LAPAROTOMY TO REMOVE A LARGE RETROPERITONEAL MASS

Information about your procedure from
The British Association of Urological Surgeons (BAUS)

This leaflet contains evidence-based information about your proposed urological procedure. We have consulted specialist surgeons during its preparation, so that it represents best practice in UK urology. You should use it in addition to any advice already given to you.

To view the online version of this leaflet, type the text below into your web browser:

http://www.baus.org.uk/_userfiles/pages/files/Patients/Leaflets/Excision of RP mass.pdf

Key Points

- The aim of the procedure is complete removal of a mass situated at the back of your abdominal cavity
- These masses are usually malignant sarcomas and can become very large, presenting a technical challenge for the surgeon
- The procedure involves complex, major, abdominal surgery and may require removal of any structure attached to the mass (e.g. bowel or kidney)
- When the pathology tests on the mass have been reviewed, some patients are found not to have cancer whilst others require further treatment for their cancer

What does this procedure involve?

Removal of a large mass at the back of your abdominal (tummy) cavity, behind the intestines where the main blood vessels (aorta and inferior vena cava) run. We may need to remove other organs such as a kidney, portions of your large or small bowel and blood vessels, to remove the mass completely. If major blood vessels are involved in the mass, we may need to replace or by-pass them with grafts.

Sometimes these masses can become very large before a patient presents to a doctor. As a result, the procedure may require a long incision and a significant amount of surgery.

What are the alternatives?

Many of these masses turn out to be sarcomas. Sarcomas do not respond well to treatment with chemotherapy or radiotherapy, so surgery is usually the only effective treatment.

What happens on the day of the procedure?

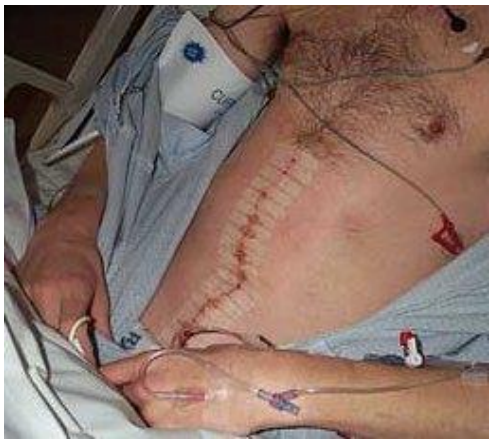
Your urologist (or a member of their team) will briefly review your history and medications, and will discuss the surgery again with you to confirm your consent.

You will be seen by an anaesthetist who will discuss the options of a general anaesthetic or spinal anaesthetic. The anaesthetist will also discuss pain relief after the procedure with you, such as a patient-controlled analgesia (PCA) system or an epidural catheter.

We may give you a pair of TED stockings to wear, and a heparin injection to thin your blood. These help to prevent blood clots from developing and from passing into your lungs. Your medical team will decide whether you need to continue these after you go home.

Details of the procedure

- we carry out the procedure under a general anaesthetic
- you will usually be given an injection of antibiotics before the procedure, after you have been checked for any allergies
- we make a long incision in your abdomen (tummy, pictured); this is usually in the midline but a sideways extension may be needed if the mass is very large



- we remove the mass and any other involved structures with grafting of any large blood vessels, as needed
- we put a bladder catheter in your urethra (waterpipe) to monitor your urine output; this is removed once you are mobile
- you can drink water from the day after the procedure but we usually pass a stomach tube through your nose (a nasogastric tube) to stop your stomach from becoming bloated with air and fluid; this is usually removed after a few days, following which you will be able to eat and drink freely
- we close the wound with staples, clips or stitches which are normally removed after seven to 10 days

- we place a drainage tube into the area from which the mass has been removed; this is normally removed after a few days
- the operation can take from three to six hours, depending on its complexity
- we may monitor your condition in a high-dependency unit (HDU) for the first few hours (or days) after the procedure
- you should expect to be in hospital approximately seven days

Are there any after-effects?

The possible after-effects and your risk of getting them are shown below. Some are self-limiting or reversible, but others are not. We have not listed very rare after-effects (occurring in less than 1 in 250 patients) individually. The impact of these after-effects can vary a lot from patient to patient; you should ask your surgeon's advice about the risks and their impact on you as an individual:

After-effect	Risk
Problems with weak or absent ejaculation after surgery (depending on the site of the mass)	 Between 1 in 10 & 1 in 50 patients
Accumulation of lymph fluid requiring needle drainage or further surgery	 Between 1 in 10 & 1 in 50 patients
Infection, pain or bulging of the incision requiring further treatment	 Between 1 in 10 & 1 in 50 patients
Temporary problems with delayed bowel function requiring prolonged nasogastric (stomach) tube insertion	 Between 1 in 10 & 1 in 50 patients
Need for removal of additional organs (which you will have discussed with your urologist before the procedure)	 Between 1 in 10 & 1 in 50 patients
Bleeding requiring transfusion or further surgery	 Between 1 in 10 & 1 in 50 patients

Need for further treatment of any cancer found		Between 1 in 10 & 1 in 50 patients
Pathology analysis of the mass may show that it is not cancer		Between 1 in 50 & 1 in 250 patients
Anaesthetic or cardiovascular problems possibly requiring intensive care (including chest infection, pulmonary embolus, stroke, deep vein thrombosis, heart attack & death)		Between 1 in 50 & 1 in 250 patients (your anaesthetist can estimate your individual risk)

What is my risk of a hospital-acquired infection?

