EFSUMB 2020 Proposal for a Contrast-Enhanced Ultrasound-Adapted Bosniak Cyst Categorization – Position Statement

EFSUMB 2020 – Vorschlag für eine an den kontrastverstärkten Ultraschall adaptierte Bosniak-Klassifikation von Zysten – Eine Stellungnahme

Authors
Vito Cantisani1, Michele Bertolotto2, Dirk-André Clevert3, Jean-Michel Correas4, Francesco Maria Drudi5, Thomas Fischer6, Odd Helge Gilja7, Antonio Granata8, Ole Graumann9, Christopher J. Harvey10, Andre Ignee11, Christian Jenssen12, Markus Herbert Lerchbaumer13, Matthew Ragel14, Adrian Saftoiu15, Konrad Friedrich Stock17, Jolanta Webb18, Paul S. Sidhu19

Affiliations
1 Department of Radiology, “Sapienza” University of Rome, Rome, Italy
2 Department of Radiology, University of Trieste, Ospedale di Cattinara, Trieste, IT
3 Department of Clinical Radiology, University of Munich-Großhadern Campus, Munich, Germany
4 Service de Radiologie adultes, Hôpital Necker, Université Paris Descartes, Paris, France
5 Department of Radiology, University La Sapienza, Italy
6 Department of Radiology, University Berlin, Charité, Berlin, Germany
7 Haukeland University Hospital, National Centre for Ultrasound in Gastroenterology, Bergen, Norway
8 Nephrology and Dialysis Unit, Emergency Hospital “Cannizzaro”, Catania – Italy
9 Research and Innovation Unit of Radiology, University of Southern Denmark, Odense C, Denmark
10 Department of Imaging, Imperial College NHS Healthcare Trust, London, United Kingdom of Great Britain and Northern Ireland
11 Innere Medizin 2, Caritas-Krankenhaus, Bad Mergentheim, Germany
12 Klinik für Innere Medizin, Krankenhaus Märkisch Oderland Strausberg/Wriezen, Germany
13 Department of Radiology, Charité Centrum 6 – Diagnostische und interventionelle Radiologie und Nuklearmedizin, Berlin, Germany
14 Radiology Department, Aintree University Hospitals NHS Foundation Trust, Liverpool, United Kingdom of Great Britain and Northern Ireland
15 Research Center in Gastroenterology and Hepatology, University of Medicine and Pharmacy Craiova, Romania
16 Department of Internal Medicine and Nephrology, Klinik Hirslanden, Zürich, Switzerland
17 Abteilung für Nephrologie, Klinikum rechts der Isar der TU München, München, Germany
18 Radiology Department, Aintree University Hospitals NHS Foundation Trust, Liverpool, United Kingdom of Great Britain and Northern Ireland
19 Department of Radiology, King’s College Hospital London, United Kingdom of Great Britain and Northern Ireland

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Correspondence
Dr. Vito Cantisani
Department of Radiology, “Sapienza” University of Rome, Viale Regina Elena, 324, 00161 Rome, Italy
Tel.: +39/34 71 74 39 47
Fax: +39/0 64 45 56 02
vito.cantisani@uniroma1.it

ABSTRACT
The well-established Bosniak renal cyst classification is based on contrast-enhanced computed tomography determining the malignant potential of cystic renal lesions. Ultrasound has not been incorporated into this pathway. However, the development of ultrasound contrast agents coupled with the superior resolution of ultrasound makes it possible to redefine the imaging of cystic renal lesions. In this position statement, an EFSUMB Expert Task Force reviews, analyzes, and describes the accumulated knowledge and limitations and presents the
current position on the use of ultrasound contrast agents in the evaluation of cystic renal lesions.

POSITION STATEMENT 1
Contrast-enhanced ultrasound can be used to characterize cystic renal lesions.

