Changes in Renal Function One Year after Radical Nephrectomy for Cancer Compared to Kidney Donation

Cristiano Trindade de Andrade¹, Wagner Eduardo Matheus¹, Ubirajara Ferreira¹, Marilda Mazzali²,³*, and Marcelo Lopes de Lima¹,³

¹Department of Surgery, University of Campinas, Campinas, Brazil
²Department of Medical Sciences, University of Campinas, Campinas, Brazil
³Laboratory of Investigation in Transplant (LINT), School of Medical Sciences, University of Campinas, Campinas, Brazil

*Corresponding author: Marilda Mazzali, Laboratory of Investigation in Transplant/Renal Transplant Unit, Department of Medicine, School of Medical Sciences, University of Campinas Rua Tessália Vieira de Camargo, 126, Cidade Universitária Zeferino Vaz, 13.083-970, Campinas, São Paulo, Brazil, Fax: (55-19) 35218204; E-mail: marildamazzali@gmail.com; mmazzali@fcm.unicamp.br

Received: 01 Nov, 2019 | Accepted: 19 Nov, 2019 | Published: 22 Nov, 2019

Abstract

Purpose: Adaptive changes to acute reduction in renal mass after radical nephrectomy can cause Chronic Kidney Disease (CKD) more frequently in patients with renal cancer compared to kidney donors. The aim of this study was to compare changes in Estimated Glomerular Filtration Rate (eGFR) 1-year after radical nephrectomy for cancer vs kidney donation and to identify risk factors for CKD.

Methods: Medical records from 79 patients submitted to nephrectomy from January 2008 to September 2013, divided into 2 groups, according to the indication of nephrectomy: kidney donor (n=39) and renal tumor (n=40) were analyzed for demographic data, presence of comorbidities, tumor size and eGFR by the Chronic Kidney Disease-Epidemiology (CKD-EPI) formula, at baseline and 12 months post nephrectomy.

Results: In the donor group, there was a reduction of 31.3% in e-GFR within 1-year, and 25.6% were classified as CKD-3 (eGFR <60 ml/min/1.73 m²). Risk factors were age >50 years old and overweight (p=0.0268). In the tumor group, reduction in e-GFR was of 18.8%, but 57.5% of patients became CKD-3. The only risk factor was the presence of comorbidities (p=0.0354). Analysis of tumor size showed a significant reduction in e-GFR for tumors ≤ 7 cm, while for tumors >15 cm eGFR remained similar to baseline levels.

Conclusion: Risk factors for CKD, 1-year after radical nephrectomy, were the presence of hypertension or diabetes in patients with renal cancer, and overweight and age >50 years old for kidney donors. The increased loss of eGFR for tumors <7 cm suggest that partial nephrectomy should be considered when possible.

Keywords: Radical nephrectomy; Kidney donation; Renal function; Renal cell carcinoma

Introduction

The reported long-term safety of living kidney donation seems a paradoxical situation when compared to the increased risk for chronic kidney disease (CKD) after radical nephrectomy in patients with renal cancer [1,2]. Despite a reported loss of 30% in glomerular filtration rate following unilateral nephrectomy, only 0.3 to 0.5% of kidney donors progressed to end stage CKD with need for renal replacement therapy [1,3]. However, for patients submitted to radical nephrectomy for cancer, rates of CKD are higher, around 40 to 75% to stage 3 and 1 to 2% of end stage CKD [4-6]. These differences can be related to patient characteristics and associated risk factors, such as age at the time of nephrectomy and the presence of comorbidities like hypertension and diabetes [7,8]. Renal function at the time of surgery also can impact progression of renal disease, with an increased risk for CKD stage 3 in patients with an initial eGFR between 60 to 89 ml/min/1.73 m² [9].

In recent years, preservation of renal mass and function has been considered as important as the oncologic quality of the procedure, with a tendency to perform partial nephrectomies or ablative procedures when possible [7]. However, for large tumors, the preservation of renal mass remains a problem. The aim of this study was to compare changes in eGFR 1-year after radical nephrectomy for cancer vs. kidney donation and to identify risk factors for CKD.

