Recurring Local Tumor Progression After Cryoablation of Renal Cell Carcinoma

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Abstract

We describe three cases of renal cell carcinoma (RCC) with recurring local tumor progression, i.e., local failure following repeat cryoablation for a locally progressed tumor. A second local progression developed in all cases after cryoablation for the first local progression, despite there being a sufficiently large ice-ball margin. In two cases, the second local progression was treated with microwave ablation and controlled in the follow-up. In one case, a third cryoablation was performed, but a third local progression developed after 12 months. These cases suggest that some RCCs may be refractory to cryoablation. In cases of recurring local progression, switching from cryoablation to another ablation modality may be an alternative.

Key words: renal cell carcinoma, cryoablation, local progression

Introduction

Cryoablation is a safe and effective treatment for renal cell carcinoma (RCC) [1]. In a meta-analysis, the local tumor progression rate after cryoablation was as low as approximately 4% [2]. In cases of local tumor progression, repeat cryoablation is feasible, offering a high secondary local tumor control rate [1, 3]. Recurring local progression, i.e., local failure following repeat cryoablation for a locally progressed tumor, is rare, as long as the repeat ablation is performed with an adequate ice-ball margin. Nevertheless, we recently experienced three cases of RCC with recurring local progression after repeat cryoablation despite a sufficiently large ice-ball margin (≥ 6 mm) [4, 5]. Here, we describe the details of those cases.

Case Report

Cryoablation was performed percutaneously under local anesthesia in all 3 cases. Two to four 17-gauge cryoprobes (IceSeed or IceRod; Galil Medical, Youknum, Israel) were placed under computed tomography (CT) fluoroscopy guidance. Ablation was performed using an argon-based cryoablation system (Cryo-Hit; Galil Medical) with two 15-min freeze cycles separated by at least 2 min of passive thawing. CT was performed at the end of each freezing cycle to assess the ice-ball margin. When the ice-ball margin was insufficient (≤ 6 mm), the cryoprobes were repositioned, and one or two freeze-thaw cycles were added to achieve an adequate ablation margin.

Case 1 (Figure 1)

An 86-year-old male presented with a biopsy-proven clear cell RCC (Fuhrman Grade 2; 27 mm in diameter; endophytic) in the right kidney. Cryoablation was performed after selective transcatheter renal arterial embolization (TAE) using a mixture of ethanol and iodized oil to enhance the local tumor control. Nine months later, CT showed a 15-mm enhancing focus in the treated area, which was histologically diagnosed as local progression using a needle biopsy. The local progression was treated with selective TAE followed...
by cryoablation with a large ice-ball margin (> 10 mm). Although the tumor enhancement completely disappeared after treatment, a CT conducted 10 months after the second cryoablation showed a nodular enhancing focus measuring 10 mm at the center of the re-treated area, indicating recurring local progression. 

A third cryoablation was performed with an ice-ball margin > 10 mm, resulting in the disappearance of the tumor enhancement. However, a nodular enhancing focus was found again at the center of the re-ablated area on CT after 15 months, indicating a third local progres-
A 76-year-old female presented with three right renal tumors (10, 14, and 13 mm in diameter; all exophytic). She had a history of left radical nephrectomy for RCC (clear cell carcinoma, Fuhrman Grade 2) seven years before and right adrenalectomy for adrenal metastasis four years prior. Two cryoablation sessions were performed for the three tumors. Thirty months after the first cryoablation, two nodular enhancing foci measuring 7 and 9 mm, respectively, were found at the center of the ablated areas. Those were radiologically diagnosed as local tumor progression, and a second cryoablation was performed with ice-ball margins exceeding 6 mm. However, 10 months later, CT showed small enhancing foci measuring 5 and 7 mm, respectively, at the center of the re-ablated areas, indicating recurring local progression. As in case 2, percutaneous MWA was performed, and no local progression was observed after 14 months.
Discussion

Second local progression after repeat cryoablation for RCC is rare [3, 4]. A large tumor size (> 3 cm) and insufficient ice-ball margin (< 6 mm) are risk factors for local progression after percutaneous cryoablation [4, 6]. Yamanaka et al. reported a case of RCC located between the renal artery and vein, showing a second local progression after repeat cryoablation [4]. All the locally progressed tumors in the present report were small in size and treated with a sufficient ice-ball margin (≥ 6 mm) in the second and third percutaneous cryoablation sessions. However, second and third local progressions occurred.

The mechanisms of cell death due to cryoablation include direct cell injury caused by ice crystal formation, failure of microcirculation, and induction of apoptosis and necrosis [7]. Exposure to temperatures under -40°C is generally recommended to ensure the death of renal cancer cells, as such low temperatures may injure the cells through intracellular crystal formation [8]. In the present report, all the locally progressed tumors were located at the center of the ice-ball during freezing, where the temperature was under -40°C based on the isotherm shown in a swine model study using the same cryoprobe as that in the present report [5]. Additionally, the tumors were not adjacent to large blood vessels that potentially prevent a decrease in temperature through the heat pump effect. Thus, local progression in our cases was unlikely to result from failure to expose the tumors to temperatures under -40°C. Previous in-vivo experiments have indicated that exposure to a temperature of -40°C may not be lethal for some types of malignant cells [7]. Furthermore, altered tumor characteristics because of incomplete ablation in the first cryoablation session may have contributed to the subsequent local progression. Further investigations are necessary regarding the existence of renal cancer cells anomalously resistant to cryoablation.

In the present report, RFA was performed for recurring local progression in one patient. Furthermore, MWA was performed for the three locally progressed tumors in two patients. All of them were successfully controlled in the follow-up. In previous studies, the local progression rates were not different between MWA and cryoablation for the first treatment of small renal tumors [2, 9]. However, in
cases refractory to cryoablation, switching from cryoablation to a different ablation modality, such as MWA or RFA, may help to avoid repeat local progression. A second local progression reported by Yamanaka et al. was also successfully controlled with RFA [4].

In conclusion, the present report described three cases of RCC refractory to repeat cryoablation with an adequate ablation margin. These cases suggest that some RCCs may be resistant to cryoablation. Switching from cryoablation to another ablation modality, such as MWA or RFA, may be an alternative for such tumors.

Conflict of interest: none

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References