Radiofrequency ablation may be considered medically necessary for any of the following:

- Pain palliation in a patient with osteolytic bone metastases who has failed or is a poor candidate for standard treatments such as radiation or opioids
- Osteoid osteomas that cannot be managed successfully with medical treatment
- Localized renal cell carcinoma that is no more than 4 cm in size with any of the following:
  - Kidney function is significantly impaired (i.e., the patient has a solitary kidney or renal insufficiency defined by a glomerular filtration rate [GFR] of less than 60 ml/min/m²)
  - Standard surgical approach (i.e., resection of renal tissue) is likely to worsen existing kidney function substantially
  - Patient is not considered a surgical candidate
- An isolated peripheral non-small-cell lung cancer lesion that is no more than 3 cm in size with documentation of all of the following:
  - Surgical resection or radiotherapy with curative intent is considered appropriate based on stage of disease, however, medical comorbidity renders the individual unfit for those interventions
  - Tumor is located at least 1 cm from the trachea, main bronchi, esophagus, aorta, aortic arch branches, pulmonary artery, and the heart
- Malignant non-pulmonary tumor(s) metastatic to the lung that is/are no more than 3 cm in size with documentation of all of the following:
  - There is no evidence of extrapulmonary metastases
  - Tumor is located at least 1 cm from the trachea, main bronchi, esophagus, aorta, aortic arch branches, pulmonary artery, and the heart
  - No more than three (3) tumors per lung will be ablated
  - The tumors targeted are amenable to complete ablation
  - No history of pulmonary ablation in the last twelve (12) months
  - Documentation of one or more of the following:
    - Surgical resection or radiotherapy is likely to worsen pulmonary status substantially
    - Patient is not considered a surgical candidate

Radiofrequency ablation is considered investigational as a technique for ablation of any of the following:

- All other tumors outside the liver including, but not limited to, the head and neck, thyroid, pancreas, adrenal gland, ovary, and pelvic/abdominal metastases of unspecified origin
- Breast tumors
- Lung cancer not meeting the criteria above
- Osteoid osteomas that can be managed with medical treatment
- Painful bony metastases as initial treatment
- Renal cell cancer not meeting the criteria above

**Policy Guidelines**

**Coding**
The following CPT code specifically describes radiofrequency ablation of osteoid osteoma and other primary or metastatic bone tumors:

- **20982**: Ablation therapy for reduction or eradication of 1 or more bone tumors (e.g., metastasis) including adjacent soft tissue when involved by tumor extension, percutaneous, including imaging guidance when performed; radiofrequency
There is a CPT code for percutaneous radiofrequency ablation of pulmonary tumors:

- **32998**: Ablation therapy for reduction or eradication of 1 or more pulmonary tumor(s) including pleura or chest wall when involved by tumor extension, percutaneous, including imaging guidance when performed, unilateral; radiofrequency

There is a CPT code for percutaneous radiofrequency ablation of renal tumors:

- **50592**: Ablation, 1 or more renal tumor(s), percutaneous, unilateral, radiofrequency

CPT code 76940 might be used to describe the ultrasound guidance for radiofrequency tissue ablation:

- **76940**: Ultrasound guidance for, and monitoring of, parenchymal tissue ablation

Code 76940 cannot be reported with code 20982.

Other than codes listed in the Codes table, there are no specific CPT codes for the other indications mentioned in this policy.

**Description**

In radiofrequency ablation (RFA), a probe is inserted into the center of a tumor; then, prong-shaped, non-insulated electrodes are projected into the tumor. Next, heat is generated locally by an alternating, high-frequency current that travels through the electrodes. The localized heat treats the tissue adjacent to the probe, resulting in a 3 cm to 5.5 cm sphere of dead tissue. The cells killed by RFA are not removed but are gradually replaced by fibrosis and scar tissue. If there is a local recurrence, it occurs at the edge and can sometimes be retreated. RFA may be performed percutaneously, laparoscopically, or as an open procedure.

**Related Policies**

- Cryosurgical Ablation of Miscellaneous Solid Tumors Other Than Liver, Prostate, or Dermatologic Tumors
- Radiofrequency Ablation of Primary or Metastatic Liver Tumors
- Stereotactic Radiosurgery and Stereotactic Body Radiotherapy

**Benefit Application**

Benefit determinations should be based in all cases on the applicable contract language. To the extent there are any conflicts between these guidelines and the contract language, the contract language will control. Please refer to the member’s contract benefits in effect at the time of service to determine coverage or non-coverage of these services as it applies to an individual member.

Some state or federal mandates (e.g., Federal Employee Program [FEP]) prohibits plans from denying Food and Drug Administration (FDA)-approved technologies as investigational. In these instances, plans may have to consider the coverage eligibility of FDA-approved technologies on the basis of medical necessity alone.

**Regulatory Status**

The U.S. Food and Drug Administration (FDA) issued a statement in September 2008, concerning the regulatory status of RFA. The FDA has cleared RFA devices for the general indication of soft tissue cutting, coagulation, and ablation by thermal coagulation necrosis. Under this general indication, RFA can be used to ablate tumors, including lung tumors. Some RFA devices have been cleared for additional specific treatment indications, including partial or complete...
Radiofrequency Ablation of Miscellaneous Solid Tumors Excluding Liver Tumors
Page 3 of 30

ablation of nonresectable liver lesions and palliation of pain associated with metastatic lesions involving bone. The FDA has not cleared any RFA devices for the specific treatment indication of partial or complete ablation of lung tumors, citing lack of sufficient clinical data to establish safety and effectiveness for this purpose. The FDA has received reports of death and serious injuries associated with the use of RFA devices in the treatment of lung tumors.

Rationale

Background

Radiofrequency Ablation

RFA was initially developed to treat inoperable tumors of the liver (see Blue Shield of California Medical Policy: Radiofrequency Ablation of Primary or Metastatic Liver Tumors). Recently, studies have reported on the use of RFA to treat other tumors. For some of these, RFA is being investigated as an alternative to surgery for operable tumors. Well-established local or systemic treatment alternatives are available for each of these malignancies. The hypothesized advantages of RFA for these cancers include improved local control and those common to any minimally invasive procedure (e.g., preserving normal organ tissue, decreasing morbidity, decreasing length of hospitalization).

Goals of RFA may include (1) controlling local tumor growth and preventing recurrence; (2) palliating symptoms; and (3) extending survival duration for patients with certain tumors. The effective volume of RFA depends on the frequency and duration of applied current, local tissue characteristics, and probe configuration (e.g., single vs multiple tips). RFA can be performed as an open surgical procedure, laparoscopically or percutaneously, with ultrasound or computed tomography guidance.

Potential complications associated with RFA include those caused by heat damage to normal tissue adjacent to the tumor (e.g., intestinal damage during RFA of kidney), structural damage along the probe track (e.g., pneumothorax as a consequence of procedures on the lung), and secondary tumors (if cells seed during probe removal).

Literature Review

Evidence reviews assess the clinical evidence to determine whether the use of technology improves the net health outcome. Broadly defined, health outcomes are the length of life, quality of life (QOL), and ability to function—including benefits and harms. Every clinical condition has specific outcomes that are important to patients and managing the course of that condition. Validated outcome measures are necessary to ascertain whether a condition improves or worsens; and whether the magnitude of that change is clinically significant. The net health outcome is a balance of benefits and harms.

To assess whether the evidence is sufficient to draw conclusions about the net health outcome of technology, two domains are examined: the relevance, and quality and credibility. To be relevant, studies must represent one or more intended clinical use of the technology in the intended population and compare an effective and appropriate alternative at a comparable intensity. For some conditions, the alternative will be supportive care or surveillance. The quality and credibility of the evidence depend on study design and conduct, minimizing bias and confounding that can generate incorrect findings. The randomized controlled trial (RCT) is preferred to assess efficacy; however, in some circumstances, nonrandomized studies may be adequate. RCTs are rarely large enough or long enough to capture less common adverse events and long-term effects. Other types of studies can be used for these purposes and to assess generalizability to broader clinical populations and settings of clinical practice.

Osteolytic Bone Metastases

Clinical Context and Therapy Purpose

After lung and liver, bone is the third most common metastatic site and is relatively frequent among patients with primary malignancies of the breast, prostate, and lung. Bone metastases
often cause osteolysis (bone breakdown), resulting in pain, fractures, decreased mobility and reduced QOL.

External-beam radiotherapy often is the initial palliative therapy for osteolytic bone metastases. However, pain from bone metastases is refractory to radiotherapy in 20% to 30% of patients, while recurrent pain at previously irradiated sites may be ineligible for additional radiation due to risks of normal tissue damage. Other alternatives include hormonal therapy, radiopharmaceuticals (e.g., strontium 89), and bisphosphonates. Less often, surgery or chemotherapy may be used for palliation, and intractable pain may require opioid medications. Radiofrequency ablation (RFA) has been investigated as an alternative for palliation of bone metastases.

The purpose of RFA in patients who have painful osteolytic bone metastases who have failed or are poor candidates for standard treatments is to provide a treatment option that is an alternative to or an improvement on existing therapies.

The question addressed in this evidence review is: Does the use of RFA improve the net health outcome in individuals with painful osteolytic bone metastases who have failed or are poor candidates for standard treatments?

The following PICOs were used to select literature to inform this review.

**Patients**
The relevant populations of interest are individuals with painful osteolytic bone metastases who have failed or are poor candidates for standard treatments.

**Interventions**
The therapy being considered is RFA, which is administered in an outpatient setting by oncologists and radiologists.

**Comparators**
The following therapies and practices are currently being used to make decisions about managing painful osteolytic bone metastases: medical management (e.g., chemotherapy) and radiotherapy, which are administered in an outpatient setting by oncologists and radiologists.

**Outcomes**
The general outcomes of interest are overall survival (OS), reduction in pain and medication use, fractures, functional outcomes, and QOL.