The Bosniak Classification System

The classification of cystic renal lesions introduced by Bosniak for CECT in 1986 [3] and recently modified by Silvermann et al. in 2019 [16] remains pertinent to the CECT diagnosis and management of complex cystic lesions [12, 17]. Cysts are classified based on the presence of certain imaging features that determine the likelihood of malignancy including hyperdensity, septations, calcifications, wall thickening, and enhancement characteristics. A “Bosniak” score is assigned to reflect the interpretation, with an increasing likelihood of malignancy [3, 18, 19]:

- **Category I:** The cystic lesion is clearly benign with imaging surveillance advised [17]. The malignancy rate for Bosniak category I is 0% (95% CI 0–6.8) [20] or 18% (12–26%) in surgical cohorts [21]. During imaging surveillance, re-classification to Bosniak category III/IV was necessary in 12% (8–17%) with a malignancy rate as high as 85% (74–92%) in re-classified cystic lesions.

- **Category II:** The cystic lesion is “presumably benign” with imaging surveillance advised [17]. The malignancy rate for Bosniak category IIF is 6.7% (95% CI 5–8.4) [20] or 18% (12–26%) in surgical cohorts [21]. During imaging surveillance, re-classification to Bosniak category III/IV was necessary in 12% (8–17%) with a malignancy rate as high as 85% (74–92%) in re-classified cystic lesions.

- **Category III:** The cystic lesion is “indeterminate” for malignancy. The malignancy rate in Bosniak category III is 55.1% (95% CI 45.7–64.5) [20], and in a surgical cohort is 51% (42–61%), and in radiological cohorts 54% (45–63%) [21].

- **Category IV:** The cystic lesion is likely malignant. The malignancy rate in Bosniak category IV is 91% (95% CI 87.7–94.2) [20], with no difference between surgical cohorts (malignancy in 86% of cases) and radiological cohorts (malignancy in 95% of cases) [21].
The Bosniak classification system is not intended to be used alone to guide the management of patients with complex renal cysts. Management of complex renal cystic lesions is dependent on the individual patient’s combination of imaging findings, clinical factors, and available treatment options [16]. The treatment decision lies with the urologist and/or the multidisciplinary renal cancer teams, based on current clinical practice and scientific evidence provided by urological guidelines [22].

**POSITION STATEMENT 2**
To guide the management of patients with renal cystic lesions, the Bosniak classification of imaging findings should always be used in conjunction with the assessment of clinical data and individual treatment options.

How accurate is risk assessment of renal cystic lesions using the CT-based Bosniak classification?

The crucial distinction is between Bosniak categories IIF and III, as category IIF may be followed-up but, in the case of category III, surgery is often indicated. The reported overall sensitivity of the CECT Bosniak cyst classification is 93 % (95 % CI 89–95) with a specificity of 67 % (95 % CI 59–76) [20]. Magnetic resonance imaging is superior to CECT in identifying lesion septations and enhancement, resulting in a higher category, most often upgrading from Bosniak category II and IIF to IIIF and III, respectively [23–25]. There is reported discrepancy regarding the performance among reporting radiologists in categorization. This discordance was greatest in the challenging categories II and III. The introduction of category IIF reduced this difficulty [24, 26]. A recent refinement of the CECT and CEMRI criteria may be helpful but requires validation [16].

**POSITION STATEMENT 3**
Risk assessment of renal cystic lesions using the CT-based Bosniak classification can be challenging and is subject to interobserver variability.

How accurate is risk assessment of renal cystic lesions using the MR-based Bosniak classification?

Both MR and CT imaging have similar results in the evaluation of the Bosniak categories [27, 28]. The pooled sensitivity and specificity for MR imaging were 0.92 and 0.91, respectively, with an AUROC of 94.7 % [29]. Using enhancement subtraction imaging, the sensitivity was improved to 95 % [30], and combined mural irregularity and intense mural enhancement is a strong predictor of malignancy [31]. Magnetic resonance imaging led to category migration with a change in the management of complex renal cysts in a significant proportion of cases; upgrades with MR imaging in 40 % [32], 23 % [28], or 10 % [27]. An inherent artifact with MR imaging is the depiction of thicker septa than on CECT [17, 25, 32, 33]. Diffusion-weighted MRI (DWI) can provide additional information (on the presence of a tumor tissue component that may help differentiate certain cases of complex renal cysts from cystic carcinomas) [34].

