Clinical Review Criteria

Cryosurgery

- Cryosurgical Ablation (CSA) for Breast Cancer
- Cryosurgical Ablation (CSA) for Liver Tumors
- Cryosurgical Ablation (CSA) for Prostate Cancer
- Cryosurgical Ablation (CSA) for Renal Tumors

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Criteria

For Medicare Members

<table>
<thead>
<tr>
<th>Source</th>
<th>Policy</th>
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<tbody>
<tr>
<td>CMS Coverage Manuals</td>
<td>None</td>
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<tr>
<td>National Coverage Determinations (NCD)</td>
<td>NCD for Cryosurgery of Prostate (230.9)</td>
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<td>Local Coverage Determinations (LCD)</td>
<td>None</td>
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<td>Local Coverage Article</td>
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For Non-Medicare Members

<table>
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<th>Indication</th>
<th>Criteria Used</th>
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<tr>
<td>Breast Cancer and Lesions</td>
<td>There is insufficient evidence in the published medical literature to show that this service/therapy is as safe as standard services/therapies and/or provides better long-term outcomes than current standard services/therapies.</td>
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<tr>
<td>Cryosurgical Ablation (CSA) for Liver Tumors</td>
<td>Medical necessity review no longer required.</td>
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<td>Cryosurgical Ablation (CSA) for Prostate Cancer</td>
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<td>Cryosurgical Ablation (CSA) for Renal Tumors</td>
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Background

Cryosurgery has been known for years, but the recent changes in the technology and the development of improved cryosurgery units are permitting its clinical use. Cryoablation is a technique that uses liquid nitrogen or argon gas to freeze and ablate tissues. Cryoablation is mainly performed laparoscopically under real time ultrasound guidance.

It is reported that the critical temperature that leads to cancer cell destruction is approximately –40°C. Normal and neoplastic tissues are ablated and rendered necrotic at temperatures of –20°C (Chosy, 1996). During cryosurgery, the temperature is lowest at the center of the iceball with an incremental increase towards the periphery. Thus with a cryoprobe tip temperature of –185° to –195°C, the temperature will be approximately 0°C at outer edge of the ice ball, –20°C at a distance of 4mm, and –40°C at a distance of 6mm towards the center of the iceball. It is important...
Cryoablation has been used to treat liver and prostate tumors. It is also proposed a treatment for small breast cancers and benign fibroadenomas of the breast. Cryoablation kills tumor cells by alternately freezing and thawing a target tissue. Freezing injures individual cells at the time of treatment. In addition, the tissue as a whole is affected because microcirculation is damaged. Cell necrosis during cytoablation depends on the lowest temperature achieved and the hold time at subzero temperatures. It is believed that uniform ablation can be achieved when tissue is exposed to at least -40°C during two consecutive freeze thaw cycles (Whitworth & Rewcastle, 2005). The procedure for using cryoablation to treat breast tumors is as follows: Using ultrasound guidance, a cryoprobe is inserted through a 3mm skin incision into the center of the tumor. Ultrasound is used to guide the cryoablation, and also to monitor the treatment. Once appropriate placement of the cryoablation is confirmed, the machine it turned on “high.” When set to “high,” argon gas, the cooling agent, is allowed to flow continuously through the cryoablation. The probe is cooled to -160°C which freezes the tumor, forming an “ice ball” around it. After the iceball is formed, the cryoablation unit set on “low” setting which allows argon gas to flow intermittently into the cryoablation for 1 of every 10 seconds to preserve freezing temperatures. Generally, two freeze-thaw cycles are used. Helium is used as the warming agent between freezing cycles (Nurko et al., 2005; Visica, manufacturer’s Web site). Benign breast fibroadenomas are common, especially among young women. Approximately 10% of women will experience a breast fibroadenoma during their lifetime. Currently accepted treatments include excisional biopsy and conservative management. Conservative management may be a reasonable choice for this benign condition, particularly smaller fibroadenomas. Moreover, women may choose to avoid immediate intervention since an estimated 30% of breast fibroadenomas resolve spontaneously within several years. Excisional biopsy provides a definitive diagnosis, but a disadvantage is morbidity including possible cosmetic and/or ductal damage. Cryoablation is less invasive than excisional biopsy and is done on breast fibroadenomas after confirmation that the tumor is benign, generally with needle biopsy (Whitworth & Rewcastle, 2005; Houssami et al. 2001). A minimally invasive procedure, such as cryoablation, may also be useful for treating early breast cancers treated with breast-conserving therapy rather than mastectomy. Other thermal methods have been used to treat breast tumors. These include radiofrequency ablation, interstitial laser therapy and high intensive focused ultrasound (Pfleider et al., 2005).

