

*Where is the wisdom we have lost in knowledge?
Where is the knowledge we have lost in information?*

The perceived wisdom that a small enhancing mass in the kidney represents a surgical lesion that automatically requires excision without the need for a pre-operative biopsy has been challenged by Fernando, Fowler and O'Brien in this journal issue .

As any one who has sat through a renal MDT the predominant presentation of renal cancer is the incidentally detected small renal mass often in elderly patients with significant co-morbidity. The authors are to be congratulated in bringing these data to publication to provoke debate on the treatment paradigm for small renal masses by reviewing nationally collected data on the main therapeutic surgical option-nephron sparing surgery.

As the authors emphasise these data are unique in representing a national picture encompassing both high and low volume centres as opposed to the majority of the literature which are from high volume tertiary referral centres.

To draw conclusions from data requires a clear understanding of the source and quality. Most importantly as these data only refer to patients undergoing nephron sparing surgery we need to be cautious about extrapolating about the management of the SRMs in general.

The striking finding of the study is the high incidence of benign lesions in the younger age groups. We have no knowledge of patients with SRMs who had biopsy which proved to be benign and avoided surgery-if these were added (particularly in the older age groups) would incidence of benign disease be even higher?

These data are self reported and incomplete as evident in almost third of cases missing surgical margin results .The BAUS data set does not define positive surgical margin-with the surgical drift to enucleation rather than excision with a margin of renal parenchyma - a clear definition needs to included in future audits.

The variation in case load between centres identified raises questions as does the finding that two fifths of patients with T1a tumours had radical nephrectomy. With the numbers involved and the absence of any measure of tumour complexity it is difficult to draw firm conclusions but it highlights the need to examine this issue in future analysis and to consider including some form of renal scoring system in future audits.

Where do we go from here.? Firstly we need to rethink our discussion with patients with SRMs.Can we justify performing major surgery with a 1 in 20 chance of a significant complication for a possible benign lesion without at least discussing biopsy with the patient.?

Secondly we need to improve the quality of the data by increasing the completion rate and considering adding data fields which will allow us to draw clearer conclusions on surgical margin and surgical outcome and volume relationships.

Thirdly we need to recognise that NSS is only one component of the management of SRMs which represent major challenge in terms of health resources and most importantly in deciding the best treat paradigm for our patients. If British Urology can do this audit could we not extend this to all SRMs whether they have surgery,ablation or surveillance and establish the role of biopsy,surgery,ablation and surveillance.?

Nephron sparing surgery across a nation-outcomes from the British Association of Urological Surgeons 2012 national partial nephrectomy audit.

Fernando,A,Fowler,S O'Brien T.