Acute Services Division

NHS
Greater Glasgow and Clyde

Information for patients about

Retroperineal Lymph Node Dissection (RPLND)

Introduction

This booklet gives you information about surgery to remove the residual lymph nodes at the back of the abdomen. This is part of your treatment for germ cell cancer which usually arises in the testicles but can occur at other sites such as the lymph nodes deep within the abdomen (retroperitoneum).

As this is highly specialised surgery only a few cancer centres carry this out.

What are lymph nodes?

The lymphatic system is a part of the body's immune system which helps to fight infection. It also helps to remove excess fluid from the body.

The lymphatic system consists of vessels similar to veins which carry lymph around the body. Along its course are groups of nodes or glands. After passing through various nodes, the lymph fluid is finally delivered into the blood stream.
Cancer cells can be carried in the lymph fluid to the lymph nodes where they can grow as "secondary deposits" of cancer. This is what happens with testicular cancer that has spread outside the testicle.

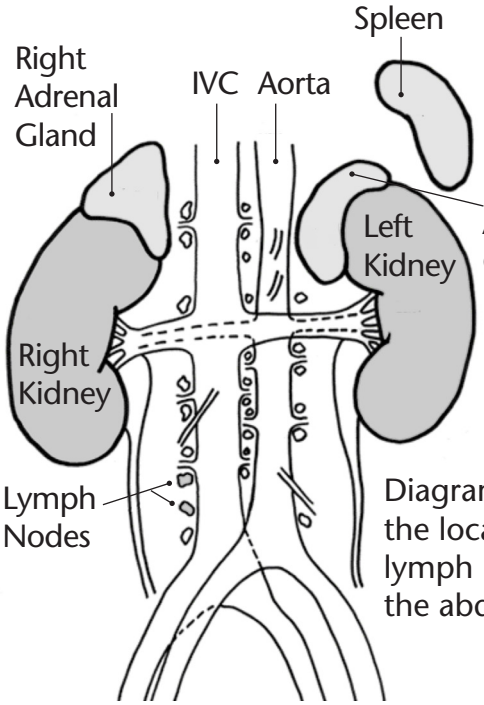

Diagram showing the location of the lymph nodes in the abdomen

Agreeing to treatment (Consent)

Your surgeon will explain the surgery and why you need to have it. The information in this booklet is to remind you of what your surgeon has explained. Please read this booklet before you sign a consent form and only do so when you feel you fully understand the surgery, what is going to happen and have an opportunity to discuss these issues with the surgeon. We will then ask you to sign a consent form agreeing to the surgery.

What are the benefits of the surgery?

After your chemotherapy treatment you had a CT scan that showed some enlarged lymph nodes in your abdomen. As these nodes are more than 1cm in size we recommend removing the nodes. The enlarged lymph nodes may be due to one of three things:

- It maybe that the chemotherapy has killed off the cancerous cells but your body has not been able to remove all the tissue. We call this necrosis of the lymph nodes.
- In 40% of men the chemotherapy has killed the aggressive cancer cells and you are left with a much less aggressive form. This is called differentiated teratoma. If this is not removed it will slowly enlarge and is likely to cause problems in the future.
- In a small number of men, about 1 in 10 there is residual active cancer which needs to be removed.

Without surgery it is not possible to confirm with certainty which type of lymph gland you have. The best available advice is that we remove all lymph glands over 1cm in size to give you the best chance of a long term cure.

It is most likely that the lymph nodes we remove from your abdomen will be benign (not cancerous). However, there is a chance that if they are left there, they will either begin to grow or change back into another cancer which occurs in about 1 in 5 men.

What are the risks of the surgery?

There are some risks that are common to all types of major surgery and some that are more specific to this surgery:

General risks of surgery include:

- bleeding at the surgical site
- infection in the wound or chest
- heart irregularities due to the anaesthetic and surgery
- blood clots in the legs (Deep Vein Thrombosis - DVT) or lungs (Pulmonary Embolism - PE).

General Advice!

We plan the surgery in advance (not an emergency) so we take precautions to avoid these risks as much as possible. However, if you need advice on smoking cessation, diet, exercise or weight loss please ask your specialist nurse.

Effects on Fertility and Sexuality

In some cases removing the lymph nodes from the abdomen can cause infertility. This is because the nerves which control ejaculation can be damaged during surgery. Your ability to achieve an erection and having an orgasm will most likely not be affected. However, you may produce less fluid or no fluid at all when you ejaculate.