Patients would be followed for several years given the impact of bone metastases on bone remodeling.

**Study Selection Criteria**
Methodologically credible studies were selected using the following principles:
- To assess efficacy outcomes, comparative controlled prospective trials were sought, with a preference for RCTs;
- In the absence of such trials, comparative observational studies were sought, with a preference for prospective studies;
- To assess long-term outcomes and adverse events, single-arm studies that capture longer periods of follow-up and/or larger populations were sought.
- Studies with duplicative or overlapping populations were excluded.

**Case Series**
Goetz et al (2004) reported on an international study conducted at 9 centers in which 43 patients with painful osteolytic bone metastases were treated palliatively with RFA.1 The study's primary outcome measure was the Brief Pain Inventory-Short Form, a validated scale from 0 (no pain) to 10 (worst pain imaginable). Patient eligibility required baseline values of four or more...
from two or fewer painful sites. Thirty-nine (91%) of the patients had previously received opioids to control pain from the lesion(s) treated with RFA, and 32 (74%) had prior radiotherapy to the same lesion. The mean pain score at baseline was 7.9 (range, 4-10). At 4, 12, and 24 weeks after RFA, average pain scores decreased to 4.5, 3.0, and 1.4, respectively (all p<0.001). Forty-one (95%) patients achieved clinically significant reductions in pain scores, prospectively defined as a decrease of 2 units from baseline. Investigators also reported statistically significant (p=0.01) decreases in opioid use at weeks 8 (by 59%) and 12 (by 54%).

An earlier case series by Gronemeyer et al (2002) showed that palliative RFA provided significant pain relief in 9 (90%) of 10 patients with unresectable, osteolytic spine metastases who had no other treatment options. Pain was reduced by an average of 74%; back pain-related disability was reduced by an average of 27%. Neurologic function was preserved in nine patients and improved in the other. In another small case series, Kojima et al (2006) assessed 24 patients with painful metastatic bone tumors who experienced pain-alleviating effects with RFA is consistent with other evidence.

Section Summary: Osteolytic Bone Metastases
Case series have shown clinically significant reductions in pain relief and reductions in opioid use following treatment with RFA of osteolytic pain metastases in patients with no or limited treatment options.

Osteoid Osteomas
Clinical Context and Therapy Purpose
Osteomas are the most common benign bone tumor, comprising 10% to 20% of benign and 2% to 3% of all bone tumors. They are typically seen in children and young adults, with most diagnosed in patients between 5 and 20 years of age. Osteomas are most common in the lower extremity (usually the long bones, mainly the femur) and less common in the spine. These tumors typically have a characteristic clinical presentation and radiologic appearance, with pain that is usually continuous and worse at night and commonly relieved by aspirin or other nonsteroidal anti-inflammatory drugs. The natural history of the osteoid osteoma varies based on location, and although they rarely exceed 1.5 cm in diameter, may produce bone widening and deformation, limb length inequality, or angular deviations when near a growth plate. When located in the spine, these lesions may lead to painful scoliosis or torticollis. Sometimes they heal spontaneously after three to seven years.

Treatment options include medical management with NSAIDs, surgical excision (wide/en bloc excision or curetting), or the use of computed tomography (CT)- or magnetic resonance imaging-guided minimally invasive procedures including core drill excision, laser photocoagulation, or RFA. For many years, complete surgical excision was the classic treatment of osteomas, usually performed in patients with pain despite medical management. However, a substantial incision may be necessary, with the removal of a considerable amount of bone (especially in the neck of the femur). This increases the need for bone grafting plus internal fixation (which often necessitates a second procedure to remove the metalwork). Other possible risks include avascular necrosis of the femoral head and postoperative pathologic fracture. In addition, surgical excision leads to a lengthier convalescence and postoperative immobilization. Anatomically inaccessible tumors may not be completely resectable and may recur. RFA of osteoid osteoma is done with a needle puncture, so no incision or sutures are needed; further, patients may immediately walk on the treated extremity and return to daily activities when the anesthetic effect wears off. The risk of recurrence with RFA of an osteoma is 5% to 10%, and recurrent tumors can be retreated with RFA. In general, RFA is not performed in many spinal osteomas because of possible thermal-related nerve damage.

The purpose of RFA in patients who have painful osteoid osteomas is to provide a treatment option that is an alternative to or an improvement on existing therapies.
The question addressed in this evidence review is: Does the use of RFA improve the net health outcome in individuals with painful osteoid osteomas?

The following PICOs were used to select literature to inform this review.

**Patients**
The relevant populations of interest are individuals with painful osteoid osteomas.

**Interventions**
The therapy being considered is RFA, which is administered in an outpatient setting by oncologists and radiologists.

**Comparators**
The following therapies and practices are currently being used to make decisions about osteoid osteomas: medical management, surgical excision, core drill excision, and laser photocoagulation.

**Outcomes**
The general outcomes of interest are reductions in pain and medication use, normal bone development, and postsurgical adverse events.

Patients would be followed through adolescence to ensure normal skeletal development.

**Study Selection Criteria**
Methodologically credible studies were selected using the principles described in the first indication.

**Systematic Reviews**
Lanza et al (2014) reported on a systematic review of various ablative techniques for osteoid osteomas. Included in the review were 23 articles on RFA, 3 on interstitial laser ablation, and 1 with a combination of ablation techniques, totaling 27 articles (total n=1772 patients). The mean technical success was 100% and clinical success, defined as being pain-free, ranged from 94% to 98%, depending on the length of follow-up. Complications occurred in 2% of patients and included skin or muscle burn in nine patients, four infections, nerve lesions or tool breakage in three patients each, delayed skin healing, hematoma, and failure to reach target temperature in two patients each, and fracture, pulmonary aspiration, thrombophlebitis, and cardiac arrest in one patient each. Eighty-six patients had tumor recurrence.

**Retrospective Studies**
In their retrospective study of the efficacy and complications of CT-guided RFA of spinal osteoid osteoma, Albisinni et al (2017) concluded that CT-guided RFA is effective as first-line therapy for the disease. After RFA, clinical symptoms were evaluated at 3, 6, and 12 months, with a final evaluation at the end of the study. Results showed that complete regression of osteoid osteoma symptoms in 57 (93.4%) of 61 (p=0.001) for patients observed between 2002 and 2012. Study limitations included the retrospective design and focus on a single treatment.

Lassalle et al (2017) conducted a single-center retrospective analysis of long-term outcomes for CT-guided RFA in 126 patients with suspected osteoid osteoma. The study was conducted from 2008 to 2015. Phone evaluations were performed. The overall success rate was 94.3% among the 88 patients who participated in the follow-up calls. The study was limited by its retrospective design, imprecision of patients' memory over follow-up, the lack of clinical and imaging follow-up, and an inability to perform multivariate statistical analysis of factors associated with treatment failure.

Rimondi et al (2012) reported on a retrospective study of 557 patients treated with CT-guided RFA as primary treatment for nonspinal osteoid osteomas. All patients were followed for a mean of 3.5 years (range, 0.5-9 years). Pain relief occurred in all 557 patients within the first week after
RFA and continued in 533 (96%) patients who remained asymptomatic through their last follow-up. Pain recurrence occurred in 24 (4%) patients. Complications occurred in five patients and included thrombophlebitis, skin burn, broken electrode, and two procedures in which the RFA generator failed to reach maximum temperature.

**Case Series**

An observational study by Knudsen et al (2015) evaluated long-term clinical outcomes after CT-guided RFA in patients diagnosed with osteoid osteoma located in the upper and lower extremities. The study population included 52 patients with a typical clinical history and radiologically confirmed osteoid osteoma who received CT-guided RFA treatment from 1998 to 2014 at a Danish university hospital. The clinical outcome was evaluated based on patient-reported outcome measures and medical record review. The response rate was 52 (87%) of 60. After 1 RFA treatment, 46 (88%) of 52 patients experienced pain relief, and 51 (98%) of 52 patients had pain relief after repeat RFA. One patient underwent open resection after RFA. No major complications were reported; four patients reported minor complications including small skin burn, minor skin infection, and hypoesthesia at the needle entry point. In all, 50 (96%) of 52 patients were reported to be "very satisfied" with the RFA treatment.

Rosenthal et al (2003) reported their experience over an 11-year period with 271 RFA procedures for osteoid osteomas in 263 patients. The short-term outcome was evaluated to detect procedure-related problems; by this definition, all procedures were considered technically successful. Long-term clinical success data (defined as being free of pain without additional procedures) were available in 126 patients, with a complete clinical success observed in 89%. For procedures performed as the initial treatment, the success rate was 91%.

**Section Summary: Osteoid Osteomas**

Numerous retrospective studies and case series, and a systematic review of case series have evaluated RFA for the treatment of painful osteoid osteomas. In a systematic review of thermal ablation techniques, clinical success (pain-free) was achieved in 94% to 98% of patients. Results have indicated that most patients (89%-96%) remained pain-free at longer-term follow-up.

**Localized Renal Cell Carcinoma**

**Clinical Context and Therapy Purpose**

Radical nephrectomy remains the principal treatment of RCC; however, partial nephrectomy (PN) or nephron-sparing surgery has been shown to be as effective as radical nephrectomy, with comparable long-term recurrence-free survival rates, in a select group of patients. Alternative therapy such as RFA is of interest in patients with small renal tumors when preservation of renal function is necessary (e.g., in patients with marginal renal function, a solitary kidney, bilateral tumors) and in patients with comorbidities that would render them unfit for surgery. Another consideration would be in patients at high-risk of developing additional renal cancers (e.g., von Hippel-Lindau disease).

The purpose of RFA in patients who have localized RCC no more than 4 cm in size is to provide a treatment option that is an alternative to or an improvement on existing therapies.