Your risk of getting an infection in hospital is between 4 & 6%; this includes getting *MRSA* or a *Clostridium difficile* bowel infection. This figure is higher if you are in a "high-risk" group of patients such as patients who have had:

- long-term drainage tubes (e.g. catheters);
- bladder removal;
- long hospital stays; or
- multiple hospital admissions.

What can I expect when I get home?

- you will get some swelling and bruising around the wound which may last several days
- you will be given advice about your recovery at home
- you will be given a copy of your discharge summary and a copy will also be sent to your GP
- any antibiotics or other tablets you may need will be arranged & dispensed from the hospital pharmacy
- a follow-up appointment will be made for you to have your dressings and your stitches/clips/staples (if still present) removed
- if you develop any reddening around your wound, discharge from the wound or swelling of your abdomen, you should contact your doctor immediately
- you should report any abdominal distension (bloating) or persistent vomiting immediately; it may be a sign of intestinal (bowel) blockage
- you should report any other post-operative problems to your GP, especially if they involve chest symptoms

- you should rest during the early days but you should also exercise regularly; start with gentle exercises and build up your levels slowly as your energy returns
- you may not feel fully recovered for six to 12 weeks
- it usually take 14 days for the results of the biopsy on your retroperitoneal mass are available; these will be discussed in a multi-disciplinary team (MDT) meeting before any further treatment decisions are made
- we will let both you and your GP know the results and will arrange a follow-up appointment for you
- your oncologist may also wish to see you during the recovery period

General information about surgical procedures

Before your procedure

Please tell a member of the medical team if you have:

- an implanted foreign body (stent, joint replacement, pacemaker, heart valve, blood vessel graft);
- a regular prescription for a blood thinning agent (e.g. warfarin, aspirin, clopidogrel, rivaroxaban, dabigatran);
- a present or previous MRSA infection; or
- a high risk of variant-CJD (e.g. if you have had a corneal transplant, a neurosurgical dural transplant or human growth hormone treatment).

Questions you may wish to ask

If you wish to learn more about what will happen, you can find a list of suggested questions called "Having An Operation" on the website of the Royal College of Surgeons of England. You may also wish to ask your surgeon for his/her personal results and experience with this procedure.

Before you go home

We will tell you how the procedure went and you should:

- make sure you understand what has been done;
- ask the surgeon if everything went as planned;
- let the staff know if you have any discomfort;
- ask what you can (and cannot) do at home;
- make sure you know what happens next; and
- ask when you can return to normal activities.

We will give you advice about what to look out for when you get home. Your surgeon or nurse will also give you details of who to contact, and how to contact them, in the event of problems.

Smoking and surgery

Ideally, we would prefer you to stop smoking before any procedure. Smoking can worsen some urological conditions and makes complications more likely after surgery. For advice on stopping, you can:

- contact your GP;
- access your local NHS Smoking Help Online; or
- ring the free NHS Smoking Helpline on **0300 123 1044**.

Driving after surgery

It is your responsibility to make sure you are fit to drive after any surgical procedure. You only need to contact the DVLA if your ability to drive is likely to be affected for more than three months. If it is, you should check with your insurance company before driving again. Following removal of a retroperitoneal mass, most patients should be fit to drive after three to four weeks.

What should I do with this information?

Thank you for taking the trouble to read this information. Please let your urologist (or specialist nurse) know if you would like to have a copy for your own records. If you wish, the medical or nursing staff can also arrange to file a copy in your hospital notes.

What sources have we used to prepare this leaflet?

This leaflet uses information from consensus panels and other evidence-based sources including:

- the Department of Health (England);
- the Cochrane Collaboration; and
- the National Institute for Health and Care Excellence (NICE).

It also follows style guidelines from:

- the Royal National Institute for Blind People (RNIB);
- the Information Standard;
- the Patient Information Forum; and
- the Plain English Campaign.

Disclaimer

We have made every effort to give accurate information but there may still be errors or omissions in this leaflet. BAUS cannot accept responsibility for any loss from action taken (or not taken) as a result of this information.

PLEASE NOTE

The staff at BAUS are not medically trained, and are unable to answer questions about the information provided in this leaflet. If you do have any questions, you should contact your urologist, specialist nurse or GP.