



CASUISTRY

Benefit of nephrectomy for treating metastatic renal cell carcinoma[☆]

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KEYWORDS

Nephrectomy;
Metastatic renal cell carcinoma;
Motzer classification

Abstract

Introduction: Systemic treatment for metastatic renal cell carcinoma (mRCC) has changed with the new therapies, and it is not clear if nephrectomy (NEP) has a survival benefit in this kind of patients.

Objective: To investigate if NEP associated to systemic treatment improves overall survival (OS) and progression-free survival (PFS).

Material and methods: A retrospective, observational, descriptive study of 45 patients with diagnosis of mRCC between 2006 and 2014. Advanced cases with only palliative care were excluded, also patients with solitary metastasis who were managed with surgical resection.

Results: Finally 34 patients were treated with systemic treatment. Twenty-six also with surgery associated. Seventy percent were intermediate/low risk at the Motzer classification and >80% Karnofsky performance status. PFS was 7 m. NEP improves PFS (10 vs. 4 m). High risk Motzer decreased PFS ($p < 0.001$). The OS was 11.5 m. Patients with Karnofsky performance status >80, intermediate or low risk Motzer treated with NEP and mTOR as second line treatment, increased the OS (14 vs. 3 m, $p = 0.0001$; 14 vs. 6 m, $p = 0.001$; and 9 vs. 5 m, $p = 0.003$, respectively). In the multivariate analysis only NEP ($p = 0.006$; HR 4.5) and intermediate/low risk at the Motzer classification ($p = 0.020$; HR 8.9) demonstrated significant improvement in OS.

Conclusions: Patients treated with NEP associated to systemic treatment and with an intermediate/low risk in the Motzer classification had a better PFS and OS. The OS also improves in patients treated with mTOR in second line, and Karnofsky performance status >80% in the univariate study, but not in the multivariable one.

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PALABRAS CLAVE

Nefrectomía;
Carcinoma renal
metastático;
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De la nefrectomía en el tratamiento del carcinoma de células renales metastásico**Resumen**

Introducción: El tratamiento sistémico del carcinoma de células renales metastásico (CCRm) ha cambiado con la aparición de nuevas terapias, planteándose la utilidad de la nefrectomía (NFT) en estos pacientes.

Objetivo: Analizar si la NFT asociada a tratamiento sistémico prolonga el tiempo libre de progresión (TLP) y la supervivencia global (SG).

Material y métodos: Estudio descriptivo retrospectivo de 45 pacientes con CCRm entre 2006–2014. Se descartaron casos avanzados con tratamiento paliativo o con metástasis únicas tratados exclusivamente con cirugía.

Resultados: Finalmente 34 pacientes fueron tratados con tratamiento sistémico. En 26 se empleó además cirugía. El 70% presentaban riesgo intermedio en la clasificación de Motzer y un índice de Karnofsky > 80%. El TLP fue de 7 m, encontrándose diferencias significativas entre los grupos con y sin NFT (10 vs. 4 m). Hubo menor TLP en pacientes con Motzer alto ($p < 0.0001$). La SG fue de 11.5 m. Se encontró mayor SG en pacientes con índice de Karnofsky > 80 (13 vs. 5 m; $p = 0.005$), Motzer medio/bajo (14 vs. 3 m; $p = 0.0001$), NFT (14 vs. 6 m; $p = 0.001$) y tratamiento inhibidor mTOR en segunda línea (9 vs. 5 m; $p = 0.003$). En el análisis multivariable solo la NFT ($p = 0.006$; HR 4.5) y un Motzer medio/bajo demostraron una mayor supervivencia ($p = 0.020$; HR 8.9).

Conclusiones: El TLP y la SG aumentaron significativamente en pacientes con NFT asociada, en CCRm de riesgo intermedio/bajo (Motzer). La SG además aumentó en pacientes tratados con mTOR de segunda línea y en pacientes con índice de Karnofsky > 80% en el análisis univariable, no pudiendo demostrarlo en el estudio multivariable.

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Clinical problem

Renal cell carcinomas account for 3% of adult malignancies. 30% are diagnosed when they are already metastatic.¹ One third of patients will develop metastases throughout their disease.² The presence of disseminated disease has a poor prognosis, with a median survival of less than one year. Less than 20% of these patients survive 2 years.³

Systemic treatment (ST) of metastatic renal cell carcinoma (mRCC) has changed in recent years with the emergence of new therapies, such as tyrosine kinase inhibitors (TKIs) or mTOR pathway inhibitors. These agents have demonstrated better overall survival (OS) than immunotherapy. Despite this, the prognosis continues to be poor, with median survival lower than 2 years. Later works analyze the role of nephrectomy (NEP) associated with these therapies, with no conclusive results regarding the increase of OS.⁴

NEP in patients with renal cell carcinomas has been shown to be a safe process even in elderly patients, which increases OS and progression-free time (PFT), also acting as a prognostic factor.⁵

The aim of this study is to analyze whether the NEP brings benefit to the PFT and the OS of patients with renal cell carcinomas that present metastases at the time of diagnosis.

Casuistry

We selected 45 patients with mRCC at diagnosis, undergoing ST from 2006 to 2014. Advanced cases in which palliative

treatment or with resectable metastases treated only with surgery was established were excluded, finally remaining 34. Of them, 25 were men (73.5%) and 9 women (26.5%). The mean age was 60.3 years (SD 10.7 [34–88]).

Twenty-six patients (76.5%) had onset pulmonary metastases, 10 bone (29.4%), 1 liver (2.9%), and 1 in the CNS (2.9%), being multiple (more than one in the same or different location) in 6 (17.6%).

All patients received ST, most of them with first-line sunitinib (82.4%). Surgery was also used in 26 of the cases (76.4%). In 24 patients (70.6%) the surgical procedure was conducted first, followed by ST; in 21, exclusively NEP, and in 3, metastasectomy in the same act – adrenal, vagina and bladder. The remaining 10 (29.4%) started with ST. Salvage NEP was performed in 2 patients (Table 1).

For the study of quantitative variables, means or medians were analyzed according to whether they had a normal distribution. Survival analysis was performed using the log rank test for the univariate study and Cox for the multivariate study. The statistical study used the SPSS package® (v.22).

In 23 patients (67.6%), the Karnofsky index (KI) was 80–100% and in 11 it was lower than 80%. Regarding the classification of Motzer, the majority (23; 67.6%) were intermediate risk, with 5 low-risk and 6 high-risk patients. Although there was no statistical association, in 82.6% ($n = 19$) of patients with a $KI \geq 80\%$, a NEP was conducted versus 63.6% ($n = 7$) with a $KI < 80\%$.

The median PFT was 7 m (1–37), defined as an increase in size or appearance of new lesions (including regional lymphadenopathies).

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