Clinical Study

Nephron-Sparing Surgery for Renal Masses Measuring Larger Than 7 cm on Preoperative Imaging: A Single Surgeon, Single Center Experience

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Objectives. To document the feasibility of nephron-sparing surgery (NSS) for the surgical treatment of renal masses measuring larger than 7 cm (cT2) on preoperative imaging. Methods. A total of 139 patients have undergone NSS between 2001 and 2012 by a single surgeon in our clinic. Of these, we identified 17 patients whose tumors were measuring greater than 7 cm on preoperative imaging studies and were limited to the kidney. Their charts were retrospectively reviewed. Results. Mean age of the study population was 49.8 ± 11.3 years. Thirteen patients were managed by open NSS, while 4 patients have undergone robot-assisted NSS. Mean diameter and mean R.E.N.A.L. score of the tumors that were enucleoresected were 8.2 cm and 8.5, respectively. A total of 5 Clavien grade 2 and higher complications were recorded within 30 days of surgery. Histopathologic examination revealed benign histology in almost 1/4 of the cases. After a median followup of 33 months, all of our patients were alive. Only one patient (5.8%) experienced local recurrence. Conclusions. NSS is a feasible and safe option for large (>7 cm) renal masses. It may be considered not only for imperative conditions but also for highly selected cases with a normal contralateral kidney.

1. Introduction

Nephron-sparing surgery (NSS) offers equivalent oncologic control, as does radical nephrectomy in patients with appropriately selected stage T1 renal tumors [1, 2]. Additionally, NSS has been associated with decreased risks for renal impairment [3–5] and cardiovascular events [6, 7], which may explain the improved overall survival, documented in partial nephrectomy series [8]. Current guidelines emphasize NSS for all anatomically amenable T1 renal tumors [9].

As the benefits of NSS become apparent, the indications may continue to expand [10]. In order to establish standards for future comparisons, we must fully appreciate the efficacy, safety, and limitations of NSS for renal masses larger than 7 cm. Therefore, we reviewed our experience and reported the results in 17 patients with renal masses, which had a maximum diameter of more than 7 cm on preoperative imaging studies, treated with either open or robot-assisted laparoscopic NSS during 13 years.

2. Methods

Between 2001 and 2012, a single surgeon (TE) performed 139 NSSs (97 open, 35 robot-assisted, and 7 laparoscopic NSSs) in one center. We retrospectively reviewed the charts of the patients, whose renal tumors measured more than 7 cm in diameter on preoperative imaging (n = 17, 17.52%). Preoperative evaluation consisted of laboratory tests and cross-sectional imaging studies (computerized tomography and/or magnetic resonance imaging). Morphometric characteristics of the renal masses were assessed by R.E.N.A.L. (radius, exophytic/endophytic, nearness, anterior/posterior, location)
scoring system [11]. Based on preoperative radiologic findings, none of the patients had lymph node involvement or distant metastasis.

Open nephron-sparing surgery (ONSS) was performed using the intercostal (between 11th and 12th ribs) extraperitoneal flank approach, as previously described elsewhere in detail [12]. Robot-assisted nephron-sparing surgeries (RANSSs) were performed using the da Vinci surgical system (Intuitive Surgical, Inc., Sunnyvale, CA, USA) with a 5-port approach, including two 8 mm ports for robotic instruments, one 12 mm port for the robotic scope, and 2 ports for the bedside assistant. RANSSs were carried out through the transperitoneal route with the patient in the flank position. After demarcating tumor margins with electrocautery, enucleoresection was carried out using cold scissors, leaving a minimal margin of normal parenchyma [13]. The tumor bed was overseen with 3–0 polyglactin sutures (in case of pelvicalyceal violation), and parenchyma was adapted with the sliding clip technique. Argon laser coagulation or hemostatic materials were used as needed. Operative data consisted of total operative time, estimated blood loss (EBL), warm-ischemia time (WIT), and adverse events.

Technical, renal functional, and oncological outcomes were abstracted from our database. All complications within 30 days of surgery were classified according to the Clavien-Dindo classification system [14]. Estimated glomerular filtration rate (eGFR) was determined before and after NSS using the modified Modification of Diet in Renal Disease (MDRD) equation [15]. Chronic kidney disease stage was assigned according to the National Kidney Foundation definition [16]. Pathological data included histological subtype, grade, and margin status. Tumor staging was designated according to the TNM classification based on the 2009 American Joint Committee on Cancer/International Union Against Cancer classification system. Tumor size was defined as the largest diameter of the tumor (cm). Tumor recurrence was defined as an enlargement of the resected tumor in the absence of distant metastasis based on imaging. Follow up was calculated from the time of surgery until the last known contact with the patient or until the date of death. Mortality status was confirmed with death certificates.

Statistical calculations were performed using the commercially available software (SPSS version 20). Student’s t-test and Fisher’s exact test were the statistical methods of reference.