**POSITION STATEMENT 4**
CEMRI and CECT have similar accuracy in the evaluation of renal cystic lesions using the Bosniak classification in the majority of cases.

How good is the interobserver agreement between CT, CEUS, and MR imaging classification of renal cystic lesions?

There was excellent interobserver agreement for Bosniak classification for both CECT (kappa score $k = 0.87$) and CEMRI ($k = 0.93$) between two readers [21]. Conversely, there was considerable disagreement among three radiologists for CECT [21, 26]. Comparing CT, MR, and CEUS imaging, there was agreement between CT and MR imaging in 78 % ($k = 0.91$) of the cases and agreement between CT and CEUS imaging in 79 % ($k = 0.86$) with discordance only in Bosniak classes II and IIF [25].

**POSITION STATEMENT 5**
Considerable interobserver variability in Bosniak classification of renal cystic lesions with CECT exists which may have a significant impact on clinical decision making.

Ultrasound Examination of Bosniak Cysts: Contrast Agents and Dose Administered

Different UCAs have been used in different studies, with no comparative studies being published. The greatest experience is with the sulfur hexafluoride–filled microbubble SonoVue (Bracco SpA, Italy), the agent used almost exclusively in Europe for CEUS of abdominal organs [4, 35]. The recommended dose for intravenous use of SonoVue in renal cyst characterization ranges between 0.6 to 2.4 mL, but depends on the US system and patient habitus [36]. If needed, a second dose of the UCA may be safely administered to reexamine the kidney or for further examination of the contralateral kidney.
Ultrasound Examination of Bosniak Cysts: Contrast Agent Safety

Ultrasound contrast agents are administered safely in various applications with minimal risk to patients [37–40]. The risk of an anaphylactoid reaction is low (1:7000 patients, 0.014%) and significantly lower compared to iodinated CT contrast agents (35–95:100 000 patients, 0.035–0.095%), and comparable to the rate of severe anaphylactoid reactions associated with gadolinium-based contrast agents at 0.001–0.010%. Serious anaphylactoid reactions to UCAs are observed in approximately 1:10 000 exposures. In most cases allergy-like events and hypotension occurred within a few minutes following the injection of the UCA [37, 41–43]. Due to the fact that UCAs are not excreted through the kidneys, there is no need for renal function blood tests prior to UCA injection [44, 45]. There is no evidence of any effect on renal function. Patients with renal insufficiency have no risk of contrast-related nephropathy. Most observed adverse events were mild and resolved spontaneously within a short time without sequelae. The safety profile in children reflects that in adults [46, 47].

Ultrasound Examination of Bosniak Cysts: Equipment

Successful CEUS examinations require use of high performance contrast-specific software, which enables separate processing of non-linear microbubble signals and linear signals emitted by normal tissue. A low mechanical index (MI) should be used in order to minimize non-linear soft tissue signals and to avoid unintentional microbubble destruction. Generally, a low MI examination is typically considered <0.3 not only to minimize microbubble disruption, but also to reduce tissue harmonics and artifacts. The optimum MI values vary with the different US manufacturers. Modern US machines can display a real-time dual-screen view, comprising a CEUS image alongside the B-mode US image. Particularly, this is helpful for the CEUS investigation of smaller lesions. Importantly, the B-mode US image is formed using low MI and is of inferior quality compared to the normally used B-mode image. Additionally, some equipment provides the possibility of a single screen presentation mode, displaying the CEUS image in an overlay mode together with the B-mode US image.

Ultrasound Examination of Bosniak Cysts: Investigator Training

In order to ensure high quality of CEUS imaging, EFSUMB suggests that CEUS should be performed by practitioners with at least competence level 1 (preferably level 2 for the kidneys), as the diagnostic performance of CEUS is operator-dependent and correlates with the experience of the operator [48–50]. Additionally, physicians should ensure that their US machine is configured for adequate CEUS imaging and data post-processing. Familiarity with administration of the available UCA as well as knowledge of potential contraindications and side effects is mandatory. The operator must also be aware of the local national medico-legal regulations.

