

## 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 or more..
- 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!



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# Urologist



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Specialist Urologist

## PATIENT INFORMATION BROCHURE

*LAPAROSCOPIC/OPEN  
PARTIAL  
NEPHRECTOMY*

See this live on:  
[vidscrip.com/urojo](http://vidscrip.com/urojo)

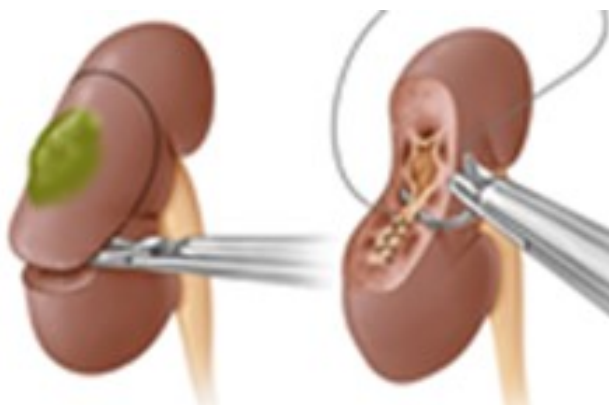
Patient well-being is my first priority!

## 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/ FDG PET Scan
  - 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 awake
- 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!**

