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EDITORIAL COMMENT

Alkhatib et al[1] provide important prospective data spanning 12 years and 958 patients from the Delayed Intervention and Surveillance for Small Renal Masses Registry, affirming the efficacy and safety of active surveillance (AS) for small renal masses. Despite being an established option, AS remains underutilized, with estimates of 3% to 10% of eligible patients receiving it as initial management.[2]

This study demonstrated extremely low renal cell carcinoma mortality rates with competing-risk cancer-specific survival at > 4 years: 0.19% for AS and 0.68% for primary intervention (PI), with no significant difference between the groups. Although overall survival favored PI, this likely reflects selection bias as PI patients were younger and healthier. The adjusted HR for all-cause mortality was 1.57 ($P = .005$), driven by noncancer deaths in the AS group. Growth rate (GR) predicted crossover to delayed intervention (DI) but was not associated with worse pathology or metastases. By contrast, tumor sizes > 3 cm had higher DI rates with more adverse pathology, more strongly predicting malignant behavior over GR alone, supporting the application of the National Cancer Insitute's "3 cm rule" to select sporadic small renal masses. Recurrence after progression showed no significant differences between PI and DI groups. Renal mass biopsies (RMBs) were performed in ~12% of patients, with only 82% sensitivity and 67% specificity; this showed RMBs may help guide management but are not required.

By contrast, Roswell Park's single-center experience of 123 patients with AS (149 tumors) over 5 years used the "GLASS" (Growth rate/Longest tumor diameter/Adverse biopsy histology/Stage/Symptomatology) framework to guide DI decisions.[3] RMB was performed in 67%, with histology revealing 71% renal cell carcinoma, 23% benign, and 6% nondiagnostic, which confirms the commonly quoted RMB nondiagnostic rate of < 10%. They showed 100% sensitivity and positive predictive value for malignancies in those who went on to surgery, showing excellent RMB accuracy.

Both studies used GR thresholds (>5 mm/y) for DI, with Roswell Park refining this based on tumor size. Despite differences in RMB usage and accuracy, both groups confirm AS as a safe and effective option. These studies confirm that AS, while underutilized, is an effective treatment option that urologists should become facile with, as we have in prostate cancer, in order to reduce treatment morbidity without compromising oncologic safety.

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