Letter to the Editor

T1a 0- to 2-cm Small Renal Masses

Re: Pecoraro A, Rosiello G, Luzzago S, et al. Small renal masses with tumor size 0 to 2 cm: a SEER-based study and validation of NCCN Guidelines. *J Natl Compr Canc Netw* 2020;18(10):1340–1347.

With considerable interest, we read the article by Pecoraro et al¹ titled “Small Renal Masses With Tumor Size 0 to 2 cm: A SEER-Based Study and Validation of NCCN Guidelines.” The authors summarized the characteristics of T1a 0- to 2-cm renal cell carcinoma (RCC). It deals with a significant clinical issue. As such, there are a few points that we would like to bring up.

First, patients diagnosed with RCC were included in this study, but multiple primary cancers were not excluded. However, another SEER-based study showed that patients with RCC were at a significantly higher risk of developing a second malignancy, which may affect patients' survival.²

Second, the patient's baseline characteristics did not include race, as shown in

Table 1 of the study.¹ A previous study suggested that African American patients had roughly 3 times higher rates of papillary RCC across disease stages than non-African American patients.³

Finally, the prognosis of RCC with lymph node metastasis is different from that with distant metastases.⁴ It would be more worthwhile to stratify patients according to the site of metastasis; in this way, readers could easily see which histologic subtype is more likely to have distant metastasis, which has more impact on survival outcomes.

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Authors' Reply

To Letter to the Editor by Guo and Liu

We thank Guo and Liu for making these important considerations. As stated in our study,¹ our aim was to reexamine surgically treated patients with renal cell carcinoma (RCC) with T1a renal tumors 0–2 cm to better elucidate the distribution of age, sex, histologic subtype, and Fuhrman grade, along with the rates of synchronous metastases, in a large contemporary population-based cohort (SEER 2002–2016). However, even if we know African Americans to be effectively subjected to higher rates of papillary tumors,^{2,3} further stratification according to race would have created too many details in this manuscript and would have probably made it difficult to consult for readers.

Moreover, we specifically decided to not focus on survival rates, as we have done in another recent study.⁴ Consequently, considering the presence of multiple primary cancers, the probability of developing a second malignancy, and survival rates according to node and distant metastases were not the main objectives of our manuscript.

Additionally, because the patients with metastatic disease (N1 or M1) represented a small group (n=56/13,364; 0.4%), we did not stratify our analyses according to metastatic site. This was also because in the SEER database this information is available only from 2010. Finally, regarding the last comment, Table 2 in our original article¹ clearly shows that patients with sarcomatoid dedifferentiation were more likely to harbor metastatic disease (n=4/13,364; 13.8%), because multilocular cystic RCC showed virtual zero rate of synchronous metastases.

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