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See related article on page 162

# Updated cystic renal lesions guideline: A springboard for shared decision-making

With updates to the cystic renal masses guideline, as seen in this issue of *CUAJ*,<sup>1</sup> the authors have strengthened what was already a very helpful tool for counselling patients and for framing nuanced discussions about these lesions. The guideline continues to offer size-based and Bosniak-based recommendations that are easy to follow and to apply in practice.

The first change is the recommendation to use the v2019 Bosniak classification. The newer classification appears to lead to a decrease in Bosniak IIF diagnoses, with no increase in higher complexity diagnoses.<sup>2</sup> An important corollary for urologists is that we should confirm with our radiologists that the updated classification has been used to describe the lesion in question. This is particularly important when the distinction between Bosniak IIF and Bosniak III could alter management.

The other main changes to the guideline are the recommendations that smaller (<2 cm) Bosniak III and Bosniak IV cystic renal masses should be offered surveillance as the preferred strategy and that for Bosniak III or IV cysts measuring 2–4 cm, active surveillance or surgery are suggested as equal options. For patients with a Bosniak III or IV cyst measuring >4 cm, surgical excision is suggested as the preferred strategy.

It is commendable that surveillance is now an accepted form of management for many Bosniak III and IV lesions. While Bosniak III and IV lesions are grouped together in the summary recommendations, the text outlines the different behavior and risks of malignancy for these lesions. It is incumbent on the careful reader to delve past the summary statements, as a well-informed patient might make a different decision knowing the risk their lesion harbors a histological cancer is equivocal compared to highly probable.

The authors acknowledge the poor quality of the data used to inform the recommendations. They cite published series that reassure us cystic renal masses are often indolent, and indeed studies with similar findings continue to be published.<sup>3</sup> One question might be: what would be the harm of offering surveillance for

large Bosniak III lesions? It is clear the risk of histological malignancy increases with cyst complexity but not so much based on size, since the lesion is primarily fluid.

We also don't know the risks of progression to advanced disease with surveillance, yet some may extrapolate from surveillance data in solid renal masses. The unknown benefits of treatment must be balanced against the known risks related to surgery. The 30-day mortality after partial nephrectomy is <1% but it is not 0.<sup>4</sup> There are the other perioperative risks and complications, especially when attempting larger or poorly located complex cysts. In fact, for large Bosniak III lesions, partial nephrectomy may not be feasible, leading to radical nephrectomy and significant nephron loss.

The difficult discussions will continue to be the medium Bosniak IV and large Bosniak III lesions. Patients must be informed of the likelihood these lesions harbor malignancy. They should also be informed that there is no good evidence that surgical treatment upfront (compared to surveillance upfront) will ultimately decrease the risk of metastasis or death from kidney cancer. There will need to be individualized discussions with every patient based on shared decision-making. This updated guideline offers an excellent framework to have that discussion.

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