



European Association of Urology



## Letter to the Editor

**Re: Rodolfo Montironi, Roberta Mazzucelli, Antonio Lopez-Beltran, et al. Cystic Nephroma and Mixed Epithelial and Stromal Tumour of the Kidney: Opposite Ends of the Spectrum of the Same Entity? Eur Urol 2008;54:1237–46**

We have read with a great interest the review article by Montironi et al about cystic nephroma (CN) and mixed epithelial and stromal tumor of the kidney (MESTK) [1]. The review was prepared mainly from a pathologic point of view. We would like to add some clinical comments that are important for everyday clinical urologic praxis. At our institution, urologists are very familiar with these ideas because the concept of MESTK was described by our pathologists [2], and we have also published clinical opinions on these tumors [3,4]. We would like to make the following recommendations for everyday clinical praxis:

1. Differentiation of MESTK and CN is useless from a clinical point of view. The unifying term REST (renal epithelial and stromal tumor) [5], encompassing both MESTK and CN, is welcome for clinical praxis.
2. RESTs are classified with the Bosniak classification mainly as a type III and more rarely as types II and IV. Type IV indicates tumors with solid components.
3. Cystic lesions of Bosniak type I are indicated for follow-up (malignant tumor is nearly excluded), and type IV is indicated for radical treatment (there is a high risk of necrotic tumors with high malignant potential). Indications for Bosniak types II, IIF, and III are unclear. We recommend surgical treatment; priority is given to nephron-sparing surgery, if it is technically feasible, but in our opinion, most tumors are so advanced that resection is not possible. Why resection only? All tumors commonly found histologically in Bosniak II and III (RESTs and multilocular cystic renal cell carcinoma [MCRCC]) are “benign” [3]. We also have to consider Bosniak II multilocular cyst, but this is very rare and is also benign. The term *carcinoma* in MCRCC is a little misleading because no malignant course has been described for MCRCC [6]. Unfortunately, precise histologic criteria for MCRCC have not been defined to date.
4. It is impossible to preoperatively distinguish individual pathologic entities in Bosniak categories II and III

by radiologic techniques (ultrasonography, computed tomography, magnetic resonance imaging). A preoperative biopsy of tumor provides no benefit.

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