

Salvage ablation for partial nephrectomy failures

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Repeat partial nephrectomy for recurrent ipsilateral kidney cancer remains challenging even for high volume surgeons. Contemporary studies highlight that attempted surgical salvage results in a not insignificant risk of completion nephrectomy with associated chronic kidney disease.¹ Therefore, minimally invasive alternatives such as salvage percutaneous renal thermal ablation present an attractive option given relatively low morbidity and the potential for kidney preservation. Clearly, oncologic outcomes remain paramount.

The article by Morgan et al² highlights a single center experience with percutaneous cryoablation for recurrent kidney cancer following partial nephrectomy. Although the series is small, oncologic outcomes were good with relatively low patient morbidity. Several essential factors, however, warrant attention when incorporating this salvage treatment modality into clinical practice.

Firstly, it is important to obtain pre-treatment biopsies to determine that there is indeed viable recurrent kidney cancer. Reports do exist that hemostatic agents (i.e. SURGICEL) can contribute pseudo-enhancement on axial imaging studies (CT or MRI) that can be mistakenly interpreted as recurrent disease.³ Biopsy presents a means to histologically confirm radiographic findings prior to subjecting a patient to additional treatment.

Secondly, patients need to be aware of the potential for incomplete salvage ablation. A large multi-institutional cohort has previously shown that salvage ablative procedures (following initial cryoablation or radiofrequency ablation) has a failure rate of approximately 25% and some of these patients will necessitate extirpative surgery thereafter.⁴

Finally, it is essential that urologists remain integral in the decision making process for selection of salvage ablation versus observation, partial, or radical nephrectomy. While radiologists are technically equipped to perform ablation procedures, urologists have the clinical expertise to determine whether this is the most appropriate treatment modality in particular scenarios. Indeed, knowledge about biology of disease, lesion complexity, and likelihood of success are unique to our field and should remain at the forefront of management of all kidney tumors either primary or recurrent. □

References

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