The question addressed in this evidence review is: Does the use of RFA improve the net health outcome in individuals with localized RCC no more than 4 cm in size?

The following PICOs were used to select literature to inform this review.

**Patients**

The relevant population of interest are individuals with localized RCC no more than 4 cm in size.

**Interventions**

The therapy being considered is RFA, which is administered in an outpatient setting by oncologists and radiologists.
Comparators
The following practice is currently being used to make decisions about managing localized RCC: surgical excision, which is performed in a hospital setting.

Outcomes
The general outcomes of interest are recurrence rates and reduction in rates of renal failure. Patients should be followed for at least ten years to monitor for tumor recurrence.

Study Selection Criteria
Methodologically credible studies were selected using the principles described in the first indication.

Systematic Reviews
In their systematic review and meta-analysis, Uhlig et al (2019) compared oncologic, perioperative, and functional outcomes for PN) with outcomes for various ablative techniques, including RFA and others, for small renal masses (mean diameter=2.53-2.84 cm). They identified 47 moderate-quality studies, mostly retrospective, published from 2005-2017, with a total of 24077 patients. Of these patients, 15238 received PN and 1877 received RFA. The network meta-analysis used PN as the reference point. Table 1 includes the statistical details of the analysis. The overall results indicated that PN had better OS and local control over ablative techniques but it was not significantly better for cancer-related mortality. In addition, ablation had fewer complications and better renal function outcomes. Across the studies included, patients treated by PN tended to be younger with less comorbidity compared with patients receiving thermal ablation—a consideration when assessing the outcomes for survival and local control.

In a systematic review and meta-analysis, Katsanos et al (2014) reviewed 1 RCT and 5 cohort studies (total n=587 patients) assessing thermal ablation (RFA or microwave) or nephrectomy for small renal tumors (size, 2.5 cm). The local recurrence rate was 3.6% in both groups (relative risk, 0.92; 95% confidence interval [CI], 0.4 to 2.14; p=0.79). Disease-free survival was also similar in both groups up to 5 years (hazard ratio, 1.04; 95% CI, 0.48 to 2.24; p=0.92). However, the overall complication rate was significantly lower in the patients undergoing ablation (7.4%) vs nephrectomy (11.1% pooled relative risk, 0.55; 95% CI, 0.31 to 0.97; p=0.04).

El Dib et al (2012) conducted a meta-analysis evaluating RFA and cryoablation for small renal masses. Selected were 11 RFA case series (426 patients) and 20 cryoablation case series (457 patients) published through January 2011. The mean tumor size was 2.7 cm (range, 2-4.3 cm) in the RFA group and 2.5 cm (range, 2-4.2 cm) in the cryoablation group. Mean follow-up times for the RFA and cryoablation groups were 18.1 and 17.9 months, respectively. Clinical efficacy, defined as cancer-specific survival rate, radiographic success, no evidence of local tumor progression, or distant metastases, did not differ significantly between groups. The pooled proportion of clinical efficacy for RFA was 90% (95% CI, 86% to 93%) and 89% (95% CI, 83% to 94%) for cryoablation.

Tables 1-3 summarize the characteristics of the systematic reviews by Uhlig et al (2019), Katsanos et al (2014), and El Dib et al (2012). Table 3 contains the results of the largest and most recent of the 3 reviews (Uhlig et al [2019]).
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<td>O’Malley (2007)</td>
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<td>Polascik (2007)</td>
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<td>Bird (2006)</td>
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<td>Lawatsch (2006)</td>
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</table>
Table 2. Characteristics of Meta-Analyses Assessing Radiofrequency Ablation for Renal Masses

<table>
<thead>
<tr>
<th>Study</th>
<th>Dates</th>
<th>Trials</th>
<th>Participants</th>
<th>N (Range)</th>
<th>Design</th>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Uhlig (2018)</td>
<td>2006-2017</td>
<td>47</td>
<td>Patients who had received PN, RFA, CRA, or MWA for small renal masses.</td>
<td>24,077 (18-1803)</td>
<td>Prospective, retrospective, 1 RCT</td>
<td>3-62 mo</td>
</tr>
<tr>
<td>Katsanos (2014)</td>
<td>2007-2012</td>
<td>6</td>
<td>Patients with small renal tumors receiving RFA or nephrectomy.</td>
<td>587 (69-150)</td>
<td>1 RCT, 5 cohort</td>
<td>Up to 6 y</td>
</tr>
<tr>
<td>El Dib (2012)</td>
<td>2000-2008</td>
<td>31</td>
<td>Patients who had received RFA or CRA for renal tumors, regardless of size.</td>
<td>957 (n/a)</td>
<td>Case series</td>
<td>7-45.7 mo</td>
</tr>
</tbody>
</table>

CRA: cryoablation; RCT: randomized controlled trial; RFA: radiofrequency ablation; n/a: data not available; mo: month(s); MWA: microwave ablation; PN: partial nephrectomy; y: year(s).

The results table below does not include Katsanos et al (2014) because of complete study overlap with Uhlig et al (2018). El Dib et al (2012) is not included because the comparator in the studies selected was cryoablation, not surgery.

Table 3. Results of Select Meta-Analyses Assessing Radiofrequency Ablation for Renal Masses

<table>
<thead>
<tr>
<th>Study</th>
<th>Cancer-Specific Mortality, IRR</th>
<th>Local Recurrence, IRR</th>
<th>Complications, OR</th>
<th>Renal Function Decline, MD</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>RFA PN</td>
<td>RFA PN</td>
<td>RFA PN</td>
<td>RFA PN</td>
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<tr>
<td>Uhlig (2018)</td>
<td>2.03 1.00</td>
<td>1.79 1.00</td>
<td>0.89 1.00</td>
<td>6.49 0.00</td>
</tr>
<tr>
<td>95% CI</td>
<td>0.81 to 5.08</td>
<td>1.16 to 2.76</td>
<td>0.59 to 1.33</td>
<td>2.87 to 10.10</td>
</tr>
</tbody>
</table>

CI: confidence interval; IRR: incidence rate ratio; MD: mean difference in glomerular filtration rate; OR: odds ratio;
RFA: radiofrequency ablation; PN: partial nephrectomy.

Randomized Controlled Trials

In an RCT, Liu et al (2016) analyzed the safety and efficacy of the operative effects of percutaneous RFA in early-stage RCC vs retroperitoneoscopic radical operation of RCC. The observation group was treated with percutaneous RFA and the control group with a radical retroperitoneoscopy. A total of 76 clinically confirmed diagnosed cases, from January 2011 to January 2013, with RCC, were randomized to the observation (n=41) or the control (n=35) groups. Operation time, blood loss during operation, length of stay, and incidence complications were lower in the control group (p<0.05). For both groups, postsurgical day at 1, 2, and 3 serum C-reactive protein, interleukin 6, and T lymphocyte counts were elevated, however, the increase in the control group was significantly greater (p<0.05). Total efficacy, tumor-free survival times, and survival rates did not differ statistically between groups (p>0.05), however, percutaneous
RFA reduced postoperative recovery time and fewer complications. Trial limitations included small sample size and the brief duration of follow-up.

Retrospective Studies
A retrospective study by Park et al (2018) compared the mid-term oncologic and functional outcomes of robotic PN with RFA for treating T1a RCC. Using propensity score matching, the study analyzed 63 similar patient cases from each treatment group for changes in tumor location, estimated glomerular filtration rates preservation, and 2-year recurrence-free survival rate. Preservation of estimated glomerular filtration rate in the robotic PN group was 91.7% and 86.8% of the RFA group (p = 0.088), and exophytic and endophytic RCC occurred in 73% (46/63) and 27% (17/63) of the robotic PN group and 52.4% (33/63) and 47.6% (30/63) of the RFA group, respectively. Two-year recurrence-free survival rate was 100% in the robotic PN group and 95.2% in the RFA group (p = 0.029). The mismatching of RCC locations between the robotic PN and RFA groups is a study limitation. Other limitations included the retrospective design, the relatively small sample and the lack of long-term outcomes assessing and kidney function measures.

Dai et al (2017) conducted a retrospective evaluation of 30 patients with 31 central renal tumors who underwent percutaneous RFA between 2005 and 2010 to assess the clinical efficacy and safety of image-guided percutaneous RFA of central RCC with adjunctive pyeloperfusion. OS was 96.0% (95% CI, 88.4% to 100.0%) and progression-free survival at 5 years was 80.9% (95% CI, 65.8% to 95.9%). The investigators found that complications were significantly higher for tumors located within 5 mm of the renal pelvis or 0 mm of a major calyx (28.6% vs 4.0%, p < 0.05) and major complications occurred in 5 (12.8%) of 39 RFA sessions. They concluded that image-guided percutaneous RFA combined with pyeloperfusion had satisfactory clinical efficacy in the treatment of renal tumor but may be associated with significant major complications. The retrospective design and the small sample base are limitations to this analysis.

Over 10 years, Dvorak et al (2017) retrospectively evaluated the technical success as well as mid-term and long-term efficacy and safety of RFA and microwave ablation with guided CT in 64 patients with small, non-central renal tumors. Ninety-one ablation procedures were performed on 68 tumors, 12 to 60 mm in size. Treatment was successful in 50 (73.5%) tumors; a second procedure was successful in 13 (19.1%) cases; and for the 5 largest tumors (range, 45-60 mm; 7.4%), a third treatment was required. Investigators concluded that percutaneous ablation is safe and effective in treating small, non-central renal tumors of the T1a group. The retrospective study design is the major limitation of this study.