Material and Methods

Retrospective study from a single center

Data was collected from medical records and Renal Transplant Unit database. The Ethics Committee from University of Campinas approved the study protocol.

Inclusion criteria

Patients submitted to unilateral nephrectomy from January/2008
to September/2013 for tumor resection or renal donations were older than 18 years old and with a follow up after nephrectomy longer than 12 months.

Exclusion criteria

Previous CKD, defined as eGFR < 60 ml/min/1.73 m²; death or loss of follow-up within 12 months after surgery; presence of metastasis at the time of diagnosis; histological diagnosis of sarcoma or urothelial carcinoma and presence of a synchronous tumor in the contralateral kidney.

Collected data

Included gender, age at nephrectomy, presence of comorbidities (hypertension and/or diabetes), serum creatinine and tumor size. eGFR was calculated by the Chronic Kidney Disease Epidemiology (CKD-EPI) equation [10], using serum creatinine at two time points: baseline (pre-operatively) and after 12 months of follow up.

For analysis, patients were divided into 2 groups: donor (nephrectomy for renal donation) and tumor (radical nephrectomy for cancer). The groups were subdivided into according to postoperative eGFR: CKD group (eGFR < 60 ml/min/1.73 m²) or control group (eGFR ≥ 60 ml/min/1.73 m²), according to CKD classification of National Kidney Foundation [11].

Statistical analysis

Numerical data was presented as mean ± standard deviation. Mann-Whitney test was used to compare means between the two groups and Wilcoxon test for paired data was used to compare 2 time points of the same group. Fisher's exact test was used for qualitative and Pearson's correlation for numerical variables. Multiple linear regression was used to identify risk factors. Statistical significance was considered if p<0.05.

Results

From January 2008 to September 2013, 130 consecutive unilateral nephrectomies were performed at Clinics Hospital of University of Campinas. For analysis, patients were divided according to the indications for surgery in the donor group (n=60, unilateral nephrectomy for kidney donation) and the tumor group (n=62, radical nephrectomy for kidney cancer). After applying the inclusion and exclusion criteria, 39 patients from the donor group and 40 patients from the tumor group were selected (Figure 1).

Patients in the tumor group were older, with a lower pre operative eGFR and presented with a higher incidence of comorbidities, such as systemic hypertension or diabetes compared to the donor group (Table 1).

Analysis of changes in glomerular filtration rate showed that both groups presented a significant reduction in eGFR at the end of the first year, with the higher eGFR for the donor group (29.9 ± 11.2 ml/min/1.73 m² body surface versus 14.2 ± 18.3 ml/min/1.73 m² body surface, donor vs tumor, p <0.05) (Figure 2), but this reduction is less significant when compared to the tumor group, whereas eGFR in the donor group is higher after one year. When we analyzed the percentage of patients with CKD, defined as glomerular filtration rate (GFR) lower than 60 ml/min/1.73 m² for greater than 3 months, the tumor group had a higher incidence of CKD (57.5% versus 25.2%, p <0.05). In order to identify possible risk factors for the unfavorable outcome, each group was divided into 2 subgroups, with 1-year eGFR < 60 ml/min/1.73 m² or e-GFR ≥ 60 ml/min/1.73 m² body surface.

In the renal donor group, the multivariate analysis showed that the increase in Body mass index (BMI) (p=0.015) and donors older than 50 years old (p=0.021) were associated with a lower postoperative eGFR and had a higher chance to progress to CKD within the first year after surgery (Table 2).

In the tumor group, in univariate analysis, risk for final eGFR < 60 ml/min/1.73 m² body surface were the presence of comorbidities like hypertension or diabetes (p=0.0034) and patients older than 60 years at the time of surgery (p=0.0235). However, after multivariate analysis, only comorbidities of hypertension and/or diabetes were risk factors (p=0.0354), with a 7-times increase in the chance for eGFR lower than 60 ml/min/1.73 m² body surface one year after surgery (Table 2).

