RETROPERITONEAL EXCISION OF ABDOMINAL LYMPH NODES

Procedure Specific Information

What is the evidence base for this information?
This publication includes advice from consensus panels, the British Association of Urological Surgeons, the Department of Health and evidence-based sources. It is, therefore, a reflection of best urological practice in the UK. It is intended to supplement any advice you may already have been given by your GP or other healthcare professionals. Alternative treatments are outlined below and can be discussed in more detail with your Urologist or Specialist Nurse.

What does the procedure involve?
This involves removal of the lymph nodes alongside the main blood vessels in the abdomen and usually follows chemotherapy or radiotherapy treatment for testicular cancer.

What are the alternatives to this procedure?
Observation (not recommended).

The retroperitoneum is the space behind the gut where the main blood vessels (the aorta and vena cava) run. Lymph nodes are small (French bean-sized) structures which trap cancer cells and may become enlarged.

The operation is designed to remove these nodes and is carried out as part of your treatment for testicular cancer. It is normally performed after you have completed chemotherapy; If this does not cause the lymph nodes to shrink to a normal size, there is a possibility that there may be some cells in them which could become cancerous in the future. The only way to know this for sure is to remove these lymph glands and to send them to the laboratory for microscopic examination (histology).

In some cases a minimally invasive or laparoscopic approach might be possible.
What should I expect before the procedure?

Although you will have discussed issues of sterility with your urologist or oncologist, it is important to be aware that the nerves which control ejaculation run through the middle of the surgical area. We try to preserve these nerves but there is always a risk of damage because there may be a lot of scar tissue around the nerves after the chemotherapy treatment. This can result in weak or absent ejaculation after the operation and the semen may even be directed back into your bladder instead of coming out through your penis (a “dry” orgasm). This is not, of course, harmful; the semen is flushed away with your urine but, if this does occur, it is very likely that you will be sterile. This does not, however, always happen and you urologist may be able to tell you if it is likely in your case.

If you have not already done so, it may be possible for you to store semen as a precaution and you should discuss this with your urologist before the procedure.

You will see the urology team in the Uro-Oncology Clinic to discuss the operation in detail and you will usually be admitted on the day before your surgery although some hospitals now prefer to admit patients on the day of surgery. You will normally receive an appointment for pre-assessment to assess your general fitness, to screen for the carriage of MRSA and to perform some baseline investigations. After admission, you will be seen by members of the medical team which may include the Consultant, Specialist Registrar, House Officer and your named nurse.

On the day before your operation, you will only be allowed to drink clear fluids such as water, squash, black tea or coffee. You may also be given a laxative to clear your bowel. Immediately before the operation, you may be given a pre-medication by the anaesthetist which will make you dry-mouthed and pleasantly sleepy.

You will be given an injection under the skin of a drug (Clexane), that, along with the help of elasticated stockings provided by the ward, will help prevent thrombosis (clots) in the veins.

Please be sure to inform your surgeon in advance of your surgery if you have any of the following:

- an artificial heart valve
- a coronary artery stent
- a heart pacemaker or defibrillator
- an artificial joint
- an artificial blood vessel graft
- a neurosurgical shunt
- any other implanted foreign body
- a regular prescription for Warfarin, Aspirin or Clopidogrel (Plavix®)
- a previous or current MRSA infection
- a high risk of variant-CJD (if you have received a corneal transplant, a neurosurgical dural transplant or previous injections of human-derived growth hormone)
At some stage during the admission process, you will be asked to sign the second part of the consent form giving permission for your operation to take place, showing you understand what is to be done and confirming that you wish to proceed. Make sure that you are given the opportunity to discuss any concerns and to ask any questions you may still have before signing the form.

**Fact File 1 • The NHS Constitution**

**Same-Sex Accommodation**

As a result of the new NHS constitution, the NHS is committed to providing same-sex accommodation in hospitals by April 2010. This is because feedback from patients has shown that being in mixed-sex accommodation can compromise their privacy. The NHS pledges that:

- sleeping and washing areas for men and women will be provided
- the facilities will be easy to get to and not too far from patients' beds

To help accomplish this, the Department of Health has announced specific measures designed to "all but eliminate mixed-sex accommodation" by 2010. These include:

- more money for improvements in hospital accommodation
- providing help and information to hospital staff, patients and the public
- sending improvement teams to hospitals that need extra support
- introducing measures so that the Department can see how hospitals are progressing

What happens during the procedure?