08/07/2006: MTAC REVIEW
Cryosurgery – Breast Cancer

Evidence Conclusion: There is insufficient evidence to permit conclusions the efficacy of cryoablation for treating benign breast tumors including fibroadenomas. No studies were identified that compared cryoablation to conservative management, an accepted approach for managing fibroadenomas. The available studies were case series. A limitation of the published series was that there was likely overlap among patients in the studies. The degree of overlap could not be determined. In addition, two of the three studies reviewed (not the registry) were funded by the manufacturer of the cryoablation system. The Kaufman et al. and Caleffi et al. studies found that a higher proportion of larger (>2.5cm) fibroadenomas than smaller fibroadenomas were palpable at 12 months. This suggests that the usefulness of cryoablation may be limited because there is likely more demand for intervention, rather than conservative management, with larger fibroadenomas. There is insufficient evidence to permit conclusions on the efficacy of cryoablation for treating early breast cancer. No studies were identified comparing cryoablation to other treatments such as radiofrequency ablation or interstitial laser therapy. The available studies were relatively small case series with sample sizes of 30 or fewer patients. In the series, cryoablation was followed by surgery 1-4 weeks later, at which time the tumor cells were evaluated. In one study, there was residual DCIS in 5 out of 30 patients and in the other study, there was residual invasive cancer or DCIS in 6 out of 27 patients. In the latter study, cryoablation was successful in all of the 10 patients with tumors <1.5 cm and with ductal or...
Cryosurgical Ablation (CSA) for Liver Tumors

Overview

Cryosurgical ablation (CSA) is a non-invasive technique that uses cryogenics to freeze and destroy tissue. By applying extreme cold temperatures (100°C or lower) for a prolonged period, CSA can effectively destroy tumors and other pathological lesions. This method utilizes liquid nitrogen or other cryogens to induce tissue freezing, which leads to the formation of ice crystals that disrupt cellular function and subsequently cause cell death. CSA is particularly advantageous for treating tumors in the liver due to its minimally invasive nature, reduced patient recovery time, and lower risk of complications compared to open surgery.

BACKGROUND

The liver is a common site for primary and secondary malignancies. Hepatocellular carcinoma (HCC), the most common primary tumor, is the fifth most common cancer in the world, and the third most common cause of cancer-related mortality. It is responsible for more than half a million deaths across the globe each year. Treatment options for patients diagnosed with primary and secondary malignancies are limited. Less than 15% are candidates for surgical resection at presentation because of inadequate liver functional reserve, extrahepatic disease, anatomic constraints of the tumor, or medical co morbidities. The use of external beam radiation is limited due to the intolerance of normal liver parenchyma to tumoricidal radiation doses (the dose required to destroy solid tumors (>70 Gy) is much higher than the liver tolerance dose of 35 Gy). In addition, systematic chemotherapy was found to have little impact on survival, and negative impact on the health-related quality of life due to the toxicity to other organs and systems. These limitations have led to the emergence of other therapies, such as radiofrequency ablation (RFA), cryosurgical ablation (CSA), percutaneous ethanol injections (PEI), hepatic arterial infusion chemotherapy, transarterial chemo-embolization (TACE), and selective intraarterial radioembolization therapy (Steel 2003, Salem 2005, Ibrahim 2008, Bult 2009, Riaz 2009, Bhardwaj 2010). Ablative techniques, such as RFA and CSA, improve the ability to treat patients with unresectable hepatic tumors. Thermal ablative techniques destroy tumors via a source that changes temperature to levels that are associated with cell death while causing minimal damage to adjacent, normal tissue. The choice of technique depends on equipment availability and physician preference. The most commonly used ablative technique in the United Stated is RFA. RFA causes tumor destruction through the use of alternating high-frequency electric current in the radiofrequency range (460-500 kHz). This current is delivered through an electrode placed in the center of a lesion. Ions within the cell follow the alternating current creating frictional heat producing local tissue temperatures that can exceed 100°C. This ionic agitation leads to tissue destruction via tissue boiling and creation of water vapors. Once temperatures greater than 60°C are reached, protein denaturation, tissue coagulation, and vascular thrombosis result in a zone of complete ablation. Partial tissue destruction can occur up to 8 mm in diameter from the zone of complete ablation. RFA can be delivered either percutaneously, laparoscopically, or through open approaches (laparotomy). Complications from RFA include: pleural effusion, hepatic abscesses, biliary injury, liver failure, intra-abdominal hemorrhage, pneumothorax, and hypoxemia. The most troubling complications arise when a probe is placed too close to the diaphragm or intra-abdominal organ, resulting in ablation of the surrounding viscera with the accompanying complications of perforation, diaphragmatic injury, or pulmonary damage. Limitations of RFA include: treating lesions in perihiliar areas or near large vascular structures, and real time monitoring of the ablative zone is difficult due to air released during heating (Yamane 2009, Arciero 2006). CSA is another ablative
Cryosurgery for Prostate Cancer

