



LAPAROSCOPY FOR RENAL CYSTIC DISEASE

Renal cysts are common. Overall, they are found in some 50% of adults and are generally asymptomatic. As such, they verge on being normal and can be left alone in most people. Cysts may rarely be malignant cancers, a change that can usually be recognised on imaging, ultrasound, CT or MRI scanning. Cysts that appear borderline for cancer present a management dilemma and may be monitored with imaging or proceed to surgery.

In some people, benign cysts may cause any or all of pain, high blood pressure, bleeding, infection, obstruction to kidney drainage, deterioration of renal function or a lump. These complications may occur in patients with an underlying, often genetic, problem where the kidney is largely replaced by cysts. There are, however, a variety of other causes for each of these symptoms and it may be difficult to know unequivocally that the cysts are the culprits. To better establish the cause-effect relationship, you may be advised to have radiological drainage of the cyst and assess the response to drainage using this treatment. The cyst fluid will undoubtedly re-accumulate. However, a more definitive treatment can be offered to patients who experience symptom improvement with the radiological drainage. Definitive treatment of symptomatic renal cysts is typically performed laparoscopically (key-hole surgery), which is associated with less pain, fewer complications and superior recovery, compared to open surgery. Internally, the surgery is very similar to the older open operation, and achieves similar results in terms of cure of the underlying condition. In general, laparoscopy has longer operating times than open surgery but this does not equate to more complications. In common with all laparoscopic surgery, hospital stay is short and recovery is quicker than the open procedure with few or no wound-related problems. The procedure is performed under general anaesthetic and surgery performed using a camera and telescope system through the ports (keyholes). If the tissue/specimen to be removed is large, this will usually require an additional wound just above the pubic symphysis (bikini-line).

WHAT TO DO BEFORE YOUR PROCEDURE:

- ensure laboratory tests are done > 48 hours prior to surgery, unless advised otherwise
- discontinue aspirin and other anticoagulants 1 week prior, other medications may also need to be stopped
- nothing to eat or drink from 6 hours prior to procedure - see Admission Booklet regarding diet restrictions
- microlax enema morning of the procedure for afternoon procedures, evening prior for morning procedures
- you will be admitted to hospital on the day of surgery.
- you do not need to shave prior to surgery

WHAT HAPPENS IN HOSPITAL AFTER YOUR PROCEDURE:

- day 1: urethral catheter will be removed
- your hospital stay is commonly 1-2 days

WHAT HAPPENS AFTER YOU LEAVE HOSPITAL:

- recovery is reasonably quick, with return to normal activities including driving after 5 days.
- withhold aspirin and other anticoagulants for 1 week but reinstate other usual medications.
- the Steristrip (tape) dressings should be left on the wounds for 4 weeks. If the Steristrips come off, the wounds should be left exposed without further dressings applied
- post-operative constipation is a common problem and may be minimised with good fluid intake, dietary fibre and laxatives.



- you may not drive for 24 hours post procedure and see Admission Booklet regarding further restrictions following general anaesthetic
- avoid heavy lifting for 2 weeks; thereafter resume normal activity including sexual intercourse
- fatigue continues for several weeks after surgery. You are encouraged to return to normal activities early, accepting the fatigue, which although limiting, will resolve progressively and completely.

WHAT CAN GO WRONG:

Although most cases proceed without particular difficulty and have excellent outcomes, surgical complications occur overall in 5% of patients. The list below details complications recognised as common or serious, but this does not include the rare and extraordinary. Risk of death is approximately 0.03% in generally healthy patients.

AT THE TIME OF AND EARLY AFTER SURGERY:

- Failed procedure and conversion to open procedure <1%
- Bleeding requiring blood transfusion in < 1%
- Infection may require antibiotic treatment <3%
- Temporary shoulder pain is common after laparoscopy
- Damage to other organs, including bowels, spleen, liver and gall bladder, nerves and lymphatics, and CO2 gas embolism
- Numbness or tingling in legs, genitalia and perineum is usually temporary
- Clots (DVT, PE), gas embolism
- Risk of death may be estimated using the nzRISK <https://nzhrisk.com> on-line pre-operative calculator. It has been developed and validated for patients in New Zealand over the age of 18, to help patients and doctors balance benefits and risks of treatment.

LATER POTENTIAL COMPLICATIONS :

- Port site hernia
- Adhesions
- Persistence of symptoms
- Recurrence of symptoms without further cyst formation
- Cyst recurrence with or without further symptoms