3. Results

A total of 17 patients with clinical T2 renal masses (>7 cm) have undergone nephron-sparing surgery between 2001 and 2012, at our institution. Thirteen patients (76.4%) were treated through the open route (Figure 1), while 4 patients (23.5%) were managed by RANSS (Figure 2). Mean age of the study population was 49.8 ± 11.3 years (range = 30–66). Male to female ratio was 1.42 (10/7). Mean ASA score of the operated patients was 1.1 ± 0.39 (range = 1–3). The majority of the tumors were discovered incidentally (n = 11, 64.7%). NSS was offered more commonly on elective indications.

The indication to perform NSS was imperative (bilateral mass n = 2, solitary kidney n = 1) in 3 patients (17.6%).

Mean tumor size was 8.24 ± 2.45 (range = 6–15) cm according to the final pathology reports. Diameter of the resected tumor was measured less than 7 cm in 5 patients (29.4%) whose preoperative imaging findings were suggestive of a T2 lesion. Mean tumor size in these 5 cases was 6.1 ± 0.14 (range = 6–6.3). Mean R.E.N.A.L. score was 8.5 (range = 6–10).

Mean operative duration and mean estimated blood loss amount were 125 ± 35.4 minutes (range = 75–220) and 267.6 ± 117.1 mL (range = 100–500), respectively. Mean warm-ischemia time was 15.2 ± 4.1 minutes (range = 10–21) in the 8 surgeries (47%) during which tumor was enucleoresected after clamping the renal pedicle. The difference between the mean R.E.N.A.L. scores of the tumors that were managed under ischemic and nonischemic conditions was statistically insignificant (8.6 versus 8.4 P = 0.72). Open conversion during robot-assisted surgery was necessary in 2 cases, whose

Figure 1: A 49-year-old female patient who had a cT2 mass in her right kidney. She was operated through the open route under warm ischemia. Final pathologic diagnosis was Fuhrman grade 2, clear cell RCC, pT2a.

Figure 2: A 66-year-old female with a multiloculated cystic mass measuring 14.5 cm in its greatest dimension. This right renal mass harbored thin septa formations that enhanced after contrast administration. She was managed with robot-assisted NSS without hilar clamping. Final pathologic diagnosis was cystic nephroma.
tumors had R.E.N.A.L. scores of 9 and 10, respectively (Figure 3).

Pathologic information has been summarized in Table 1. According to the final pathology reports, surgical margins did not harbor malignant infiltration in any case. Patients were hospitalized for a mean duration of 5 ± 5.4 days (range = 3–26). Three patients suffered from a total of 6 grade 2 and higher complications within 30 days of surgery. Blood transfusion and bladder catheterization due to gross hematuria were the recorded grade 2 and 3 complications in 2 patients, respectively. Blood transfusions, angioembolization, double-J catheter insertion due to urinary extravasation, and temporary hemodialysis are counted for the grade 2, 3a, 3b, and 4a complications encountered during the postoperative course of another patient who had a 9 cm enhancing mass in his solitary kidney (Figure 4).

Mean preoperative and postoperative eGFR was 89.3 ± 20.5 mL/min/1.73 m² (range = 60–136.1) and 76.9 ± 23.5 mL/min/1.73 m² (range = 8.3–111.6), respectively. The difference between these 2 mean values was statistically insignificant (P = 0.11).

Mean duration of follow-up was 35.2 ± 28.1 months. During the followup period, tumor bed recurrence was detected in one patient (5.8%), who underwent radical nephrectomy as a complementary procedure in another center. None of the patients in this cohort was lost either due to RCC or due to other comorbidities.

4. Discussion
Multiple previous studies have shown the oncological equivalency of NSS to radical nephrectomy (RN) for T1a and even T1b renal masses [2, 24–27]. Considering the facts that some of these localized renal lesions will be benign and/or low grade, and renal preservation has documented benefits on long-term cardiovascular health [6–8], the guidelines advocate NSS as a standard of care for all T1 renal masses [9].

Although, there is a paucity of clinical series evaluating the oncologic results of NSS for T2 renal lesions, initial results are encouraging (Table 2). Breau et al. found that cancerspecific survival and overall survival were similar between NSS and RN for T2 tumors or greater [20]. Karellas et al. found that 71% of the patients were alive and free of disease at a median followup of 17 months [19]. Becker et al. reported 5-year overall and cancer-specific survival rates of 88.0% and 97.0%, respectively [18]. Conversely, Haefez et al. found a significant increase in recurrence rates as well as decreased survival in their study consisting of partial resections performed for tumors ≥ 7 cm in size [23]. It is also important to note that a recent analysis of almost 19,000 localized RCCs in the SEER database showed that greater than 75% of localized renal cancers ≥ 7 cm in size and more than 65% of those ≥10 cm in size are low-grade lesions, suggesting that NSS for large renal masses may be oncologically sound [28]. In our series, after a median followup of 33 months, all 17 patients were alive and free of disease. Local recurrence was detected only in one patient (5.8%), 10 months after the nephron-sparing procedure.