Pantelidou et al (2016) retrospectively compared the oncologic outcomes of RFA with robotic-assisted PN for the treatment of T1 stage RCC. Sixty-three cases were included in each treatment group. Baseline renal function for those who received RFA was poorer; and there was an imbalance between groups in the number of patients with tumors in a single kidney (16/63 RFA patients vs 1/63 PN patients; p < 0.001). Postprocedure renal function decline at 30 days was significantly smaller in the RFA group (-0.8 mL/min/1.73 m² vs -16.1 mL/min/1.73 m²; p < 0.001). The robotic-assisted PN group experienced more minor complications (10/63 vs 4/63, p = 0.15) and the RFA group had a higher local recurrence (6/63 vs 1/63, p = 0.11). The authors concluded that both RFA and RNA offered good oncologic outcomes for T1 RCC with low morbidity. The retrospective study design, the tertiary center location's specific referral procedures, a loss of follow-up case data, and the heterogeneous patient demographics are study limitations.

A publication by Iannuccilli et al (2016) reported a mean 34.1-months follow-up (range, 1-131 months) of RFA with intent to cure in 203 patients with renal tumors. Patients referred for RFA at high-risk or had refused surgery. Smaller tumors were treated with a single electrode with a 2 or 3 cm active tip. Larger tumors were treated with a cluster electrode with three active tips. Patients were assessed annually for the appearance of residual tumor at the treatment site, and 26 (13%) had residual disease. Treatment effectiveness was 87% during follow-up. The likelihood of recurrence was increased for tumors 3.5 cm or larger, clear cell subtype, and treatment temperature of 70° or less. All-cause mortality increased with increasing tumor size. The median
survival was 7 years for patients with tumors less than 4 cm, with 80% survival at 5 years. Major complications, including urinary stenosis or urine leak, occurred in eight (3.9%) treatments.

**Section Summary: Localized RCC**

The evidence on RFA for renal tumors includes an RCT, meta-analyses, retrospective and cohort studies, and case series, that have compared RFA with nephrectomy or cryoablation. A 2014 meta-analysis that included 1 RCT and 5 cohort studies found that RFA was as effective as nephrectomy for small renal tumors, with a reduction in complications. Another, more recent, meta-analysis (2019) found that PN was superior to ablative techniques (the study included RFA but also cryoablation and microwave ablation) in overall mortality and local recurrence but not in cancer-specific mortality. It also found fewer complications and improved renal function with ablation. The correlation between tumor size and RFA efficacy has been demonstrated by a large case series with a mean 34-month follow-up; it found that residual disease and mortality increased with tumors over 4 cm.

**Primary Pulmonary and Nonpulmonary Tumors**

**Clinical Context and Therapy Purpose**

Surgery is the current treatment of choice in patients with stage I primary non-small-cell lung cancer (NSCLC; stage I includes IA [T1N0M0] and IB [T2N0M0]). Approximately 20% of patients present with stage I disease, although this number is expected to increase as a result of screening programs, advances in imaging modalities and widespread use of CT scans for other indications. Postsurgical recurrence rates of stage I NSCLC have been reported as between 20% and 30% with most occurring at distant sites; locoregional recurrences occur in approximately 12%. Large differences in survival outcome are observed after surgery in stage I patients, with 5-year OS rates ranging from 77% for small T1 tumors to 35% for large T2 tumors. Untreated, stage I NSCLC has a 5-year OS rate range from 6% to 14%.

Patients with early-stage NSCLC who are not surgical candidates may be candidates for radiotherapy with curative intent. In 2 large retrospective radiotherapy series, patients with the inoperable disease treated with definitive radiotherapy achieved 5-year survival rates of 10% and 27%. In both studies, patients with T1 N0 tumors had better 5-year survival rates of 60% and 32%, respectively.

Stereotactic body radiotherapy has gained more widespread use as a treatment option because it is a high-precision mode of therapy that delivers very high doses of radiation. Two- to 3-year local control rates of stage I NSCLC with stereotactic body radiotherapy have ranged from 80% to 95%. Stereotactic body radiotherapy has been investigated in patients unfit to undergo surgery, with survival rates similar to surgical outcomes.

RFA also is being investigated in patients with small primary lung cancers or lung metastases who are deemed medically inoperable.

The purpose of RFA in patients who have inoperable primary pulmonary tumors or nonpulmonary tumors metastatic to the lung is to provide a treatment option that is an alternative to or an improvement on existing therapies.

The question addressed in this evidence review is: Does the use of RFA improve the net health outcome in individuals with inoperable primary pulmonary tumors or nonpulmonary tumors metastatic to the lung?

The following PICOs were used to select literature to inform this review.

**Patients**

The relevant population of interest are individuals with inoperable primary pulmonary tumors or nonpulmonary tumors metastatic to the lung.
Interventions
The therapy being considered is RFA, which is administered in an outpatient setting by oncologists and radiologists.

Comparators
The following practice is currently being used to make decisions about managing primary pulmonary tumors or nonpulmonary tumors metastatic to the lung: radiotherapy, which is administered in an outpatient setting by oncologists and radiologists.

Outcomes
The general outcomes of interest are OS, tumor recurrence, and treatment-related adverse events (e.g., pneumothorax). Patients would be followed for at least five years.

Study Selection Criteria
Methodologically credible studies were selected using the principles described in the first indication.

Systematic Reviews
In a systematic review of RFA, surgery, and stereotactic body radiotherapy for CRC lung metastases, Schlijper et al (2014) did not identify any randomized trials, and evidence was insufficient to draw conclusions on the comparative effectiveness of these therapies.19. In comparative effectiveness review conducted for the Agency for Healthcare Research and Quality, Ratko et al (2013) assessed local nonsurgical therapies for stage INSCLC.20. In this review, no comparative RFA studies were identified. Reviewers found that available evidence was insufficient to draw conclusions on the comparative effectiveness of local nonsurgical therapies for NSCLC, including RFA.

In a review of 16 studies, Bilal et al (2012) compared RFA with stereotactic ablative radiotherapy in patients with inoperable early-stage NSCLC.21. Reviewers found that OS rates for RFA and stereotactic ablative radiotherapy were similar in patients at 1 year (68.2%-95% vs 81%-85.7%) and 3 years (36%-87.5% vs 42.7%-56%), all respectively. However, survival rates at 5 years were lower with RFA (20.1%-27%) than with stereotactic body radiotherapy (47%). These findings were drawn from comparisons of results of uncontrolled case series and retrospective reviews.

In an evidence-based review by Chan et al (2011), 46 studies on RFA for lung tumors were evaluated, which included 2905 ablations in 1584 patients with a mean tumor size of 2.8 cm.22. Twenty-four studies reported rates of local recurrence, which occurred in 282 (12.2%) cases at a mean follow-up of 13 months (range, 3-45 months). Primary lung cancer rates of local recurrence did not differ significantly (22.2%) from metastases (18.1%). Twenty-one studies reported mean OS rates of 59.4% at a mean follow-up of 17.7 months. The mean cancer-specific survival rate was 82.6% at a mean follow-up of 17.4 months. The mean overall morbidity was 24.6% and most commonly included pneumothorax (28.3%), pleural effusion (14.8%), and pain (14.1%). Mortality related to the RFA procedure was 0.21%, overall.

Prospective Studies
Huang et al (2011) prospectively followed 329 consecutive patients treated with RFA for lung tumors (237 primary, 92 metastatic).23. Complications were experienced by 34.3% (113) of patients, most commonly pneumothorax (19.1%). OS rates at 2 and 5 years were 35.3% and 20.1%, respectively. The risk of local progression did not differ significantly for tumors less than 4 cm but was statistically significant for tumors greater than 4 cm.

Zemlyak et al (2010) prospectively compared 3 treatments for medically inoperable patients with stage I NSCLC: RFA in 12 patients, sublobar resection in 25 patients, and percutaneous cryoablation in 27 patients.24. At 3-year follow-up, survival rates did not differ significantly between groups. OS and cancer-specific 3-year survival rates were 87.5%, 87.1%, and 77% and
87.5%, 90.6%, and 90.2%, respectively, in the 3 groups. The authors concluded that all three procedures were reasonable options for treating lung tumors in patients unfit for major surgery. The authors also noted that because surgeons chose the treatment option with patient input for this study, selection bias limited study interpretation.

**Inoperable Lung Tumors**

In a prospective, single-arm, multicenter trial from 7 centers in Europe, the U.S., and Australia, Lencioni et al (2008) reported the technical success, safety, response of tumors, and survival in 106 patients with 183 lung tumors. All patients were considered unsuitable for surgery and unfit for radiotherapy or chemotherapy. Tumors measured less than 3.5 cm (mean, 1.7 cm) and included patients with NSCLC (n=22), colorectal metastases (n=41), and other metastases (n=16). The technical success rate was 99%. Patients were followed for 2 years, and a confirmed complete response lasting at least 1 year was observed in 88% of assessable patients, with no differences in response rate between those with primary and metastatic tumors. OS rates in patients with NSCLC were 70% at 1 year (95% CI, 51% to 83%; cancer-specific survival, 92% [78% to 98%]), and 48% at 2 years (95% CI, 30% to 65%; cancer-specific survival, 73% [54% to 86%]). OS rates in patients with metastatic CRC were 89% at 1 year (95% CI, 76% to 95%; cancer-specific survival, 91% [78% to 96%]) and 66% at 2 years (95% CI, 53% to 79%; cancer-specific survival 68% [54% to 80%]). OS rates in patients with other metastases were 92% at 1 year (95% CI, 65% to 99%; cancer-specific survival, 93% [67% to 99%]) and 64% at 2 years (95% CI, 43% to 82%; cancer-specific survival, 67% [48% to 84%]). Patients with stage I NSCLC (n=13) had an OS rate of 75% (95% CI, 45% to 92%) at 2 years (cancer-specific, 92%; 95% CI, 66% to 99%). No differences in response rates were seen between patients with NSCLC or lung metastases.