Ultrasound Examination of Bosniak Cysts: Examination Techniques

The renal cystic lesion may have been found on a routine US examination, or have been seen on CT without adequate characterization, for instance during a CT examination for possible renal colic. A curved array transducer, with a frequency between 1 and 9 MHz is deployed although linear transducers with a higher frequency can also be used in the detection of superficial renal cysts [51]. Following B-mode US to identify lesion location and color Doppler US to assess vascularity, the best approach to perform the CEUS examination is determined. Prior to the administration of the UCA, it is good practice to get oral or written informed consent for the use of intravenous contrast agents, according to local regulations. The examination should be performed with both the patient and the examiner in a comfortable position, with a view of the lesion in a longitudinal plane to allow continuous observation during respiration.

The UCA is administered by an assistant, and the examination is recorded continuously for at least 60 seconds and still images thereafter [52]. The kidneys enhance rapidly and intensely after UCA administration, with potential to assess both the macro- and the microvasculature, the former immediately after UCA arri-
val. The arterial pedicle and main arterial branches enhance first, followed rapidly by the segmental, interlobar, arcuate and interlobular arteries and then complete cortical enhancement. Medul-

ARY enhancement follows, with the outer medulla enhancing first, followed by gradual fill-in of the pyramids [53]. As UCAs are not excreted by the kidneys, there is no UCA in the renal collecting system. With CEUS only two enhancement phases occur: a corti-

cal phase, 15–30 s after UCA administration with cortical en-

hancement seen, and a parenchymal phase, when both the cortex and medulla enhance at 25 s – 4 min after UCA administration. There is normally excellent depiction of renal perfusion throughout the kidney, superior to color Doppler US techniques. Contrast enhancement is reported to be less intense and fades earlier in patients with chronic renal disease [54]. Any abnormal enhance-

ment pattern, when compared with the marked enhancement of the cortex, should be observed for subsequent wash-out, thought to be an indicator of malignancy [4, 36]. It is important to record the examination as a dynamic cine clip, and to review the exami-

nation carefully following completion of the examination [52].

POSITION STATEMENT 10
An appropriate examination technique is important to evalu-

ate complex renal cystic masses accurately both with conven-

tional US modes and CEUS.

POSITION STATEMENT 11
CEUS precisely depicts renal vascularization and its changes in pathological conditions.

Bosniak Cyst Classification on Multiparametric Imaging

The Bosniak categorization is a scale of increasing probability of cancer based upon imaging features and works well for cystic renal lesion evaluation in clinical practice [55]. The CECT-based Bosniak cyst classification system has been used to categorize cystic renal lesions on CEMRI and CEUS, with comparable results [7, 8, 56–58], but both CEMRI and CEUS tend to upgrade complex renal cystic les-

ions [59]. Imaging methods evaluate the various aspects of renal cystic lesions in different ways, and the single features are valued with different degrees of sensitivity and specificity. This must be considered when assigning the Bosniak category based on CECT, CEMRI, or multiparametric US. In particular, a CEUS examination performs better than CECT in the detection of lesion vascularity [59, 60], depicts more septa and is superior in depicting the degree of both septal and wall thickening, septal enhancement and en-

hancement of solid components within the lesion compared with CECT [7, 56, 61, 62]. CEUS is extremely sensitive in revealing even the tiny capillaries that feed hair-like thin septa with a superior tem-

poral and spatial resolution compared to any other imaging modal-

ity [63], with the potential to falsely upgrade lesions when applying the original Bosniak criteria for categorization [8, 24, 56, 61–66]. Contrast-enhanced ultrasound inherently demonstrates more complex ity in cystic lesions and has the potential to improve lesion char-

acterization and change therapeutic management effectively [5, 14]. Cystic renal lesions initially categorized on CECT can be subject to CEUS to improve diagnostic accuracy [67, 68]. Modified or new diagnostic Bosniak categorizations for CEUS, to improve specificity and overall performance, have been advocated but these are inconsis-
tent [8, 14, 15, 63, 68]. Most of the investigators who use a CEUS-modified Bosniak category actually use the Bosniak scoring system but assign the Bosniak scores through imaging criteria specific for CEUS. Any modified categorization using CEUS should define these criteria unequivocally, rather than developing a sepa-

rate classification.

