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 describes a number of procedures to re-establish drainage of urine into the bladder when it has been interrupted because of scarring or damage to one of the ureters (the tubes which drain urine from the kidney to the bladder).

What are the alternatives to this procedure?
Long-term drainage with a ureteric stent, nephrostomy tube (external drain), conservative management (leaving the kidney to lose its function spontaneously).

What should I expect before the procedure?
If you are taking Aspirin or Clopidogrel on a regular basis, you must discuss this with your urologist because these drugs can cause increased bleeding after surgery. There may be a balance of risk where stopping them will reduce the chances of bleeding but this can result in increased clotting, which may also carry a risk to your health. This will, therefore, need careful discussion with regard to risks and benefits.

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.

You will be asked not to eat or drink for 6 hours before surgery and, 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 also be given an injection under the skin of a drug (Clexane®) which, along with elasticated stockings provided on the ward, will help prevent
thrombosis (clots) in your 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.

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**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?

A full general anaesthetic (where you are asleep throughout the procedure) will normally be used.

Drainage may be re-established by a variety of means; by directly re-joining the ends of the ureter above and below the area of blockage, by re-implanting the ureter into the bladder, by fashioning a tube of bladder to reach up to the ureter above the blockage (a bladder flap), by transferring the end of the blocked ureter over to the ureter on the other side or by replacing the ureter along its whole length with a segment of intestine (bowel).

The choice of procedure will be discussed with you in detail by your Consultant. However, it is often not clear before the operation which procedure will be most appropriate for your particular problem, so a range of options are usually discussed.

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

An internal drain (ureteric stent) is usually placed across the join where the blockage has been in order to allow free drainage of urine into the bladder and to avoid leakage outside the ureter.

There will be a drainage tube close to the wound to drain fluid away from the internal area where the operation has been done. There is usually a catheter in the urethra (water pipe) and, possibly, an additional catheter directly into the bladder through the skin of the lower abdomen (a suprapubic catheter).

After the operation, you may spend some time in the Intensive Care Unit or in the Special Recovery area of the operating theatre before returning to the ward. You will normally have a drip in your arm and, occasionally, a further drip into a vein in your neck.

You will be encouraged to mobilise as soon as possible after the operation because this encourages the bowel to begin working. We will start you on fluid and food as soon as possible. We normally use elastic stockings to minimise the risk of blood clot (deep vein thrombosis) in your legs. A physiotherapist will come and show you some deep breathing and leg exercises, and you will sit out in a chair for a short time after your operation.
If you have a drain or a tube in your blocked kidney (a nephrostomy tube), this may be removed on the ward or at a later stage after your discharge.

The average stay in hospital will last approximately 10-14 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)**
- Recurrent urine infections requiring long-term antibiotics
- Infections (if a segment of bowel is used)
- Decreased kidney function with time

**Occasional (between 1 in 10 and 1 in 50)**
- Anaesthetic or cardiovascular problems possible requiring intensive care admission (including chest infection, pulmonary embolus, stroke, deep vein thrombosis, heart attack and death)
- Failure to establish good drainage requiring repeat surgery
- Blood loss requiring transfusion or further surgery
- A temporary of long-term tendency for the blood to be more acidic than normal requiring medication, especially if a segment of bowel is used
- Infection or hernia of the incision requiring further treatment
- Diarrhoea/vitamin deficiency/constipation due to shortened bowel requiring treatment (if a segment of bowel is used)
- Scarring of the bowel requiring further surgery

**Rare (less than 1 in 50)**
- Tumour formation in the bowel if a segment of bowel is used

**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
The British Association of Urological Surgeons

- 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.

It will be at least 6 weeks before full healing occurs. You may return to work when you are comfortable enough and your GP is satisfied with your progress.

It can take several months for the strength of the wound to return to normal and you should avoid heavy lifting for up to 6 months.

What else should I look out for?
If you develop a temperature, increased redness, throbbing or drainage at the site of the operation, please contact your GP.

Any other post-operative problems should also be reported to your GP, especially if they involve chest symptoms.

Are there any other important points?
An appointment will be made within 6 weeks for you to have your stent removed, either under local or general anaesthetic. This will be discussed with you and arrangements made before you go home.

A follow-up outpatient appointment will be arranged for you some 6-8 weeks after the operation. You will receive this appointment either whilst you are on the ward or shortly after you get home.

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:......................................................
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
While every effort has been made to ensure the accuracy of the information contained in this publication, no guarantee can be given that all errors and omissions have been excluded. No responsibility for loss occasioned by any person acting or refraining from action as a result of the material in this publication can be accepted by the British Association of Urological Surgeons Limited.

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