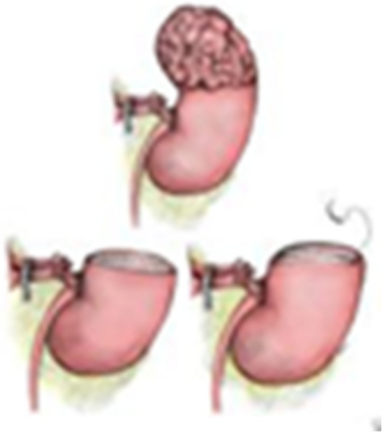
Very Important!!

The correct side for surgery should be checked :

CT scan present
Your approval
Prior to anaesthesia being commenced

Risks

- Blood loss 20-500cc
- May convert from a laparoscopic to open procedure.
- May loose your kidney in up to 5% of cases.
- Wound Infection.
- Post-operative hernia formations especially associated in the elderly with atrophic abdominal muscles
- NB! Each person is unique and for this reason symptoms vary!



Jo Schoeman
FRACS, FCS (Urol) SA, MBChB

Pelvic Medicine Centre
St Andrews War Memorial Hospital
Wickham Terrace
Springhill, Brisbane QLD 4000

Ph: 07) 3831-9049
Fax: 07) 3834-4471
E-mail: admin@brisbane-urology.com.au
Emerg: 0403 044 072

Urologist

Dr Jo Schoeman
Specialist Urologist

PATIENT INFORMATION BROCHURE

LAPAROSCOPIC/OPEN PARTIAL NEPHRECTOMY

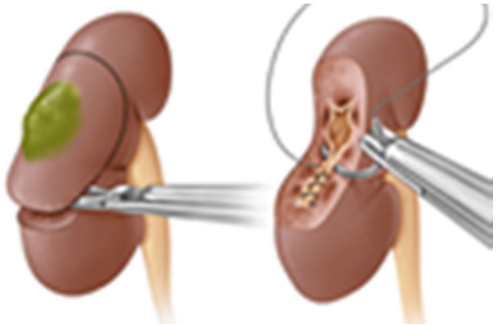
Patient well-being is my first priority!

Laparoscopic/Open Partial Nephrectomy

For small renal cancers where nephron-sparing is an issue. Similar to an open Radical Nephrectomy.

Why is it done?

- Incidental finding of a solid renal mass larger than 3cm suspicious of a renal cancer
- Exophytic lesion
- Usually asymptomatic
- Curative process for Renal Cell Carcinoma
- Staging should be negative ie. No spread of tumour
- Staging with
  CT abdomen and chest
  Bonescan
  MRI if in Renal Failure or Contrast Allergy



How is it done?

- Patients will receive a general anaesthesia, unless contra-indicated.
- Prophylactic anti-biotics is given.
- An indwelling catheter is placed.
- The correct kidney is identified and marked while you are a
- Depending on the side of the tumour
  3-4 incisions will be made :
  1 for the hand-port of approximately 8cm depending on the amount of sub-cutaneous fat present
  1 for the camera-port
  1 for the working-port
  (1 for the liver retractor on the right)
- The colon is reflected to reveal the retro-peritoneal space
- The ureter is identified and cleared up to the hilum
- The arteries are identified and marked with vessel loops More than 1 can be present. Confirmed with CT arteriography
- Then the vein/ veins are identified and marked with a vessel loop.
- The tumour is identified using intraoperative ultrasound and marking the area with a 0.5cm margin with cautery. Its overlying fat removed is removed and sent for histology.
- Note is made of the depth of the tumour
- Vessel clamps are placed on the artery and the tumour is cut out with a combination of blunt and sharp dissection. Bleeders are clipped as encountered.
- Collecting system is closed if exposed.
- Vessel occlusion is released with a check for bleeding vessels in the wound.
- Compressing parenchymal sutures are place over a hemostatic agent role.
- A drain is left post-operatively.

What next?

- You will spend up to 3-5 nights in hospital.
- You will have a catheter for that time.
- A drain for 2-3 days.
- Your darin will be removed with minimal drainage present.
- You will a trial without the catheter on the 3rd day
- You will be discharged as soon as your renal function has stabilised and you have opened your bowels.
- Allow for 6 weeks for stabilization of symptoms.
- No dietary restrictions apply.
- A ward prescription will be issued on your discharge, for your own collection at any pharmacy
- A follow-up appointment will be scheduled for 6 weeks. Remember there is no pathology due to vaporization.
- Don't hesitate to ask Jo if you have any queries
- **DON'T SUFFER IN SILENCE, OR YOU WILL SUFFER ALONE!**