Undoubtedly, NSS for tumors larger than 7 cm represents a surgical challenge, especially in relatively unexperienced hands. The surgical team has to decide upon the route (open, laparoscopic, or robot assisted NSSs) by which resection is going to be carried out. The idea and the method of (clamping the vasculature or manual parenchymal compression) creating ischemic conditions is another tough decision to be made. Maintaining hemostasis and reconstructing the pelvicalyceal system over a large parenchymal defect might be technically demanding especially while performing minimally invasive NSS. Surgical expertise, technologic availabilities, and patient preference will definitely have an influence on the surgical choices.

Recently described morphometric scoring systems may be used to predict operative complexity. Hence, preoperative morphometric data might tailor the surgical approach. In our series, mean R.E.N.A.L. score of the tumors that were resected under perfused conditions was insignificantly lower than that of the tumors operated under ischemic conditions. Although
Table 1: Histopathological profile of the renal masses, with a maximal diameter of more than 7 cm on preoperative imaging, which were managed by NSS.

| NSS for renal masses >7 cm on preoperative imaging (n = 17) | Histology (n, %) | RCC (13, 76.47%) | Benign (4, 23.52%) | Fuhrman-1 | Fuhrman-2 | Fuhrman-3 |
|---|---|---|---|---|---|---|
| Clear cell | 8 | 2 | 3 |
| Papillary | 2 | 3 | 2, 11.76% | 8, 47.05% | 3, 17.64% |
| Chromophobe | 3 | |

Table 2: Outcomes of the case series dealing with nephron-sparing surgery for renal masses measuring more than 7 cm.

| Reference number | Number of tumors ≥7 cm | Median followup (months) | Positive margins (n, %) | Overall survival at 5 years (%) | Median tumor size (cm) | Median preoperative creatinine or eGFR | Median postoperative creatinine or eGFR |
|---|---|---|---|---|---|---|---|
| [17] | 49 | 13.1 | 5 (10.2) | 94.5 | 8.7 | 1.18 mg/dL | 1.30 mg/dL |
| [18] | 91 | 28 | NR | 88 | 8.0 | 92.1 mL/min | 81 mL/min |
| [19] | 37 | 17 | 0 | NR | 7.5 | 65 mL/min | 55 mL/min |
| [20] | 57 | 38 | NR | 75 | 7.5 | 1.2 mg/dL | 9.5% increase |
| [21] | 29 | 54 | NR | 84 | 8.5 | NR | NR |
| [22] | 16 | 70 | 5 (31) | 66 | 8.4 | 1.32 mg/dL | 1.41 mg/dL |
| [23] | 50 | 47 | NR | 82 | 9.9 | NR | NR |
| Present study | 17 | 35.2 | 0 | NR | 8.24 | 89.3 mL/min | 76.9 mL/min |

NR: not reported; eGFR: estimated glomerular filtration rate.

Table 1: Histopathological profile of the renal masses, with a maximal diameter of more than 7 cm on preoperative imaging, which were managed by NSS.

Table 2: Outcomes of the case series dealing with nephron-sparing surgery for renal masses measuring more than 7 cm.
CKD stage in only 11% of their study population [17]. Brea et al. detected a median increase in serum creatinine value by 9.5% compared to 33% for RN [20]. In the studies conducted by Becker et al. [18] and Karellas et al. [19], median eGFR decreased after NSS. Peycelon et al. demonstrated a small increase in mean serum creatinine values at followup in their small cohort of patients [22]. In our study, median eGFR value decreased from 89.37 to 79.15 mL/min/1.73 m² postoperatively and CKD stage progressed in 5 patients (29.4%). Temporary renal replacement therapy, in the form of hemodialysis, had to be initiated for one patient who had a large (9 cm) upper pole mass in his solitary kidney. Although the surgery was carried under nonischemic conditions, the extent of the resection may be the factor underlying the need for renal replacement.

Our study has several limitations such as the retrospective nature with its inherent biases, small sample size, heterogeneous study population, limited follow-up duration, and pathological understaging in 5 patients. Nonetheless, our findings are in concordance with the previous studies, encouraging the utility of NSS for renal masses larger than 7 cm.

5. Conclusions

Nephron-sparing surgery is a feasible option for renal masses, measuring larger than 7 cm on preoperative imaging studies. Despite a limited duration of followup in our series, oncologic results are promising. Renal functional status did not change significantly after NSS for large (>7 cm) renal masses. Less than 1/5 of the study population suffered grade 2 and higher complications during the postoperative period. Regardless of tumor stage, nephron-sparing surgery may be considered for carefully selected patients, including those with a normally functioning contralateral kidney.

Conflict of Interests

The authors have no conflict of interests.

Acknowledgment

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