Zhu et al (2009) assessed the incidence and risk factors of various pulmonary neoplastic complications after RFA. They prospectively evaluated the clinical and treatment-related data for 129 consecutive percutaneous RFA treatment sessions for 100 patients with inoperable lung tumors. There was no postprocedural mortality. The overall morbidity rate was 43% (55/129). The most common adverse event was a pneumothorax, occurring in 32% (41/129) of treatment sessions. Other significant complications included pleuritic chest pain (18%), hemoptysis (7%), pleural effusions (12%), and chest drain insertion (20%). Both univariate and multivariate analyses identified more than two lesions ablated per session as a significant risk factor for overall morbidity, pneumothorax, and chest drain insertion. The length of the ablation probe trajectory greater than 3 cm was an additional independent risk factor for overall morbidity and pneumothorax.

Pennathur et al (2009) reported on 100 patients with inoperable lung tumors. Forty-six patients had primary lung neoplasm, 25 had recurrent cancer, and 29 had pulmonary metastases. The mean follow-up was 17 months. Median OS for all patients was 23 months. The probability of 2-year OS for primary lung cancer patients, recurrent cancer patients, and metastatic cancer patients were 50% (95% CI, 33% to 65%), 55% (95% CI, 25% to 77%), and 41% (95% CI, 19% to 62%), respectively.

**Section Summary: Primary Pulmonary and Nonpulmonary Tumors**

The evidence on RFA for primary NSCLC and nonpulmonary tumors metastatic to the lung includes prospective and observational studies and systematic reviews of those studies. No RCTs identified compared treatment approaches. For inoperable lung tumors, a multicenter study found that RFA for tumors less than 3.5 cm can lead to a complete response in as many as 88% of patients for at least 1 year. Two-year survival has been reported to range from 41% to 75% in case series. Survival at one and two years appears to be similar, following treatment with RFA or stereotactic ablative radiotherapy in patients with inoperable lung tumors. Survival rates at 5 years were lower with RFA (20.1%-27%) than with stereotactic ablative radiotherapy (47%), but this finding was drawn from comparisons of uncontrolled case series and retrospective reviews. Prospective comparison in an RCT would permit greater certainty for this finding but the studies are consistent with some effect of RFA on lung tumors.
Breast Tumors

Clinical Context and Therapy Purpose

The treatment of small cancers of the breast has evolved from total mastectomy to more conservative treatment options such as lumpectomy, with more acceptable cosmetic outcomes and preservation of the breast. The selection of the surgical approach balances the patient's desire for breast conservation and the need for tumor-free margins in resected tissue. Minimally invasive nonsurgical techniques such as RFA are appealing if they can produce local control and survival equivalent to breast-conserving surgical alternatives. Nonsurgical ablative techniques pose difficulties such as the inability to determine tumor size, complete tumor cell death, and local recurrence. Additionally, RFA can burn the skin and damage to muscle, possibly limiting use in patients with tumors near the skin or chest wall.

The purpose of RFA in patients who have breast tumors is to provide a treatment option that is an alternative to or an improvement on existing therapies.

The question addressed in this evidence review is: Does the use of RFA improve the net health outcome in individuals with breast tumors?

The following PICOs were used to select literature to inform this review.

 Patients
The relevant population of interest are individuals with breast tumors.

 Interventions
The therapy being considered is RFA, which is administered in an outpatient setting by oncologists and radiologists.

 Comparators
The following practices are currently being used to make decisions about managing breast cancer: radiotherapy and surgical excision, which are administered in an outpatient or hospital setting by oncologists, radiologists, and surgeons.

 Outcomes
The general outcomes of interest are tumor recurrence, reduction in medication, and treatment-related adverse events.

 Patients would be followed for up to five years.

 Study Selection Criteria
Methodologically credible studies were selected using the principles described in the first indication.

 Systematic Reviews
Peek et al (2017) conducted a systematic review and meta-analysis of all studies evaluating the role of ablative techniques in the treatment of breast cancer published between 1994 and 2016.28 Selection criteria included at least 10 patients with breast cancer treated with RFA, high-intensity ultrasound, or cryo-, laser, or microwave ablation; 63 studies (total n=1608 patients) were identified through PubMed and MEDLINE library databases. Fifty studies reported complete ablation, and RFA had the highest rate of complete ablation (87.1% [491/564]) as well as the shortest treatment time (15.6 minutes). A major limitation of this systematic review was the authors' inability to perform a comparative meta-analysis due to the inclusion of only four RCTs and one retrospective analysis that compared two or more of techniques. There was also considerable heterogeneity across included studies.

Zhao and Wu (2010) conducted a systematic review of 38 studies on ablation techniques for breast cancer treatment published from 1994 to 2009.29 Nine studies focused on RFA. Reviewers
included small tumors ranging in size from 0.5 to 7 cm. Tumor resection was performed immediately after ablation or up to four weeks after RFA. Complete coagulation necrosis rates of 76% to 100% were reported. The results suggested RFA for breast cancer tumors is feasible but further studies with longer follow-up on survival, tumor recurrence, and cosmetic outcomes would be needed to establish clinical efficacy.

In another review, Soukup et al (2010) examined 17 studies on RFA for the treatment of breast tumors and found RFA is feasible. Even though few adverse events and complications occurred with breast RFA, incomplete tumor ablation remains a concern.

**Clinical Studies**

Retrospectively, Ito et al (2018) studied the safety and efficacy of percutaneous RFA of breast carcinomas in 386 patients from 10 institutions treated with RFA between 2003 and 2009. Patients were followed for a median of 50 months and ipsilateral breast tumor recurrence was more frequent in patients with initial tumor sizes of 2 cm or more (10% [3/30]) than those with initial tumors 2 cm or less (2.3% [8/355]; p = 0.015). Ipsilateral breast tumor recurrence rates 5 years after RFA were 97%, 94%, and 87% in patients with initial tumor sizes of 1 cm or less, 1.1 to 2.0 cm, and greater than 2 cm, respectively. The authors concluded that RFA was safe for tumors of 2 cm or less. The retrospective design and lack of data on ipsilateral breast tumor recurrence for different types of chemotherapy and endocrine therapy and analyses to ascertain whether adjuvant chemotherapy or endocrine therapy influenced outcomes are the limitations of this study.

The efficacy and safety of using ultrasound-guided RFA for multiple breast fibroadenoma as an alternative to surgical resection were retrospectively analyzed by Li et al (2016). From 2014 to 2016, 65 patients with 256 nodules were treated with ultrasound-guided RFA and complete ablation was achieved for 251 nodules (98.04%) after the first month of treatment; after the first and third months, tumor volume overall was reduced by 39.06% and 75.99%, respectively. The study reported minimal to no complications such as skin burns, hematoma, or nipple discharge. The retrospective design and short follow-up time limited the conclusions drawn from this study.

Wilson et al (2012) reported on 73 patients with invasive breast cancer who had a lumpectomy followed immediately by RFA to the lumpectomy bed. The average breast tumor size was 1.0 cm (range, 0.2-2.6 cm) and follow-up averaged 51 months. Disease-free survival was 100%, 92%, and 86% at 1, 3, and 5 years, respectively. One patient had tumor recurrence within 5 cm of the lumpectomy site, and three patients had ipsilateral breast recurrences.

In a phase 1/2 study reported by Kinoshita et al (2011), 49 patients were treated with RFA for breast tumors (mean size, 1.7 cm) followed immediately with surgical resection. Complete ablation was achieved in 30 (61%) patients. The complete ablation rate increased to 83% in 24 patients with tumor sizes of 2 cm or less in diameter. Adverse events related to the procedure included three muscle and two skin burns.

Imoto et al (2009) reported on a series of 30 patients with T1N0 breast cancer who had sentinel node biopsy followed by RFA and breast-conserving surgery. Twenty-six patients showed pathologic degenerative changes in tumor specimens, and, in 24 of 26 cases, tumor cell viability was diagnosed. Two patients had skin burns, and seven had muscle burn related to RFA.

In a 2-stage, phase 2 clinical trial reported by Garbay et al (2008), patients with histologically confirmed noninflammatory and 3 cm or less ipsilateral breast tumor recurrence were treated with RFA followed by mastectomy. The study was ended early due to lack of efficacy of the technique tested.

**Section Summary: Breast Tumors**

Systematic reviews, retrospective studies, and observational studies have reported varied and incomplete ablation rates as well as concerns about postablation tumor cell viability. Long-term
improvements in health outcomes have not been demonstrated. Additionally, available studies have not compared RFA with conventional breast-conserving procedures. For small breast tumors, further study, with long-term follow-up, is needed to determine whether RFA can provide local control and survival rates compared with conventional breast-conserving treatment.

Benign Thyroid Nodules
Clinical Context and Therapy Purpose
Surgical resection is the primary treatment choice for medically unresponsive, symptomatic benign thyroid tumors and thyroid carcinomas. However, techniques for ablation of thyroid tumors (e.g., RFA, microwave ablation) are being investigated.

The purpose of RFA in patients who have benign thyroid tumors is to provide a treatment option that is an alternative to or an improvement on existing therapies.

The question addressed in this evidence review is: Does the use of RFA improve the net health outcome in individuals with benign thyroid tumors?

The following PICOs were used to select literature to inform this review.

Patients
The relevant population of interest are individuals with benign thyroid tumors.

Interventions
The therapy being considered is RFA, which is administered in an outpatient setting by oncologists and radiologists.

Comparators
The following practices are currently being used to make decisions about managing thyroid tumors: radiotherapy and surgical excision, which are administered in an outpatient or hospital setting by oncologists, radiologists, and surgeons.

Outcomes
The general outcomes of interest are a reduction in nodule volume, hyper- and hypothyroidism, and treatment-related adverse events (e.g., voice changes).

Patients would be followed for at least five years.

Study Selection Criteria
Methodologically credible studies were selected using the principles described in the first indication.