Bosniak Cyst Classification: Unique Features of CEUS

The key features to be considered are the presence of enhancing wall and septa, with or without irregularities, and intratlesional enh-

hancing masses or nodules. Areas of calcification pose a difficulty for imaging with US and sometimes with MRI and CT, interfering with the assessment of enhancement [69]. Time intensity curve analysis of an administered contrast agent has no established role for the classification of renal cystic lesions [36, 61]. The characteristics of contrast enhancement on CEUS and CECT are differ-

ent. The UCA agent is strictly intra-vascular, while agents used in CEMR and CECT have an equilibrium phase in which contrast leaks out of vessels. Therefore, the criteria used to score the lesions on CECT must be adapted to the CEUS technique.

These are the most relevant differences between CEUS and CECT:

- Attenuation is a specific criterion for CECT scanning. The pres-

ence of echogenic content can act as a surrogate for high at-

tenuation [15], although it is not equivalent, since hyperdense cysts can show anechoic content on B-mode US [12, 60].

- CEUS cannot differentiate between perceived and measurable enhancement, as enhancement is either present or not. Of note, perceived enhancement is no longer considered in the current CECT/CEMRI categorization [16]. A surrogate could be the identification of single microbubbles running within tiny
CEUS is superior to CECT in detecting enhancement. Septa can
be seen in Bosniak IV complex renal cysts and are
reported with notable differences from the CT-based cate-

Scoring Criteria on Multiparametric US

<table>
<thead>
<tr>
<th>B-mode appearance</th>
<th>CEUS appearance</th>
<th>Bosniak score on multiparametric US</th>
</tr>
</thead>
<tbody>
<tr>
<td>Simple cysts with thin wall (&lt;2 mm), sharp margins without irregularities and calcifications; anechoic content; posterior acoustic enhancement</td>
<td>CEUS not necessary</td>
<td>I</td>
</tr>
<tr>
<td>Cysts that otherwise meet the criteria of simple cysts but are characterized by 1–3 thin septa (&lt;2 mm) without irregularities. Calcifications of the wall and/or septa may be present which do not hamper evaluation of the cystic content</td>
<td>CEUS not necessary</td>
<td>II</td>
</tr>
<tr>
<td>Cysts with internal debris, echogenic content, or mixed appearance</td>
<td>CEUS necessary</td>
<td>II</td>
</tr>
<tr>
<td>Cysts with multiple septa, internal debris, echogenic content, or mixed appearance. Calcifications of the wall and/or septa may be present slightly hampering the evaluation of the cyst wall, content, and septa</td>
<td>CEUS necessary</td>
<td>IIF</td>
</tr>
<tr>
<td>Totally intrarenal cysts otherwise meeting the category II criteria</td>
<td>CEUS necessary</td>
<td>IIF</td>
</tr>
<tr>
<td>Cysts with multiple septa, internal debris, echogenic content, or mixed appearance</td>
<td>CEUS necessary</td>
<td>III</td>
</tr>
<tr>
<td>Cysts with multiple septa, internal debris, echogenic content, or mixed appearance</td>
<td>CEUS necessary</td>
<td>IV</td>
</tr>
</tbody>
</table>

vessels in the wall and septa, a phenomenon which is believed
to be responsible for perceived enhancement [12].
- CEUS is superior to CECT in detecting enhancement. Septa can
appear thicker, and subtle wall/septa irregularities are more evi-
dent on CEUS. Moreover, thin septa with faint enhancement can
appear thicker and with heavy enhancement if an excessive dose
of UCA is injected (microbubble piling and blooming artifact).
- The presence of cyst wall calcification, with acoustic shadowing,
may hamper the visualization of any deeper enhancing nodules
or septa, making lesion categorization ineffective [70].
- Large patient habitus or overlying bowel gas may also obscure
visualization with US.
- Nodules are only seen in Bosniak IV complex renal cysts and are
easily distinguished from localized wall or septal thickening on
a CEUS examination.

