

1 These recommendations are to be followed only if non-neoplastic causes of a renal mass (e.g., infections) have been excluded; see Ref. 48 for details. The recommendations are offered as general guidance and do not necessarily apply to all patients. See Table 1 for detailed description of Bosniak Classification.

2 When a mass smaller than 1 cm has the appearance of a simple cyst, further work-up is not likely to yield useful information.

3 Interval and duration of observation may be varied (e.g., longer intervals may be chosen if the mass is unchanged; longer duration may be chosen for greater assurance).

4 In selected patients (e.g., young), early surgical intervention may be considered, particularly if a minimally invasive approach (e.g., laparoscopic partial nephrectomy) can be utilized.

5 Morphologic change refers to change in feature characteristics, such as number of septations or their thickness. Growth should be noted, but by itself does not indicate malignancy.

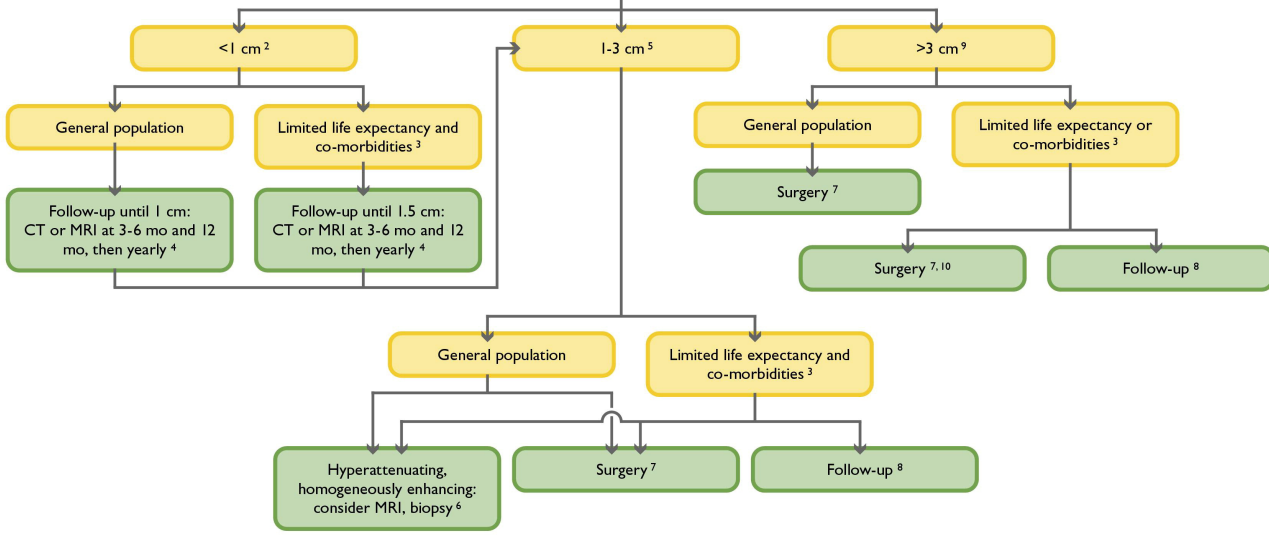
6 Surgical options include open or laparoscopic nephrectomy and partial nephrectomy; each provides a tissue diagnosis. Open, laparoscopic, and percutaneous ablation may be considered where available, but biopsy would be needed to achieve a tissue diagnosis. Long-term (5- or 10-year) results of ablation are not yet known.

7 Limited life expectancy and co-morbidities that increase the risk of treatment.

8 Cystic masses 1.5 cm or smaller that are not clearly simple cysts or that cannot be characterized completely may not require further evaluation in patients with co-morbidities and in patients with limited life expectancy.

9 Percutaneous biopsy of Bosniak Category III masses may be considered, but may not be diagnostic.

Incidental Solid Renal Mass ¹
Detected on CT



- 1 These recommendations are to be followed only if non-neoplastic causes of a renal mass (e.g., infections and fat-containing angiomyolipomas) have been excluded; see Ref. 48 for details. The recommendations are offered as general guidance and do not necessarily apply to all patients.
- 2 Differential diagnosis includes renal cell carcinoma, oncocytoma, angiomyolipoma. Benign entities are more likely in small renal masses than large ones.
- 3 Limited life expectancy and co-morbidities that increase the risk of treatment.
- 4 Interval and duration of observation may be varied (e.g., shorter interval if the mass is enlarging).

- 5 Probable diagnosis renal cell carcinoma, provided there is no detectable fat at CT or MRI using protocols designed to evaluate renal masses.
- 6 If hyperattenuating and homogeneously enhancing, consider MRI and percutaneous biopsy to diagnose angiomyolipoma with minimal fat.
- 7 Surgical options include open or laparoscopic nephrectomy and partial nephrectomy; both provide a tissue diagnosis. Open, laparoscopic, and percutaneous ablation may be considered where available, but biopsy would be needed to achieve a tissue diagnosis. Long-term (5- or 10-year) results of ablation are not yet known.

- 8 Observation may be considered for a solid renal mass of any size in a patient with limited life expectancy or co-morbidities that increase the risk of treatment, particularly when the mass is small. It may be safe to observe a solid renal mass beyond 1.5 cm; however, there are insufficient data to provide definitive recommendations on the risks and benefits of observation. Thin (≤ 3 mm) sections help confirm enhancement.
- 9 Probable diagnosis renal cell carcinoma. Angiomyolipoma with minimal fat, oncocytoma, and other benign neoplasms may be found at surgery.
- 10 Percutaneous biopsy can be utilized preoperatively to confirm renal cell carcinoma.