Normally, a full general anaesthetic will be used and you will be asleep throughout the procedure. In some patients, the anaesthetist may also use an epidural anaesthetic which improves or minimises pain post-operatively.

A long incision is made in your abdomen to enable the surgeon to access and remove the necessary lymph nodes. The operation normally takes 3-6 hours to perform.

What happens immediately after the procedure?

In general terms, you should expect to be told how the procedure went and you should:

- ask if what was planned to be done was achieved
- let the medical staff know if you are in any discomfort
- ask what you can and cannot do
- feel free to ask any questions or discuss any concerns with the ward staff and members of the surgical team
- ensure that you are clear about what has been done and what is the next move
You will be taken from the operating theatre to the recovery area where your condition will be closely monitored until you are awake enough to return to the ward. Some men require observation in the intensive therapy unit (ITU) to allow closer monitoring; visiting times in these areas are flexible and will depend on when you return from the operating theatre.

You will have a drip to keep you hydrated, through which you can also be given medication. You will be given separate information about patient-controlled analgesia (PCA) or an epidural anaesthetic which are designed to minimise post-operative pain. You will be given oxygen via a mask or nasal spectacles.

A catheter is usually inserted into the bladder and a dressing will cover your wound; the wound itself is usually closed with staples which are removed after 7-10 days.

You will receive physiotherapy, starting on the day after the operation, to encourage mobility, deep breathing and leg movements. You can usually start drinking water 2-3 days after the procedure and, once bowel activity has returned, you will be able to drink and eat freely.

The average hospital stay is 9 days.

Are there any side-effects?
Most procedures have a potential for side-effects. You should be reassured that, although all these complications are well-recognised, the majority of patients do not suffer any problems after a urological procedure.

Common (greater than 1 in 10)
- Temporary insertion of a bladder catheter and wound drain
- Problems with ejaculation failure after the surgery
- Accumulation of lymph fluid after the operation, requiring drainage
- Infection, pain or bulging of the incision site requiring further treatment
- The microscopic examination of the lymph nodes may subsequently show no sign of cancer in the lymph glands removed

Occasional (between 1 in 10 and 1 in 50)
- Bleeding requiring further surgery or transfusions
- It may not be possible to remove the nodes without removing the kidney on the affected side
- Need for further treatment of the cancer
- Involvement or injury to nearby local structures (blood vessels, spleen liver, lung, pancreas and bowel) requiring more extensive surgery
Rare (less than 1 in 50)

- Anaesthetic or cardiovascular problems possibly requiring intensive care admission (including chest infection, pulmonary embolus, stroke, deep vein thrombosis, heart attack and death)
- Entry into the lung cavity requiring insertion of a temporary drainage tube

Hospital-acquired infection

- Colonisation with MRSA (0.9% - 1 in 110)
- Clostridium difficile bowel infection (0.2% - 1 in 500)
- MRSA bloodstream infection (0.08% - 1 in 1250)

The rates for hospital-acquired infection may be greater in high-risk patients e.g. with long-term drainage tubes, after removal of the bladder for cancer, after previous infections, after prolonged hospitalisation or after multiple admissions.

What should I expect when I get home?

By the time of your discharge from hospital, you should:

- be given advice about your recovery at home
- ask when to resume normal activities such as work, exercise, driving, housework and sexual intimacy
- ask for a contact number if you have any concerns once you return home
- ask when your follow-up will be and who will do this (the hospital or your GP)
- ensure that you know when you will be told the results of any tests done on tissues or organs which have been removed

When you leave hospital, you will be given a “draft” discharge summary of your admission. This holds important information about your inpatient stay and your operation. If you need to call your GP for any reason or to attend another hospital, please take this summary with you to allow the doctors to see details of your treatment. This is particularly important if you need to consult another doctor within a few days of your discharge.

You will get home about 7-9 days after surgery and will require a minimum 6 week period of convalescence. After this you should be able to resume exercise gradually. The return to work will depend on the type of work you do. Very heavy manual labour might require up to 3 months further time off work. Light work would be possible normally after 2 months or so.