Cryosurgical ablation of liver cancer. The literature consisted mainly of case series and cohort studies. Two prospective cohort studies were selected for critical appraisal. One study (Pearson 1999) assessed the relative safety and efficacy of CSA versus RFA and one study (Niu 2007) evaluated recurrence and survival rates of CSA combined with resection versus resection alone in patients with liver metastases from colorectal carcinomas. The following studies were critically appraised:


Cryosurgery for Prostate Cancer

BACKGROUND

Radical prostatectomy and external beam radiation therapy are considered standard treatments for localized prostate cancer. Both can result in significant morbidity such as incontinence and impotence. There is interest in other treatments that are of similar or greater effectiveness and have less morbidity. Cryosurgery (also known as...
Cryoablation was first used to treat prostate cancer in the last 1960s. Originally, clinicians used an open perineal approach that had high morbidity. The procedure was re-introduced in 1993 by Onik and colleagues using transrectal ultrasound (Onik, 1993). The technique continued to evolve and is now performed with modifications to the procedure introduced by Onik. In the basic modern technique, six to eight 3.4 mm diameter cytoprobes are inserted transperineally into the prostate guided by transrectal ultrasound. Temperature probes are placed in the right and left neurovascular bundles and the apex of the prostate gland to ensure that temperatures reach optimal levels in the margins of the gland. In addition, temperature probes are placed in the Denonvilliers fascia and the external sphincter and are used to make sure that sensitive areas adjacent to the prostate are not frozen. A urethral warming catheter is used to prevent the urethra from being frozen. Patients are treated with one or two freeze-thaw cycles (two is used more often in recent procedures) using a target temperature of –40°C. When the target temperature is attained, the ice ball is maintained at a static size for up to 10 minutes if this is possible without endangering the rectal wall (Bahn et al., 2002). Cryosurgery is also used as salvage therapy to treat recurrent prostate cancer after radiation therapy. Salvage prostatectomy is the standard treatment, but about half of patients have positive surgical margins and there is significant associated morbidity (Cespedes et al., 1997).

06/11/2003: MTAC REVIEW
Cryosurgery – Prostate Cancer
Evidence Conclusion: Primary treatment of clinically localized prostate cancer - Only case series data were available, the lowest grade of evidence because there is no control or comparison group. In addition, the case series did not evaluate a standard intervention; instead, the procedure changed over time. Both case series reported an intermediate outcome, biochemical success, as their primary health outcome. Conclusions about the effectiveness of cryosurgery compared to standard treatments for prostate cancer (e.g. radical prostatectomy, external beam radiation therapy) or no treatment can be drawn. Randomized controlled trials testing cryotherapy as primary treatment for prostate cancer should be feasible. The case series data suggest that cryosurgery is associated with a high-rate of impotence. Among men potent before surgery, in Bahn, 95% became impotent after cryosurgery and 90% remained so at follow-up (a mean of 5.4 years) and in Donnelly, 100% became impotent after cryosurgery and 53% remained so at 3 years, even with the use of sildenafil.
Salvage treatment for recurrent prostate cancer- Only case series data were available, the lowest grade of evidence because there is no control or comparison group. In addition, the procedure was inconsistent and changed over time. In a series of 131 patients (Izawa), 5-year disease-specific survival was 79% and 5-year disease-free survival was 40%. The long-term post-cryosurgery incontinence rate was 29%. Conclusions about the effectiveness of cryosurgery as salvage therapy after radiation treatment for patients with recurrent prostate cancer, or associated morbidity, compared to an alternate treatment such as salvage prostatectomy cannot be drawn.
Articles: Primary treatment of clinically localized prostate cancer: There were no randomized or non-randomized controlled trials. The only empirical data were from case series. The two largest case series that had data both on outcomes and adverse effects were critically appraised: Bahn DK, Lee F, Badalament R et al. Targeted cryoablation of the prostate: 7-year outcomes in the primary treatment of prostate cancer. Urology 2002 (Suppl 2A): 3-11. See Evidence Table. Donnelly BJ, Saliken JC, Ernst S et al. Prospective trial of cryosurgical ablation of the prostate: Five-year results. Urology 2002; 60: 645-649. See Evidence Table.
Salvage treatment for recurrent prostate cancer: Three case series were identified. Two were from the same institution and reported different outcomes on virtually the same group of patients. These studies were critically appraised. The other case series, which had a smaller sample size and a shorter follow-up, was excluded. Cespedes RD, Pisters LL, von Eschenbach AC et al. Long-term follow-up of incontinence and obstruction after salvage cryosurgical ablation of the prostate: Results in 143 patients. J Urol 1997; 157: 237-240. See Evidence Table. Izawa JI, Madsen LT, Scott SM et al. Salvage cryotherapy for recurrent prostate cancer after radiotherapy: Variables affecting patient outcome. J Clin Oncol 2002; 20: 2664-2671. See Evidence Table.

