

Editorial referring to the paper: Harris KT, Ball MW, Gorin MA, Allaf ME, Pierorazio PM. Outcomes of partial nephrectomy in patients who meet percutaneous ablation criteria. *Cent European J Urol*. 2015; 68: 132-136.

What matters when selecting candidates for renal ablation: tumor size or the patient's condition?

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Kelly and cols compared outcomes in their cohort of RAPN between those that meet the criteria for percutaneous ablation (PA) [1] and those who did not. Not surprisingly, they concluded that RAPN is a safe and effective treatment even in patients who meet ablation criteria. Aside from methodological considerations, retrospective analysis, and a very small comparative sample for a fair comparison, the point to be stressed is the selection criteria used for PA in their series.

Only tumors smaller than 3 cm, posterior, and completely exophytic were selected as candidates for PA [2]. While true that these tumors can be easily ablated percutaneously, the spectrum of tumors that can be treated by percutaneous ablation is larger than that included in their study, theoretically and in practice.

Major guidelines actually recommend ablation in cT1a (tumors with a clinical maximal diameter up to 4 cm) as an option [3, 4]. It seems to be technology that drives the indication based on size. There is a clear relationship between size and oncological ablation outcomes (residual and recurrent disease) [5, 6]. Excellent ablation results are found for radiofrequency ablation limited to a maximal size of 3 cm, while size limit for cryoablation is around 4 cm. Whether larger tumors should or should not be treated by ablation is another question out of scope. The tumor location does indeed play a role when

the percutaneous route is chosen, but it is less evident that only completely exophytic tumors are suitable for percutaneous ablation.

Lastly as important, or even more than anatomical characteristics of the tumor, is the general condition of the patient. In spite of a few reports stressing good outcomes of ablation in young healthy patients, as the ones included in the present study [7], it is the physical condition and the accompanying co-morbidity translated into surgical risk that drives the indication for ablation. Patients with renal tumors and criteria for ablation are different than those that receive PN or non-surgical management. Certainly, overlap does exist when considering Active Surveillance (AS), based on the fact that AS implies interventional treatment being indicated and possible at progression or because of other reasons (e.g. patient's wish). Unfortunately, the body of evidence in ablation is weak; the ideal profile of the ablation candidate is still ill defined and, shamefully, technical availability supersedes good medical practice in some cases.

For the oncoming years in the field of the small renal masses, the urological community should better invest in defining profiles of candidates for the different interventions, as well as embark in well designed multicenter observational studies when RCTs are, for whatever reason, not feasible.

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