

## Renal tumours

The classic triad of pain, haematuria (blood in the urine) and palpable abdominal mass is rarely seen today and most renal tumours are found incidentally on ultrasound or CT scan performed for another reason. The majority of renal tumours are malignant renal adenocarcinomas or renal cell carcinomas and arise from the parenchyma or meat of the kidney but benign tumours are found as well. Small tumours are often watched with serial CT scans in older patients as they may be benign and even malignant tumours are often low grade and very slow growing. Sometimes a CT scan guided biopsy may be undertaken to help decide whether to watch a tumour or remove it. Larger tumours and most tumours in younger patients are best removed.

Surgery for renal cell carcinomas either involves removal of a portion of the kidney containing a small tumour, called a partial nephrectomy or removal of the entire kidney, a radical nephrectomy. Sometimes the surgery can be performed laparoscopically using keyhole surgery. Provided the other kidney is functioning well there is no problem losing one kidney.

Following surgery there is ongoing surveillance to detect any possible recurrent disease, particularly in the renal bed, the liver and the lungs. Chemotherapy is available to treat recurrent disease or it had spread at the time of diagnosis.

The other type of tumour, arising from the collecting system or lining of the kidney is a transitional cell carcinoma. Patients with these tend to present with haematuria, are more often in smokers and they are less obvious on U/S and CT, more often high grade and invasive and have often spread at the time of diagnosis. Surgery for transitional cell carcinomas involves removing the ureter as well as the kidney and post-operative surveillance involves regular cystoscopies as recurrences often appear in the bladder.