The use of cryosurgery in the treatment of prostate cancer does not meet the Kaiser Permanente Medical Technology Assessment Criteria.

Cryoablation of Renal Tumors
BACKGROUND
With the widespread use of body imaging techniques as magnetic resonance imaging (MRI) and computed tomography (CT), there is an increasing number of incidentally detected small renal masses or lesions with unclear clinical significance. The standard treatment for renal masses is radical nephrectomy. Other available treatment options include watchful waiting or partial nephrectomy. Recently, with the current trend of minimally invasive surgery, nephron-sparing approaches have gained more acceptance. Open, percutaneous, and laparoscopic renal cryoablation, radiofrequency ablation, and high intensity focused ultrasonography (HIFU) have been performed but are still under development. These techniques only target selected, small renal tumors with a diameter of 4 cm or less. Cryosurgery has been known for years, but the recent changes in the technology and the
development of improved cryosurgery units are permitting its clinical use. Cryoablation is a technique that uses liquid nitrogen or argon gas to freeze and ablate tissues. Cryoablation is mainly performed laparoscopically under real time ultrasound guidance. It is reported that the critical temperature that leads to cancer cell destruction is approximately –40°C. Normal and neoplastic renal tissues are ablated and rendered necrotic at temperatures of –20°C (Chosy, 1996). During cryosurgery, the temperature is lowest at the center of the iceball with an incremental increase towards the periphery. Thus with a cryoprobe tip temperature of –185°C to –195°C, the temperature will be approximately 0°C at outer edge of the ice ball, –20°C at a distance of 4mm, and –40°C at a distance of 6mm towards the center of the iceball. It is important that the edge of the cryolesion be 1 cm beyond the margin of the tumor to make sure that a lethal temperature of –40°C or less was achieved throughout the tumor. The effect of cryosurgery occurs in two phases, freezing and thawing. The freezing phase is performed rapidly, and passive thawing is performed more slowly for a maximum effect. A double freeze-thaw cycle is usually preformed to ensure the extension of the iceball to approximately 1 cm beyond the tumor edge. The size of the cryolesion depends on several factors including the temperature at the tip of the cryoprobe, area of tissue contact, freeze time, and tissue vascularity. The response of a tumor to cryoablation depends on its biological characteristics e.g. density, specific heat, thermal conductivity, and rate of blood flow (Gage 1992). Potential complications of renal cryosurgery include post-thaw hemorrhage, urine leakage due to caliceal cryoinjury, and fistula formation.

04/09/2003: MTAC REVIEW
Cryosurgery – Renal Tumors

Evidence Conclusion: There is insufficient published evidence to determine the efficacy, safety, and long-term outcome of cryoablation for the treatment of renal tumors. No randomized controlled trials or non-randomized comparative studies were conducted to compare the procedure to surgery or other alternatives and assess its long-term benefits. All studies were either case reports or case series with very small sample sizes. The case series reviewed included small numbers of patients, were subject to selection and observation biases, and had short follow-up durations. These series showed that after a mean follow-up of 9 months in Shingleton’s study, 14 months in Lee’s study and 16 months in Gill’s study the ablated renal tumor was no longer detectable in 25-40% or reduced in size in 20-75% of the patients with available follow-up data. Large randomized controlled studies with long-term follow up duration will be needed to compare cryoablation to other alternatives, and to determine its efficacy, safety, and long-term benefits.

Articles: The search yielded 48 articles. Many were reviews or tutorials that dealt with the technical aspects of the procedure. There were no meta-analyses or randomized controlled trials. There were 13 case reports (with 1-9 patients), and 9 case series with a small number of patients (10 to 32 patients). The 3 largest series were selected for critical appraisal: Gill IS, Novick AC, Meraney AM, et al. Laparoscopic renal cryoablation in 32 patients. Urology 2000;56:748-753. See Evidence Table. Lee DI, McGinnis DE, Feld R, et al. Retroperitoneal laparoscopic cryoablation of small renal tumors: intermediate results. Urology 2003;61: 83-88. See Evidence Table. Shingleton WB and Sewell PE. Percutaneous renal tumor cryoablation with magnetic resonance imaging guidance. J Urol 2001;165:773-776. See Evidence Table.

The use of cryoablation in the treatment of renal tumors does not meet the Kaiser Permanente Medical Technology Assessment Criteria.