In this series, the mean size of tumors in patients submitted to nephrectomy was 9.77 ± 4.5 cm. When nephrectomy was performed for tumors ≥ 15 cm there was no variation in eGFR (58.3 ± 19.1 vs. 57.4 ± 18.6 ml/min/1.73 m² body surface, p=ns); whereas for tumors smaller than 7 cm we observed a higher reduction in eGFR within the first year after transplant (80.8 ± 18.8 vs. 57.5 ± 15.9 ml/min/1.73
Table 1: Demographic characteristics of patients according to study groups.

<table>
<thead>
<tr>
<th></th>
<th>Donor group</th>
<th>Tumor group</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of patients</td>
<td>39</td>
<td>40</td>
<td></td>
</tr>
<tr>
<td>Age (years)</td>
<td>43.1 ± 8.0</td>
<td>64.1 ± 8.5</td>
<td>&lt;.0001</td>
</tr>
<tr>
<td>Gender (male:female)</td>
<td>16:23</td>
<td>18:22</td>
<td>0.1431</td>
</tr>
<tr>
<td>Hypertension-n (%)</td>
<td>0</td>
<td>24 (60)</td>
<td>&lt;.0001</td>
</tr>
<tr>
<td>Diabetes</td>
<td>0</td>
<td>12 (30)</td>
<td>&lt;.0001</td>
</tr>
<tr>
<td>Tumor size (cm)</td>
<td>na</td>
<td>9.77 ± 4.5</td>
<td></td>
</tr>
<tr>
<td>eGFR (ml/min/1.73m²)</td>
<td>pre-operative</td>
<td>95.5 ± 15.2</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1-year follow up</td>
<td>65.6 ± 13.0</td>
<td>&lt;.0001</td>
</tr>
<tr>
<td>Variation of eGFR (ml/min/1.73m²)</td>
<td>29.9 ± 11.2</td>
<td>14.2 ± 18.3</td>
<td>&lt;.0001</td>
</tr>
</tbody>
</table>

In the tumor group was around 80 ml/min/1.73 m², which contributed to a lower eGFR 1-year after nephrectomy.

The differences in progression to CKD from donor and tumor groups could be attributed to the patient’s characteristics. Kidney donors are usually younger with initial renal function higher than 80 ml/min/1.73 m² and don't have comorbidities such as hypertension or diabetes.

Patients with tumors are older with an initial lower eGFR and usually have associated comorbidities like hypertension and diabetes that were isolated risk factors for progression to CKD in this group, similar to previous reports [2,13]. For donors, the presence of hypertension and diabetes are contra indications to donation. These variables were not analyzed. However, the higher body mass index was a risk factor for lower eGFR in the donor group. Previous studies showed an association of higher BMI and lower eGFR after surgery [7,16,17]. Bello RC, et al. reported that the frequency of systemic hypertension increased by 10% for every 1 unit of increase in BMI, which probably explains the worse outcome in this group of patients [16]. Also, increase in BMI is an initial trigger for other metabolic syndrome abnormalities.

The influence of age at nephrectomy in the progression to CKD is controversial, but should be considered when analyzing the risks of surgery. In this study, for donors older than 50 years we observed a trend towards lower one-year eGFR. Similar data was observed by Dols LF, et al. in which the frequency of eGFR increased by 10% in patients older than 60 years [14]. However, despite of the higher incidence of CKD stage 3, none of the patients progressed to stages 4 or 5 [14]. In contrast, in the tumor group, age >60 years old in this series was a risk factor only by univariate analysis.

One should consider that radical nephrectomy in patients with renal cancer and absence of comorbidities could have a similar impact than in healthy donors. Timsit MO, et al. analyzed a group of patients with radical nephrectomy due to cancer with few comorbidities and compared to the kidney donors paired for age and length of follow up. They observed a reduction of 30% in eGFR in both groups, suggesting that the presence of comorbidities at the time of surgery has a negative impact on long term renal function [18].