Bosniak Cyst Classification:
Scoring Criteria on Multiparametric US

The criteria for a US-based Bosniak category assessment have
been reported with notable differences from the CT-based cate-
gories [6, 15, 51, 61, 70–72]. While characterization of simple
cysts (category I) and of a subgroup of minimally complicated be-
nign cysts (category II) is obtained on B-mode US, the majority of
complex renal cysts are effectively characterized on CEUS. The
criteria described below represent a synthesis of those reported
in the different studies. ▶ Table 1 shows how Bosniak scoring is
obtained using multiparametric US, following the recommen-
dations of the present paper.
- Category I: Simple benign cysts. These cysts meet the sono-
graphic criteria for simple cysts anywhere in the body: thin
(<2 mm) wall, sharp margins without irregularities and calcifi-
cations; anechoic content; posterior acoustic enhancement
[68]. These lesions are fully characterized as benign on B-mode
US; no UCA administration is needed (▶ Fig. 1).
- Category II: Minimally complex benign cysts. These cysts pres-
ent with one of the following appearances: Cysts that meet the
criteria of simple cysts, but with a few [1–3] thin (<2 mm)
septa without irregularities [68]. Calcification of the wall and/
or septa may be present which do not hamper evaluation of the
cystic content. These lesions are characterized as benign
on B-mode US (▶ Fig. 2). No UCA administration is needed,
but, if used, individual microbubbles are demonstrated within
tiny vessels in the wall and septa [6, 7, 73]. Cysts with internal debris, echogenic content, or a mixed appearance with thin walls show no enhancement on CEUS (▶ Fig. 3), a limited number of thin septa [1–3] without irregularities, or few microbubbles identified in the wall or septa [36].

**Category IIF** – Presumably benign, imaging surveillance is advised. Cysts with multiple thin septa, minimally thickened (2–3 mm) smooth septa and cyst border (▶ Fig. 4). Internal debris, echogenic or mixed content, and calcification may be present [6, 58, 68, 73]. Cysts meeting the category II criteria with existing calcification slightly hampering the evaluation of the cyst wall, content, and septa. Totally intrarenal cysts otherwise meeting the category II criteria for which differentiation between non-enhancing and enhancing border cannot be achieved (▶ Fig. 4C) [15].

**Category III** – Indeterminate lesions. Cystic lesions with enhancing smooth thick (≥ 4 mm) wall or septa, and/or with enhancing irregular (> 3 mm) walls and/or septa (▶ Fig. 5). No nodules are seen [6, 15, 36, 58, 68, 70, 73].

**Category IV** – Likely malignant cystic tumors. Cystic lesions with the characteristics of category III cysts, which also contain enhancing soft-tissue protrusions (▶ Fig. 6), either nodules with obtuse margins (≥ 4 mm), or with acute margins of any size [6, 15, 36, 63, 70, 73].

**POSITION STATEMENT 14**

The likelihood of malignancy of complex renal cystic lesions can be assessed using CEUS-based criteria.
Specific points regarding the CEUS Bosniak classification

Cysts with thick or nodular calcifications, without hampering evaluation of cyst content, are placed in category IIF; calcification is not a sign of malignancy provided that there is no associated suspicious lesion [18, 51, 73]. There is no definition for a threshold for labelling a septum as ‘thick’ [32]; septa ≤ 1 mm are considered thin, by the majority of investigators [6, 62, 70, 73]. Others suggest a 2 mm threshold [8, 51, 72, 74]. A “hairline septum” is a subjective assessment, dependent on the US equipment used, for which a precise thickness threshold cannot be assigned effectively. There is no threshold to differentiate between “few septa” and “multiple septa” with an arbitrary threshold at three septa. “Few” equals 1–3 and “many” is ≥ 4 septa [16, 32, 75]. Lesion size is not a consideration for cyst categorization with conflicting results for predicting malignancy [76–80]. On CECT, totally intrarenal non-enhancing high-attenuation cysts < 3 cm are assigned to category II, while cysts with the same characteristics > 3 cm are assigned to category IIF [12]. Large (≥ 3 cm) homogeneous,
hyperattenuating, non-enhancing renal masses, originally considered IIF masses, are rare. The need for follow-up is because of difficulty in the differentiation between non-enhancing and enhancing wall.

