Canadian guidelines for SRMs: How Canadian are they?

Peter Black, MD, FRCSC

Department of Urologic Sciences, University of British Columbia, Vancouver, BC

See related article on page 160.

Cite as: Can Urol Assoc J 2015;9(5-6):163,213. http://dx.doi.org/10.5489/cuaj.3040
Published online June 15, 2015.

Small renal masses (SRM) are encountered by most urologists as part of their routine clinical practice, which makes best practice statements or guidelines like those published in this month’s CUAJ important in standardizing care.1 While it is good for patients to have options, the management of SRMs has started to resemble that of localized prostate cancer – each patient and the treating physician have many potentially difficult choices to make, and there is an underlying concern for over-treatment.

The European Association of Urology (EAU) and the National Comprehensive Cancer Network (NCCN) have recently updated their kidney cancer guidelines including the management of SRMs.2,3 The American Urological Association (AUA) published guidelines specifically on SRMs in 2009 and validated these in 2010.4 Furthermore, the Kidney Cancer Research Network of Canada (KCRNC), which includes many of the same contributors who drew up these SRM guidelines, has developed best practice guidelines in the past.5 The question therefore arises how these new guidelines compare to other international guidelines, how they differ from the prior KCRNC consensus statement, and what makes them specifically Canadian. The answer to all these questions is: not much.

Specific Canadian content to the literature on the management of SRMs relates primarily to the utility of renal mass biopsy6-8 and the adoption of active surveillance,9 both of which we as a Canadian community of urologists would generally promote. However, neither of these components is emphasized particularly strongly in the current guidelines, reflecting a degree of uncertainty in their widespread adoption. With respect to these two issues, these guidelines do not read much differently than the AUA guidelines from 2010, which also recognize an increased role for biopsy and allow for active surveillance in older patients and those with significant medical comorbidities.4 The EAU and NCCN guidelines do not really entertain the notion of SRM biopsy to decide on surgical intervention versus surveillance, but instead limit its scope to patients with metastatic disease, those on surveillance, or those undergoing ablation. The NCCN guidelines are more restrictive than these Canadian guidelines with respect to use of ablative procedures, and reserve these for patients who are explicitly not candidates for surgery. However, this represents a deviation of the

Continued on page 213


Correspondence: Dr. Peter Black, Department of Urological Sciences, University of British Columbia, Level 6, 2775 Laurel St., Vancouver, BC, V5Z 1M9; pblack@ubc.ca