What else should I look out for?

You should watch out for signs of inflammation of the wound or swelling of the abdomen which might indicate fluid collection.
Are there any other important points?
You have had a large operation and will feel tired when you get home. It is important to rest and, at first, you may feel like having a sleep during the day. It is also important to take exercise regularly; this should be very gentle at first but can be gradually built up as you start to have more energy. You may not feel fully recovered for 6-12 weeks.

The area around your incision will heal quickly but you may wish to cover it with a dressing to keep it clean and dry. You should keep physical activity to a minimum for the first 10 days after returning home. If you require a sick certificate, you can obtain this from the ward to cover the time you spent in hospital; thereafter, you will need to obtain a further certificate from your GP.

It will be at least 14-21 days before the pathology results on the tissue removed are available. It is normal practice for the results of all biopsies to be discussed in detail at a multi-disciplinary meeting before any further treatment decisions are made. You and your GP will be informed of the results after this discussion.

You will normally be reviewed in outpatients 6 weeks after your operation to monitor your progress. Your oncologist, however, will normally arrange to see you earlier than this (after 2-3 weeks) to discuss the pathology (biopsy) results. If you have any concerns about this, please contact Jane Robson in the Oncology Centre.

Driving after surgery
It is your responsibility to ensure that you are fit to drive following your surgery. You do not normally need to notify the DVLA unless you have a medical condition that will last for longer than 3 months after your surgery and may affect your ability to drive. You should, however, check with your insurance company before returning to driving. Your doctors will be happy to provide you with advice on request.

Is there any research being carried out in this area?
Before your operation, your surgeon or Specialist Nurse will inform you about any relevant research studies taking place, and, in particular, if any surgically-removed tissue may be stored for future study. If this is the case, you will be asked if you wish to participate and, if you agree, to sign a special form to consent to this.

All surgical procedures, even those not currently the subject of active research, are subjected to rigorous clinical audit so that we can analyse our results and compare them with those of other surgeons. In this way, we can learn how to improve our techniques and our results; this means that our patients will get the best treatment available.
Who can I contact for more help or information?
For further information on the internet, here are some useful sites to explore:

- www.rcseng.ac.uk/patient_information/internet_sources
- www.patient.co.uk
- www.patientinformation.org.uk
- www.rcoa.ac.uk (for information about anaesthetics)
- www.prodigy.nhs.uk.PILs
- www.nhsdirect.nhs.uk
- www.besttreatments.co.uk

What should I do with this information?
Thank you for taking the trouble to read this publication. If you wish to sign it and retain a copy for your own records, please do so below.

If you would like a copy of this publication to be filed in your hospital records for future reference, please let your Urologist or Specialist Nurse know. However, if you do agree to proceed with the scheduled procedure, you will be asked to sign a separate consent form which will be filed in your hospital record. You will, if you wish, be provided with a copy of this consent form.

I have read this publication and I accept the information it provides.

Signature...............................................................       Date..........................................

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How can I get information in alternative formats?
Please ask your local NHS Trust or PALS network if you require this information in other languages, large print, Braille or audio format.

Most hospitals are smoke-free. Smoking increases the severity of some urological conditions and increases the risk of post-operative complications. For advice on quitting, contact your GP or the NHS Smoking Helpline free on 0800 169 0 169

Disclaimer
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Fact File 2 • The NHS Constitution
Patients’ Rights & Responsibilities

The constitution, as a result of extensive discussions with staff and the public, sets out new rights for patients which will help improve their experience within the NHS. These new rights include:

- a right to choice and a right to information that will help them make that choice
- a right to drugs and treatments approved by NICE when it is considered clinically appropriate
- a right to certain services such as an NHS dentist and access to recommended vaccinations
- the right that any official complaint will be properly and efficiently investigated, and that they be told the outcome of the investigations
- the right to compensation and an apology if they have been harmed by poor treatment

The constitution also lists patient responsibilities, including:

- providing accurate information about their health
- taking positive action to keep themselves and their family healthy
- trying to keep appointments
- treating NHS staff and other patients with respect
- following the course of treatment that they are given
- giving feedback, both positive and negative, after treatment