**POSITION STATEMENT 15**
The features of US modes must be taken into consideration when criteria developed for CECT and for CEMRI are adapted to categorize renal cystic lesions on CEUS.

### Reporting the CEUS Bosniak classification

A CEUS report should include information on examination conditions, quality, and limitations. All technical limitations that could hamper a confident diagnosis should be detailed, such as: difficult-to-image patient, deep position of the cyst, calcification hampering evaluation of the intra-cystic content, large cysts incompletely examined due to superimposition of bowel gas, poor acoustic window or other barriers, and presence of artifacts. Lesion appearance on B-mode US should be reported, in particular, with regard to the presence of septa, wall and septa calcification, presence of echogenic cyst content, and features on color Doppler techniques. Then, lesion appearance on CEUS should be described with an emphasis on the presence of smooth enhancing wall and septa, enhancing wall and septa irregularities (either circumscribed or diffuse, subtle or marked), and on presence of enhancing solid components. The intensity of observed enhancement should be subjectively described either as unequivocal enhancement, or identification of single microbubbles running within tiny vessels in the wall and septa. A cine clip should be recorded for subsequent evaluation of the CEUS examination.

### Limitations of Bosniak scoring on CEUS

Complex cystic renal masses pose a particular interpretative challenge for the observer because the imaging boundary between benign and malignant lesions is often unclear. The Bosniak classification works well but is intrinsically subjective when applied to other imaging techniques and is dependent on the observer’s experience. This leads to an unavoidable high degree of interobserver disagreement [65]. Moreover, the main limitations of B-mode and Doppler US will apply to CEUS as well. Heavily calcified lesions cannot be evaluated. Assessment is influenced by the location of the lesion in poorly visualized kidneys, shadowing from bowel gas or ribs, and patient body habitus.

**POSITION STATEMENT 17**
When scoring renal cystic lesions on CEUS the intrinsic limitation of this technique must be considered.
Controversies with CEUS of Bosniak Categories

Does the CEUS-based classification upgrade or downgrade the risk of malignancy of renal cystic lesions?

The presence of enhancement, indicating neovascularization, is the most important factor in determining the need for surgery in cystic renal lesions [12, 13]. Improved CT resolution when compared to the original CECT categories has resulted in fewer indeterminate cyst findings and increased specificity [81]. With CEUS, 31% of renal cysts were attributed a higher Bosniak category compared to CECT [7, 8, 13, 56, 65]. The increased contrast enhancement and better temporal and spatial resolution of CEUS (and MR imaging) demonstrate previously undetected features. Minimal septa enhancement is not indicative of malignancy, and an increased sensitivity of CEUS demonstrating enhancing nodules not seen with CECT has been noted [56, 82]. A similar higher Bosniak category with MR imaging has been seen [10, 28, 32] but an apparent wall thickening artifact is an issue [66]. Both upgrading and downgrading of Bosniak categories with MRI and CEUS compared to CT imaging is apparent in >20% of cases [25], with CEUS demonstrating lower specificity but improved sensitivity and accuracy compared to MR imaging [57].

**POSITION STATEMENT 18**
The imaging criteria used to assign the Bosniak categories are developed for CECT and must be adapted to be successfully applied for scoring on CEMRI and CEUS, as changes in category will occur.

Should CEUS be considered an equivalent, complimentary, or alternative technique to contrast-enhanced CT for renal cystic lesions?