Systematic Reviews
To evaluate the efficiency of RFA for the treatment of benign thyroid nodules, Chen et al (2016) conducted a systematic review and meta-analysis of outcomes based on a literature search to January 2016. Meta-analysis of data from 20 articles covering the RFA treatment of 1090 patients with 1406 benign thyroid nodules showed a significant decrease in nodule volume at months 1, 3, 6, 12, and last follow-up. Heterogeneous inclusion criteria, limited sample sizes, indirect transformation methods in the analysis, and selection bias of studies mainly from the Republic of Korea and Italy are the major limitations of this study.

Fuller et al (2014) reported on a systematic review of studies on RFA for benign thyroid tumors. Selected were 9 studies (5 observational studies, 4 randomized studies), totaling 306 treatments. After RFA, statistically significant improvements were reported in nodule size reduction (29.77 mL; 95% CI, -13.83 to -5.72 mL), combined symptom improvement and cosmetic scores on the 0 to 6 scale (mean, -2.96; 95% CI, -2.66 to -3.25), and withdrawal from methimazole (odds ratio, 40.34; 95% CI, 7.78 to 209.09). Twelve adverse events were reported, two of which were considered
significant but did not require hospitalization. The interpretation of meta-analytic results was limited by the variability in the comparator arms (percutaneous ethanol injection, percutaneous laser ablation, and high-intensity focused ultrasound ablation). The only RCT included in the meta-analysis was small (n=30).

**Prospective Studies**

From 2010 to 2011, Jung et al (2018) conducted a multicenter prospective assessment of the efficacy and safety of thyroid RFA for benign thyroid nodules in 345 patients. Volume reduction 12 months after RFA was 80.3% (n=276), and at the 24-, 36-, and 60-month follow-ups, reductions were 84.3% (n=198), 89.2% (n=128), 91.9% (n=57), and 95.3% (n=6), respectively. Therapeutic success was 97.8% overall, and mean symptom and cosmetic scores showed significant improvements (p<0.001). Lack of long-term follow-up is a limitation of this study.

**Case Series**

Lim et al (2013) reported on a case series of 111 patients treated with RFA for 126 benign nonfunctioning thyroid nodules. The mean duration of patient follow-up was 49.4 months. The RFA significantly decreased the volume of the thyroid nodules from 9.8 to 0.9 milliliters (p<0.001), for a mean volume decrease of 93.4%. Tumors recurred in 7 (5.6%) patients. Complications occurred in 4 (3.6%) patients. There was also a significant improvement in thyroid symptom scores (p<0.001).

Baek et al (2012) retrospectively reviewed RFA for 1543 benign thyroid nodules in 1459 patients at 13 thyroid centers. Forty-eight (3.3%) complications occurred and included 20 major complications: voice changes (n=15), brachial plexus injury (n=1), tumor rupture (n=3), and permanent hypothyroidism (n=1). Twenty-eight minor complications included: hematoma (n=15), skin burn (n=4), and vomiting (n=9).

A case series by Spiezia et al (2009) assessed 94 elderly subjects with solid or mainly solid benign thyroid nodules was reported by an Italian center. Thyroid nodule volume, compressive symptoms, and thyroid function were evaluated at baseline and 12 to 24 months posttreatment. All thyroid nodules significantly decreased in size after RFA. Compressive symptoms improved in all patients, disappearing completely in 88% of patients. Hyperthyroidism resolved in most patients, permitting complete withdrawal of methimazole therapy in 79% of patients with pretoxic and toxic thyroid nodules (100% with pretoxic and 53% with toxic thyroid nodules).

**Section Summary: Benign Thyroid Tumors**

Evidence on the treatment of benign thyroid nodules includes randomized and nonrandomized trials, case series, and systematic reviews of these studies. A systematic review that included one RCT, three randomized studies, and five observational studies found significant reductions in nodule size and withdrawal from methimazole following treatment with RFA. Reports of complications vary. The most frequent major complication from a large multicenter series was voice changes. However, the comparators were variable and nonconventional. The single RCT had a small sample size of 30.

**Miscellaneous Solid Tumors**

**Clinical Context and Therapy Purpose**

RFA has been investigated for use in individuals with different lesions in different anatomic sites. These anatomic sites include but are not limited to, breast and head and neck.

In patients with head and neck cancer with recurrent disease, surgical salvage attempts are poor in terms of local control, survival, and QOL; further, these recurrent tumors are often untreatable with standard salvage therapies. Palliative chemotherapy or comfort measures may be offered. The safety and efficacy of RFA have been investigated as an option for palliative treatment in these situations.
The purpose of RFA in patients who have miscellaneous solid tumors is to provide a treatment option that is an alternative to or an improvement on existing therapies.

The question addressed in this evidence review is: Does the use of RFA improve the net health outcome in individuals with miscellaneous solid tumors?

The following PICOs were used to select literature to inform this review.

**Patients**
The relevant population of interest are individuals with miscellaneous solid tumors (e.g., head and neck, thyroid cancer, pancreas).

**Interventions**
The therapy being considered is RFA, which is administered in an outpatient setting by oncologists and radiologists.

**Comparators**
The following practices are currently being used to make decisions about managing miscellaneous solid tumors: radiotherapy and surgical excision, which are administered in an outpatient or hospital setting by oncologists, radiologists, and surgeons.

**Outcomes**
The general outcomes of interest vary by disease state but include OS, tumor recurrence, and reductions in pain.

Patient follow-up will vary by disease state.

**Study Selection Criteria**
Methodologically credible studies were selected using the principals described in the first indication.

**Thyroid Cancer**
Kim et al (2015) reported on a comparative review of 73 patients with recurrent thyroid cancer smaller than 2 cm who had been treated with RFA (n=27) or repeat surgery (n=46). RFA was performed in cases of patient refusal to undergo surgery or poor medical condition. Data were weighted to minimize potential confounders. The 3-year recurrence-free survival rates were similar for RFA (92.6%) and surgery (92.2%, p=0.681). Posttreatment hoarseness rate did not differ between the RFA (7.3%) and surgery (9.0%) groups. Posttreatment hypocalcemia occurred only in the surgery group (11.6%).

**Head and Neck Cancer**
Owen et al (2011) reported on RFA for 13 patients with recurrent and/or unresectable head and neck cancer who failed curative treatment. Median patient survival was 127 days. While the stable disease was reported in eight patients after RFA, and QOL scores improved, three deaths occurred (one carotid hemorrhage, two strokes).

A case series of RFA for 14 patients with recurrent advanced head and neck malignancies was reported by Brook et al (2008). Tumor targeting and electrode deployment were successful in all cases, and four of six patients who completed QOL assessments showed improvement. Three major complications (in 27 [11%] applications) occurred 7 days to 2 weeks postprocedure. They included stroke, carotid artery rupture leading to death, and threatened carotid artery rupture with subsequent stroke. Retrospective analysis of intraprocedural CT scans revealed that the retractable electrodes were within 1 cm of the carotid artery during ablation in these cases.

A case series by Owen et al (2004) showed that palliative CT-guided RFA provided subjective improvement with regard to pain, appearance, and function in 12 patients who had recurrent
and advanced head and neck malignancies and were not candidates for radiotherapy or surgery. The procedure appeared reasonably safe and feasible for this indication.

**Other Tumors**

A prospective observational study by Rey et al (2019) assessed the effectiveness of transvaginal ultrasound-guided RFA of myomas in reducing tumor volume and eliminating metrorrhagia associated with myomas. The study included 205 women with symptomatic type I/II uterine submucosal or intramural cavity-distorting myomas undergoing RFA. The preoperative mean standard deviation volume of the myomas was 122.4 (182.5) cm³ (95% CI, 82.1 to 162.8). Mean myoma volume decreased significantly at 1 (85.2 [147.9] cm³; P=0.001), 3 (67.3 [138.0] cm³; P=0.001), 6 (59.3 [135.3] cm³; P=0.001, and 12 months (49.6 [121.4] cm³; P=0.001). At 12 months, the mean volume reduction was 60% compared with preoperative volume. All patients returned to normal menstruation at a mean follow-up of 3 months and 12 months. Of the 205 patients, 201 (98.04%) were satisfied with the procedure. The investigators conceded that a larger population with a longer follow-up is needed but their study suggests that transvaginal ultrasound-guided RFA of myomas is effective and safe for treating select patients with metrorrhagia secondary to myomas.

Liu et al (2016) retrospectively compared laparoscopic adrenalectomy with CT-guided percutaneous RFA for the treatment of aldosterone-producing adenoma, evaluating short-term and long-term outcomes of normalized aldosterone-to-renin ratio, hypokalemia, and hypertension. Of 63 patients, 27 were in the laparoscopic adrenalectomy group and 36 were in the RFA group. Primary aldosteronism was seen in 33 of 36 patients treated with RFA and all 27 who had laparoscopic adrenalectomy (p=0.180), within a median follow-up of 5 to 7 years. RFA was associated with faster recovery postprocedure, but hypertension was less frequently resolved using RFA (13/36 patients) compared with laparoscopic adrenalectomy (19/27 patients; p=0.007). The use of posture test and CT for subtype classification of primary aldosteronism is the major limitation of the study, as well as the retrospective design.

Retrospectively, Yang et al (2016) compared the efficacy and safety of RFA with laparoscopic adrenalectomy in treating aldosterone-producing adenoma of the adrenal gland. From 2009 to 2013, 25 patients diagnosed with unilateral adrenal aldosterone-producing adenoma and similar tumor size (<25 mm) were allocated to a control group (n=18) that underwent laparoscopic adrenalectomy and a test group (n=7) that underwent CT-guided percutaneous RFA. Complete tumor ablation on follow-up CT scan and normalization of serum aldosterone-to-renin were the primary outcomes compared in this study. Success in the RFA group reached 100% within 3 to 6 months, compared with 94.4% in the laparoscopic adrenalectomy group, and normalization ability was statistically equivalent in both groups. The study's retrospective design and small sample are the main limitations of this study.

