

# Commentary on Characterization of Fibromuscular Pseudocapsule in Carcinoma of Renal Cells

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## COMMENTRY

A common malignant tumour in the urinary system is renal cell carcinoma. Chromophobe renal cell carcinoma (chRCC) accounts for approximately 3 percent to 5 percent of all RCCs among the various sub-types of renal cell carcinoma. ChRCC is known to be derived from mitochondrial alterations of the collecting duct, harbours, and can be found in Birt-Hogg-Dubé syndrome. In general, homogenous and indolent tumours have been considered to be chRCCs. The degree of early improvement during the corticomedullary process was shown to be the highest for clear cell RCC, followed by oncocytoma, chRCC, and papillary RCC. As far as is understood, however, few studies are devoted to the imaging manifestations of chRCCs. ChRCCs currently have the best prognosis of all the various RCC subtypes, with a 5-year survival rate of over 90 percent, as compared to clear cell and papillary RCCs, which have survival rates of 55 percent - 60 percent and 80 percent - 90 percent. Active monitoring, radiofrequency ablation, radical nephrectomy and nephron-sparing surgery are included in the localised chRCC treatments. Simple enucleation (SE) is a nephron-sparing surgery which dissects the tumour between the tumour pseudocapsule and healthy kidney parenchyma bluntly along the natural cleavage plane. In benign renal tumours, SE was first used. SE is now regularly done for family RCC and intermittent RCC, which can maintain the full normal parenchyma to minimise the risk of developing chronic kidney disease. Tumor SE has recently been reported to have disclosed comparable oncology results compared to normal partial margin nephrectomy for RCC. It is, however, acknowledged that, in the treatment of clear cell RCCs, most of the previous articles were about SE. No

prior studies have exclusively tested the safety and viability of this technique in chRCCs. It reviewed a lot of previous evidence and concluded that simple enucleation was a surgical technique that met the oncological safety requirements of the EAU guidelines. The first laparoscopic SE for chRCC was performed at one Institute in November 2010. Therefore, in a series of pathologically confirmed localised chRCCs at that institute, the object of this study is to evaluate the CT manifestations, enhancement features and protection, feasibility and oncological outcomes of laparoscopic SE care. Patients who were usually anaesthetized were put in a lateral decubitus role. Three trocars, by retroperitoneal laparoscopic method, were positioned on the affected flank. With an artery clamp, the renal artery was completely dissected and blocked. The renal parenchyma, adjacent to the tumour fringe, was incised sharply over a length of 5 mm. The tumour can be quickly separated bluntly from the usual acrotic parenchyma when the right surgical plane is entered and the capsule is reached and clearly enucleated from the kidney without any visible rim of normal parenchyma. At the beginning and end of the suture procedure, a single-layer suture with Hem-lock was applied to the renal capsule. Then, from the renal pedicle, the artery clamp was taken off. It reported the activity time, warm ischemia time (WIT) and blood loss. There is a great tendency for homogeneity and complete pseudocapsule in localised chRCCs. The attenuation values were marginally lower than those of the normal renal cortex and the degree of change was minimal. Laparoscopic SE is a secure and efficient treatment for localised chRCC with little impact on renal function, based on the homogenous appearance and well circumscribed picture manifestation.

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