The influence of tumor size in adaptation of GFR was analyzed. In patients with tumors larger than 15 cm, we did not observe significant changes in GFR within 1-year after the procedure, suggesting that the
Table 2: Risk factors for 1-year eGFR <60 ml/min/1.73m² body surface, according to study groups.

<table>
<thead>
<tr>
<th>Age &gt;50 years</th>
<th>BMI</th>
<th>eGFR 60 to 89</th>
<th>Comorbidities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Univariate</td>
<td>p</td>
<td>multivariate</td>
<td>p</td>
</tr>
<tr>
<td>Donor group</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age &gt;60 years</td>
<td>13</td>
<td>(2.1-71.4)</td>
<td>0.5574</td>
</tr>
<tr>
<td>BMI</td>
<td>2</td>
<td>(1.4-3.7)</td>
<td>0.468</td>
</tr>
<tr>
<td>eGFR 60 to 89</td>
<td>2,6</td>
<td>(0.7-9.4)</td>
<td>0.1991</td>
</tr>
<tr>
<td>Comorbidities</td>
<td>8,7</td>
<td>(2.0-38.5)</td>
<td>0.0034</td>
</tr>
</tbody>
</table>

Tumor group

<table>
<thead>
<tr>
<th>Age &gt;60 years</th>
<th>eGFR 60 to 89</th>
<th>Comorbidities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Univariate</td>
<td>p</td>
<td>multivariate</td>
</tr>
<tr>
<td>Donor group</td>
<td></td>
<td>p</td>
</tr>
<tr>
<td>Age &gt;60 years</td>
<td>5,2</td>
<td>(1.3-20.4)</td>
</tr>
<tr>
<td>eGFR 60 to 89</td>
<td>2,6</td>
<td>(0.7-9.4)</td>
</tr>
<tr>
<td>Comorbidities</td>
<td>8,7</td>
<td>(2.0-38.5)</td>
</tr>
</tbody>
</table>

diffuse tumor infiltration spares only a small amount of healthy renal parenchyma. These kidneys behave as a functionally excluded kidney. For tumors smaller than 7 cm radical nephrectomy was associated with a higher variation in GFR, similar to that observed in the donor group, suggesting that healthy renal tissue should be preserved. A previous study from Ohno Y, et al. showed similar changes in GFR, comparing tumors smaller or larger than 7 cm, which suggests that partial nephrectomy should be indicated for tumors smaller than 7 cm if technically possible [19].

The limitations of the study are the retrospective design and the small number of patients evaluated. However, this series contributes clinically and can serve as the basis for a nomogram to estimate the impact of nephrectomy on the GFR, considering the various risks factors. Preservation of renal function is a part of good surgical programming.

Conclusion

In this series, despite a reduction of 30 ml/min/1.73 m² body surfaces one year after nephrectomy, only a quarter of donors progressed to CKD stage 3, with an increased risk for overweight donors. In the tumor group, more than a half of patients progressed to CKD-3 and independent risk factors resulted in a worse prognosis because of comorbidities like hypertension or diabetes.

Tumor size influenced postoperative GFR in this study. Nephrectomies for tumors smaller than 7 cm had a greater variation of GFR, whereas patients with tumors larger than 15 cm showed no significant change in GFR after the procedure.

Author’s Contribution

CT Andrade: data collection, manuscript writing, WE Matheus: tumor group database, U Ferreira: tumor group database, M Mazzali: project development, manuscript correction, ML Lima: project development, manuscript writing.

Acknowledgment

We are thankful to the Urology-Oncology group of University of Campinas, especially to Prof. Ubirajara Ferreira and Dr. Wagner Eduardo Matheus for facilitating the access to medical records of patients from the tumor group.

We are thankful to Mariana Bertoncelli Tanaka to help us with data collection.

References