Although CECT is the reference standard for Bosniak categories of renal cystic malignancy risk, CECT is inherently inaccurate, with a reported sensitivity of 89.6% and specificity of 65.1% in distinguishing between benign and malignant renal cysts [20]. The comparability of CEUS with the reference standard of CECT has been addressed with excellent agreement [7, 56, 83] with a single study indicating that experience in CEUS interpretation is crucial [65]. There was a potential for CEUS to overestimate the Bosniak category, with the ‘real-time’ examination able to demonstrate minor enhancement (a marker of malignant potential). The current view suggests that this is an advantage, rather than a drawback. This requires, however, a fundamental change in imaging assessment of renal cysts, centered on CEUS demonstration of lesion vascularity [5]. When CEUS is inconclusive due to poor visualization (i.e., due to patient habitus or poor acoustic window), CECT usually permits better characterization and furthermore allows staging of a malignant renal lesion. There is better demonstration of calcification on CECT which could affect the Bosniak category on US [18, 84]. Using CEUS only in cases of contraindications or non-acceptance of CECT is not justified based on the current knowledge of the potential of this technique and would be detrimental to acquiring further cumulative experience in CEUS.

**Characteristics of non-progressive Bosniak Category IIIF cysts**
The initial cyst size, change in lesion size (increase or decrease), and growth rate (growth rate = [follow-up size minus initial size]/years between measurements) were not found to correlate with progression. A multilobulated border of the lesion was not found to correlate with progression and no lesions with calcification progressed. Growth rates in cystic lesions are often a consequence of fluid accumulation (downgrading to a Bosniak category II). Progression to malignancy is based on the appearance of enhancing solid portions, an increase in number, thickness or irregularity of enhancing septa, and on an increase in thickness of the enhancing wall [85]. There is no difference in progression to malignancy on follow-up CECT imaging compared with MR imaging [16, 86–88]. When there is indeterminate enhancement on CECT, CEMR or CEUS imaging can be the next imaging stage [59, 89, 90].

**POSITION STATEMENT 19**
Follow-up of cystic renal lesions can be carried out effectively with CECT, CEMR, or CEUS imaging. The current evidence shows similar performance for the three techniques.

When should CEUS be supplemented by CT or MR imaging for follow-up?

A CEUS examination is suited for the follow-up of nonsurgical lesions to detect any morphologic changes such as thickening of septa, appearance of a solid nodule, or contrast-enhanced alterations indicative of progression of the disease. A CEUS examination has at least the same diagnostic accuracy as CECT for renal cyst categorization but image acquisition is influenced by the location of the lesion in poorly visualized kidneys, shadowing from bowel gas or ribs, patient’s constitution, and wall calcification [29, 57, 91]. Smaller lesions localized within the renal parenchyma may be difficult to characterize with CEUS, as these lesions often disappear (“masked”) during a CEUS examination due to the prominent vascularity of the renal cortex, with the possibility of a lower dose of UCA being helpful. With these issues, further CT or MR imaging is necessary [25].

**POSITION STATEMENT 20**
CEUS-based Bosniak categorization must be supplemented by CT or MR imaging when there is inadequate visualization of the cystic renal lesion.
Conclusion

The Bosniak categorization was originally formulated for CECT, and then applied to MR imaging and CEUS without adapting the criteria developed primarily for CT. With differences in imaging specifics, an inaccurate assignment of the Bosniak category and ultimately inappropriate treatment could result from the CEUS and MR imaging interpretation. The criteria used to assign the Bosniak category scores on CEUS have been reviewed, redefined, and standardized, taking into account the unique characteristics of the CEUS examination. The aim is to allow for clearly defined criteria allowing for a better assessment of the performance of CEUS in the categorization of complex renal cysts. The CEUS categorization is not intended to replace, but rather to complement the current Bosniak CT categorization, thereby improving its accuracy in the assessment of malignancy in each category. The Bosniak categorization system is used worldwide and provides a common language but is intrinsically subjective, a shortcoming which will likely be reduced when using the redefined criteria which include a CEUS examination.

Conflict of interest

Vito Cantisani: lecturer fees from Bracco, Samsung, Toshiba.
Paul Sidhu: lecture fees from Bracco.
Adrian Saitou: lecture fees from Bracco.
Dirk-André Clevert: speaker bureau Bracco, Siemens, Esaote, Samsung, Philips.

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