In a large series, Yin et al (2015) evaluated the effectiveness and safety of RFA for uterine myomas in a 10-year retrospective cohort study. From 2001 to 2011, a total of 1216 patients treated for uterine myomas were divided into 2 groups. Group A consisted of 476 premenopausal patients (average age, 36 years) who had an average of 1.7 myomas with an average diameter of 4.5 cm. Group B consisted of 740 menopausal patients (average age, 48 years) with an average of 2.6 myomas with an average diameter of 5.0 cm. Patients were followed for a mean of 36 months. At 1, 3, 6, 12, and 24 months after RFA, the average diameters of myomas in group A were 3.8, 3.0, 2.7, 2.4, and 2.2 cm, respectively; 48% (227/476) of patients had a residual tumor at 12 months. In group B, myoma diameters were 4.7, 3.7, 3.3, 2.3, and 2.3 cm, respectively; 59% (435/740) of patients had trace disease at 12 months. Three months after RFA treatment, myoma volumes were significantly reduced in both groups (p<0.01), although group B had a higher rate of residual tumor 12 months after RFA than group A (p<0.05). Clinical symptoms and health-related QOL were significantly improved after RFA in both groups. The postoperative recurrence rate of uterine myomas was significantly higher in group A at 10.7% (51/476) than in group B at 2.4% (18/740; p<0.05).
A case series by Mayo-Smith and DuPuy (2004) assessed 13 patients with adrenal neoplasms treated with RFA. Eleven of the 13 lesions were treated successfully with RFA, defined by follow-up CT scans and normalization of preprocedural biochemical abnormalities.50.

A single-arm, retrospective, paired-comparison study by Locklin et al (2004) evaluated the short-term efficacy of RFA in reducing pain and improving function in patients with unresectable, painful soft tissue neoplasms recalcitrant to conventional therapies.51. Patients had tumors located in a variety of sites including chest wall, pelvis, breast, perirectal, renal, aortocaval, retroperitoneal, and superficial soft tissues. All had failed conventional methods of palliation or experienced dose-limiting adverse events from pain medication. Although not all Brief Pain Inventory scores were statistically significant, all mean scores trended down over time after ablation. Complications from RFA were minor or insignificant in all but one patient who had skin breakdown and infection of an ablated superficial tumor site.

Additional research has addressed the use of RFA in solid malignancies52,53, and in the pancreas.54-56. A systematic review by Rombouts et al (2015) has examined studies of ablative therapies, including RFA, in patients with locally advanced pancreatic cancer.57. No RCTs were identified, and conclusions limited by the sparse evidence available on RFA in this setting.

Stereotactic radiofrequency thermocoagulation for epileptogenic hypothalamic hamartomas was described in a retrospective analysis by Kameyama et al (2009) who evaluated 25 patients with gelastic seizures (a rare type of seizure).58. Other seizure types were exhibited in 22 (88.0%) patients, precocious puberty in 8 (32.0%), behavioral disorder in 10 (40.0%), and mental disability in 14 (56.0%). Gelastic seizures resolved in all but two patients. Complete seizure freedom was achieved in 19 (76.0%) patients. These patients experienced resolution of all seizure types and behavioral disorder and also demonstrated intellectual improvement.

Preliminary results of endoscopic RFA of rectosigmoid tumors have been described by Vavra et al (2009).59. Twelve patients were treated with the Endoblate RFA device, with ten patients having surgical resection after ablation. Histology of the resected specimens showed that, on average, 82% (range, 60%-99%) of the tumor mass was destroyed in the ablation zone.

Small case series on RFA for colorectal and rectal carcinoma have demonstrated a debulking role for RFA.60,61. These case series did not permit comparison with an available alternative.

**Section Summary: Miscellaneous Solid Tumor**

Evidence on the use of RFA to treat other types of solid tumors consists of a small number of case series, prospective studies, or retrospective comparative studies. Reporting on outcomes is limited. The evidence base does not support a conclusion on the effects of RFA for the tumor types included in this evidence review.

**Summary of Evidence**

**Bone Tumors**

For individuals who have painful osteolytic bone metastases who have failed or are poor candidates for standard treatments who receive RFA, the evidence includes case series. The relevant outcomes are symptoms, change in disease status, QOL, medication use, and treatment-related morbidity. Case series have shown clinically significant pain relief and reduction in opioid use following treatment of painful osteolytic metastases. The population is comprised of patients with few or no treatment options, for whom short-term pain relief is an appropriate clinical outcome. The evidence is sufficient to determine that the technology results in a meaningful improvement in the net health outcome.

For individuals who have painful osteoid osteomas who receive RFA, the evidence includes numerous observational studies and a systematic review of these studies. The relevant outcomes are symptoms, change in disease status, QOL, quality of life, medication use, and treatment-related morbidity. In a systematic review of thermal ablation techniques, clinical success (pain-
free) was achieved in 94% to 98% of patients. Most patients (89%-96%) remained pain-free when assessed during longer-term follow-up. Although no randomized trials of RFA for osteoid osteomas have been performed, the uncontrolled studies have demonstrated RFA can provide adequate symptom relief with minimal complications, for a population for whom short-term symptom relief and avoidance of invasive procedures are appropriate clinical outcomes. The evidence is sufficient to determine that the technology results in a meaningful improvement in the net health outcome.

**Localized Renal Cell Carcinoma**

For individuals who have localized RCC that is no more than 4 cm in size who receive RFA, the evidence includes an RCT, numerous observational studies, and systematic reviews of these studies. The relevant outcomes are OS, change in disease status, QOL, and treatment-related morbidity. A recent meta-analysis that included only an RCT and cohort studies found that RFA was as effective as nephrectomy for small renal tumors, with a reduction in complications. Another recent meta-analysis found that PN was superior to ablative techniques (the study included RFA but also cryoablation and microwave ablation) in overall mortality and local recurrence but not in cancer-specific mortality. It also found fewer complications and improved renal function with ablation. Although inconsistent, the evidence does suggest that, for small renal tumors, RFA may result in a similar rate of disease progression with a lower complication rate than nephrectomy. However, comparative trials are needed to determine with greater certainty the effects of these treatments in the same patient population. The evidence is insufficient to determine the effects of the technology on health outcomes.

**Inoperable Primary Pulmonary and Nonpulmonary Tumors Metastatic to Lung**

For individuals who have inoperable primary pulmonary tumors or nonpulmonary tumors metastatic to the lung who receive RFA, the evidence includes prospective observational studies and systematic reviews of these studies. The relevant outcomes are OS, change in disease status, QOL, and treatment-related morbidity. A multicenter study found that for tumors less than 3.5 cm in size, RFA can lead to a complete response in as many as 88% of patients for at least 1 year. Two-year survival rates have been reported to range from 41% to 75% in case series, with 5-year survival rates of 20% to 27%. In general, the evidence suggests that RFA results in adequate survival and tumor control in patients who are not surgical candidates, with low morbidity rates. The evidence is sufficient to determine that the technology results in a meaningful improvement in the net health outcome.

**Breast Tumors**

For individuals who have breast tumors who receive RFA, the evidence includes observational studies and systematic reviews of these studies. The relevant outcomes are OS, change in disease status, QOL, and treatment-related morbidity. Evidence has reported varied and incomplete ablation rates with concerns about postablation tumor cell viability. Long-term improvements in health outcomes have not been demonstrated. Additionally, available studies do not permit comparisons with conventional breast-conserving procedures. Further studies, with long-term follow-up, should focus on whether RFA of the breast for small tumors can provide local control and survival rates compared with conventional breast-conserving treatment. The evidence is insufficient to determine the effects of the technology on health outcomes.

**Benign Thyroid Tumors**

For individuals who have benign thyroid tumors who receive RFA, the evidence includes RCTs, prospective studies, case series, and systematic reviews of these studies. The relevant outcomes are symptoms, change in disease status, QOL, medication use, and treatment-related morbidity. A systematic review that included four RCTs and five observational studies found significant reductions in nodule size and withdrawal from methimazole following treatment with RFA when compared with a variety of local treatment. Reports of complications vary. The most frequent major complication in a large multicenter series of specialty centers was voice change. The evidence is insufficient to determine the effects of the technology on health outcomes.
Miscellaneous Solid Tumors

For individuals who have miscellaneous tumors (e.g., head and neck, thyroid cancer, pancreas) who receive RFA, the evidence includes a few case series, prospective studies, and retrospective comparative studies. The relevant outcomes are OS, change in disease status, QOL, and treatment-related morbidity. There is a limited evidence base for these tumor types. Reporting on outcomes or comparisons with other treatments is limited. These studies do not permit conclusions on the health benefits of RFA. The evidence is insufficient to determine the impact of technology on health outcomes.

Supplemental Information

Clinical Input From Physician Specialty Societies and Academic Medical Centers

While the various physician specialty societies and academic medical centers may collaborate with and make recommendations during this process, through the provision of appropriate reviewers, input received does not represent an endorsement or position statement by the physician specialty societies or academic medical centers, unless otherwise noted.

2010 Input

In response to requests from Blue Cross Blue Shield Association, input was received from 2 physician specialty societies (4 reviewers) and 2 academic medical centers (4 reviewers) in 2010. Input was similar to that received in 2009, except support for the use of radiofrequency ablation (RFA) to treat lung tumors was declined (only 1 respondent indicated this was an option in tumors metastatic to lung). One respondent also indicated a potential use for adrenal tumors. Input supported RFA for localized renal cell carcinoma no more than 4 cm in size when preservation of kidney function is necessary and a standard surgical approach would likely substantially worsen kidney function or when the patient is not considered a surgical candidate.

