in preserving renal function compared with RN.[2] Donors are *not* an appropriate '*control*' as they are younger, healthier and have fewer comorbidities and higher GFR at baseline.[3]

Complications from laparoscopic partial nephrectomy (LPN) *used to be* higher than open partial nephrectomy (OPN). Improvement in surgical techniques including 'early unclamping LPN' has now decreased ischaemia time by more than 50% (mean 13.9 min) and reduced postoperative haemorrhage rate to 2%, similar to OPN.[4] Importantly, positive cancer margin rates of LPN and OPN were similar: 1.6 versus 1%,[4] with 5-year cancer-specific survival after LPN being 100%.[5] As such, LPN now equals OPN in all important respects, albeit with decreased patient morbidity.

The 2007 European Association of Urology Guidelines on Renal Cell Carcinoma state that 'Radical nephrectomy … is no longer the gold standard treatment for small renal tumours… Nephron-sparing surgery is an established curative approach for the treatment of patients with RCC'.[6]

We should not shy away from either OPN or LPN, both of which are viable treatments for many, if not most, SRM. Despite the potential of low numbers of LPN in the ANZ context, any learning curve influence is probably minimized if LPN is carried out by surgeons already well versed in advanced urological laparoscopy. The statement that PN is now the standard of care for SRM should not spur any debate in 2008.

References

1. Vivian J. The dilemma of the small renal mass. *ANZ J. Surg*. 2008; **78**: 426.
2. Huang WC, Levey AS, Serio AM *et al*. Chronic kidney disease after nephrectomy in patients with renal cortical tumours: a retrospective cohort study. *Lancet Oncol*. 2006; **7**: 735–40.
3. Go AS, Chertow GM, Fan D, McCulloch CE, Hsu CY. Chronic kidney disease and the risks of death, cardiovascular events, and hospitalization. *N. Engl. J. Med*. 2004; **351**: 1296.
4. Koenig P, Gill IS, Kamoi K *et al*. Kidney cancer and the risk for chronic kidney disease: matched-paired comparison with living donors. *J. Urol*. (Suppl.) 2008; **179**: 170 (MP15).
5. Nguyen MM, Gill IS. Halving ischemia time during laparoscopic partial nephrectomy (Epub 2007 Dec 21). *J. Urol*. 2008; **179**: 627–32; discussion 632.
6. Ljungberg B, Hanbury DC, Kuczyk MA *et al*. Renal cell carcinoma guideline. *Eur. Urol*. 2007; **51**: 1502–10.

Prem Rashid,* PhD, FRACS
Jeremy Goad,† FRACS
Monish Aron,‡ MCh, FRCS
Troy Gianduzzo,‡ FRACS
Inderbir S. Gill,‡ MD, MCh
**Department of Urology, Port Macquarie Base Hospital, Port Macquarie, New South Wales, Australia, and †Department of Urology, St Vincent's Hospital, Melbourne, Victoria, Australia; and ‡Glickman Urological Institute, Cleveland Clinic, Foundation, Cleveland, Ohio, USA*

Dear Editor,

Re: Dilemma of small renal mass

The authors seem to have misunderstood my editorial. I am not proposing that all small renal masses undergo a radical nephrectomy, quite the reverse. If sparing nephrons is all important, there is evidence that observation has a similar outcome to surgery, with less sacrifice of renal tissue. If that is not acceptable to the patient why not biopsy the lesion and avoid surgery on benign tumours that formed 16% of the authors' own series. Finally, if the lesion is to be excised should this be open or laparoscopic partial nephrectomy or a laparoscopic radical nephrectomy? Patients with low calculated glomerular filtration rate, comorbidities that negatively affect renal function or coexisting nephrolithiasis have more reasons to consider nephron-sparing surgery. For other patients there is insufficient evidence to answer this question definitively. A randomized clinical trial should form the basis of gold standards, as case series and population studies are subject to bias.

Justin Vivian, MB BS, FRACS
School of Surgery, University of Western Australia, Perth, Western Australia, Australia

doi: 10.1111/j.1445-2197.2008.04812.x