2009 Input

In response to requests from Blue Cross Blue Shield Association, input was received from 1 physician specialty society (4 reviews) and from 2 academic medical centers (3 reviews) in 2009. All reviewers supported the use of RFA in the treatment of painful bone metastases that have failed standard treatment and in the treatment of osteoid osteomas. Reviewers were divided over the use of RFA for lung tumors, although several agreed that, while it may be useful in a select population of patients, it should be used in the clinical trial setting. Reviewers were also split with regard to RFA in the treatment of renal tumors, with some supporting its use in a select population of patients. With the exception of one disagreement and one nonresponse, the reviewers agreed to the investigational statement on the use of RFA in all other tumors outside the liver that are addressed in this policy.

Practice Guidelines and Position Statements

American College of Chest Physicians

The American College of Chest Physicians (2013) guidelines on the treatment of stage I and II non-small-cell lung cancer (NSCLC) have indicated RFA has been used effectively in clinical stage I NSCLC.62 Therefore, in medically inoperable patients, peripheral NSCLC tumors less than 3 cm may be treated with RFA. The College also collaborated with the Society of Thoracic Surgeons to develop consensus guidelines on the treatment of high-risk patients with stage I NSCLC.63 These 2012 consensus guidelines indicated RFA is an alternative treatment option for patients who are not surgical candidates due to severe medical comorbidity.

National Comprehensive Cancer Network

The NCCN guidelines for the treatment of non-small cell lung cancer (v.5.2019) state:64, "For medically operable disease, resection is the preferred local treatment modality (other modalities include SABR, thermal ablation such as radiofrequency ablation and cryotherapy)."

The NCCN guidelines for thyroid carcinoma (v.1.2019) indicate that local therapies such as RFA may be considered for locoregional recurrence of thyroid carcinoma-papillary carcinoma.65
The NCCN guidelines (v.1.2020) for renal cancer indicate that “thermal ablation (e.g., cryosurgery, radiofrequency ablation) is an option for the management of patients with clinical stage T1 renal lesions. Thermal ablation is an option for masses <3 cm, but it may also be an option for larger masses in select patients. Ablation in masses >3 cm is associated with higher rates of local recurrence/persistence and complications.”

The NCCN colon cancer guidelines (v.2.2019), which are currently under discussion, state that “for the local treatment of resectable metastatic disease, patients with liver or lung oligometastases can be considered for tumor ablation therapy….” Evidence on the use of RFA as a reasonable treatment option for non-surgical candidates and those with recurrent disease after hepatectomy with small liver metastases that can be treated with clear margins is growing.”

The NCCN guidelines for head and neck cancers (v.2.2019) and pancreatic adenocarcinoma (v.3.2019) do not mention RFA.

**National Institute for Health and Care Excellence**

The NICE guidance (2004) on osteoid osteoma indicated that “current evidence on the safety and efficacy of computed tomography (CT)-guided thermocoagulation of osteoid osteoma appears adequate to support its use.”

Updated NICE guidance (2010) on renal cancer has indicated that “evidence on the safety and efficacy of percutaneous radiofrequency ablation (RFA) … in the short and medium term appears adequate to support the use of this procedure provided that patients are followed up in the long term.”

The NICE guidance (2010) on RFA for primary and secondary lung cancers has stated: “[C]urrent evidence on the efficacy of percutaneous radiofrequency ablation (RFA) … is adequate in terms of tumor control.” The NICE also indicated RFA might be used in patients with small, early-stage lung cancers or small numbers of lung metastases who are unsuitable for, or prefer not to undergo, surgery. It may also have a place in multi-modality treatment of more advanced primary lung cancers.” The guidance warned of serious complications (e.g., pneumothorax) among lung cancer patients.

The NICE guidance (2016) on benign thyroid nodules stated: “Current evidence on the safety and efficacy of ultrasound-guided percutaneous radiofrequency ablation … is adequate to support the use of this procedure.”

**U.S. Preventive Services Task Force Recommendations**

Not applicable.

**Medicare National Coverage**

There is no national coverage determination. In the absence of a national coverage determination, coverage decisions are left to the discretion of local Medicare carriers.

**Ongoing and Unpublished Clinical Trials**

Some currently unpublished trials that might influence this review are listed in Table 4.

### Table 4. Summary of Key Trials

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<th>Trial Name</th>
<th>Planned Enrollment</th>
<th>Completion Date</th>
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<tr>
<td>NCT01051037</td>
<td>Phase II Study Evaluating Safety and Efficacy of Stereotactic Body Radiotherapy and Radiofrequency Ablation for Medically Inoperable and Recurrent Lung Tumors Near Central Airways</td>
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<td>Dec 2017 (completed)</td>
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Radiofrequency Ablation of Miscellaneous Solid Tumors Excluding Liver Tumors

<table>
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<th>NCT No.</th>
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<th>Planned Enrollment</th>
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<tr>
<td>NCT00776399</td>
<td>Radiofrequency Ablation in Resectable Colorectal Lung Metastasis: A Phase-II Clinical Trial</td>
<td>70</td>
<td>Aug 2018 (completed)</td>
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</table>

NCT: national clinical trial.

References


**Documentation for Clinical Review**

*Please provide the following documentation (if/when requested):*

- History and physical and/or consultation notes including:
7.01.95  Radiofrequency Ablation of Miscellaneous Solid Tumors Excluding Liver Tumors

Page 29 of 30

- Reason for procedure
- Prior treatment(s) and response(s)
- Size and location of tumor
- Reason patient is not a surgical candidate
- Glomerular filtration rate (GFR) for renal cell cancer patients

**Post Service**
- Operative report(s) or procedure report(s)

**Coding**

This Policy relates only to the services or supplies described herein. Benefits may vary according to product design; therefore, contract language should be reviewed before applying the terms of the Policy. Inclusion or exclusion of codes does not constitute or imply member coverage or provider reimbursement.

**MN/IE**

The following services may be considered medically necessary in certain instances and investigational in others. Services may be considered medically necessary when policy criteria are met. Services may be considered investigational when the policy criteria are not met or when the code describes application of a product in the position statement that is investigational.

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<tr>
<th>Type</th>
<th>Code</th>
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<td>CPT®</td>
<td>20982</td>
<td>Ablation therapy for reduction or eradication of 1 or more bone tumors (e.g., metastasis) including adjacent soft tissue when involved by tumor extension, percutaneous, including imaging guidance when performed; radiofrequency</td>
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<tr>
<td></td>
<td>32998</td>
<td>Ablation therapy for reduction or eradication of 1 or more pulmonary tumor(s) including pleura or chest wall when involved by tumor extension, percutaneous, including imaging guidance when performed, unilateral; radiofrequency</td>
</tr>
<tr>
<td></td>
<td>50542</td>
<td>Laparoscopy, surgical; ablation of renal mass lesion(s), including intraoperative ultrasound guidance and monitoring, when performed</td>
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<tr>
<td></td>
<td>50592</td>
<td>Ablation, 1 or more renal tumor(s), percutaneous, unilateral, radiofrequency</td>
</tr>
<tr>
<td></td>
<td>76940</td>
<td>Ultrasound guidance for, and monitoring of, parenchymal tissue ablation</td>
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<tr>
<td></td>
<td>77013</td>
<td>Computed tomography guidance for, and monitoring of, parenchymal tissue ablation</td>
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<tr>
<td></td>
<td>77022</td>
<td>Magnetic resonance guidance for, and monitoring of, parenchymal tissue ablation</td>
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</table>

**HCPCS**

None

**Policy History**

This section provides a chronological history of the activities, updates and changes that have occurred with this Medical Policy.

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<thead>
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<th>Effective Date</th>
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<tr>
<td>12/07/2006</td>
<td>BCBSA Medical Policy adoption</td>
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<tr>
<td>01/07/2011</td>
<td>Policy title change from Radiofrequency Ablation of Miscellaneous Solid Tumors Excluding Liver Tumors</td>
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### Definitions of Decision Determinations

**Medically Necessary:** Services that are Medically Necessary include only those which have been established as safe and effective, are furnished under generally accepted professional standards to treat illness, injury or medical condition, and which, as determined by Blue Shield, are: (a) consistent with Blue Shield medical policy; (b) consistent with the symptoms or diagnosis; (c) not furnished primarily for the convenience of the patient, the attending Physician or other provider; (d) furnished at the most appropriate level which can be provided safely and effectively to the patient; and (e) not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the Member’s illness, injury, or disease.

**Investigational/Experimental:** A treatment, procedure, or drug is investigational when it has not been recognized as safe and effective for use in treating the particular condition in accordance with generally accepted professional medical standards. This includes services where approval by the federal or state governmental is required prior to use, but has not yet been granted.

**Split Evaluation:** Blue Shield of California/Blue Shield of California Life & Health Insurance Company (Blue Shield) policy review can result in a split evaluation, where a treatment, procedure, or drug will be considered to be investigational for certain indications or conditions, but will be deemed safe and effective for other indications or conditions, and therefore potentially medically necessary in those instances.

### Prior Authorization Requirements (as applicable to your plan)

Within five days before the actual date of service, the provider must confirm with Blue Shield that the member's health plan coverage is still in effect. Blue Shield reserves the right to revoke an authorization prior to services being rendered based on cancellation of the member's eligibility. Final determination of benefits will be made after review of the claim for limitations or exclusions.

Questions regarding the applicability of this policy should be directed to the Prior Authorization Department at (800) 541-6652, or the Transplant Case Management Department at (800) 637-2066 ext. 3507708 or visit the provider portal at www.blueshieldca.com/provider.

Disclaimer: This medical policy is a guide in evaluating the medical necessity of a particular service or treatment. Blue Shield of California may consider published peer-reviewed scientific literature, national guidelines, and local standards of practice in developing its medical policy. Federal and state law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over medical policy and must be considered first in determining covered services. Member contracts may differ in their benefits. Blue Shield reserves the right to review and update policies as appropriate.