The surgeon will try to avoid damaging the nerves involved in erections and ejaculation by reducing the size of the surgical

field (operation site). However it is not always possible to do this after chemotherapy, as the lymph nodes may be close to the nerve pathways. In some cases trying to preserve the nerves would increase the chances of leaving behind some of the lymph nodes. This would increase the possibility of the cancer coming back.

If, in the future, you feel that your sex life has been affected by the surgery, please discuss this with your doctor or nurse.

Effects on Blood Vessels

The affected lymph glands are often stuck to the major blood vessels in the abdomen (the aorta [main artery], and the vena cava [main vein]). The blood vessels near to a kidney may also be closely involved with the lymph glands. If this is the case then there is a risk to the blood vessels and kidney, and on rare occasions it may be necessary to repair or replace the major blood vessels with an artificial graft. In 5-10% of men it may be necessary to remove a kidney.

If either of these procedures are necessary your overall long term health should not be affected.

Are there any alternatives to this surgery?

The other treatment for testicular cancer is chemotherapy and, if appropriate for your type of germ cell cancer, you will have already received this type of treatment.

It may be possible to delay the surgery and keep you under regular review (surveillance) using CT scans. The disadvantage of this is that in many cases it is impossible to tell whether there is an active tumour present in the nodes we are monitoring. Also, there is a possibility that the lymph nodes may become larger and more complicated to operate on in the future.

What will happen if I do not have this surgery?

If you do not have the surgery to remove the lymph nodes there is the possibility that they will continue to grow. This may make any future chance of surgery more difficult or impossible. More seriously, there is a 1 in 5 chance that the lymph nodes will become cancerous again. If they do, this may be life threatening.

What does the surgery involve?

The average length of the surgery is between 4 and 10 hours. The surgeon makes a cut (incision) down the middle of the abdomen extending from the bottom of the breast bone to the pubic region. Sometimes, it is necessary to extend the incision up on to the rib cage on the right or the left side. This will heal completely but it will leave a long scar. If the incision goes on to the chest there may be tenderness in the lower rib area after the surgery as the ribs have to heal.

Before the surgery

We will ask you to attend the hospital for an assessment at the 'pre-admission clinic'. At this clinic a healthcare professional will:

- ask questions about your medical history
- assess your heart and lung function
- take a specimen of blood including tumour markers if appropriate
- take swabs from your skin to make sure that you do not have an existing infection
- ask you if you have any questions about the surgery

You will have the date for your surgery before you come to the pre-admission clinic.

Coming into hospital

We will admit you to ward 6A or 6B in Gartnavel General Hospital the day before your surgery. You will meet the other members of the team looking after you such as the anaesthetist, the ward nurses and ward doctor. Usually your stay in hospital will be about 7 to 10 days.

After the surgery

After your surgery we will transfer you to the recovery area in theatre for an hour or two. Then we will move you to the High Dependency Unit (HDU). Your stay in the HDU will probably last 48 hours until you are ready to return to the main ward. The purpose of your stay in the HDU is to monitor your blood pressure, heart rate and fluid levels very closely. The ratio of nursing staff per patient is higher than in the normal ward.

To reduce the pain in your abdomen after the surgery we will give you pain killers. The anaesthetist will discuss the different options with you:

- A pain killer device which you control. This device releases pain killers into your blood stream via a drip (Patient Controlled Analgesia).
- An epidural by which pain killers and local anaesthetic are given directly around the spinal nerves. This involves inserting a very fine plastic tube into your back and the drugs are given through this.
- A technique called pre-peritoneal block where local anaesthetic is pumped into a fine plastic tube beside the wound.

About two days after your surgery your need for these types of pain killers will be greatly reduced, and we will remove these devices. The ward staff will then give you pain killing tablets or injections instead. Please tell the staff if you are still in pain or discomfort as they many need to change your medication.

You will have a drip running into a vein in your neck to give you fluids until you are able to drink normally (about 1 to 2 days after the surgery). When you are able to drink you will then be able to start eating again. (About 2 to 4 days after surgery).

Physiotherapy

After your surgery the physiotherapists will visit you on the ward to teach you deep breathing and leg exercises. It is important that you carry out these exercises regularly as they will help to prevent a chest infection and, or blood clots in the legs which can occur as you are not moving about as much as usual.

Drain

If your surgery involves a cut that goes into your chest, the surgeon may need to put a drain into the side of your chest during your surgery. The chest drain allows the lung, which collapses during the surgery, to re-inflate. You will have a chest x-ray to make sure that the lung has re-inflated before we remove the chest drain'. Sometimes we use a stitch (small thread) below the skin to close the site. This stitch will dissolve on its own around 10 days after surgery.

Your Wound

We will put a dressing over the clips that hold the edges of the wound together. The clips usually stay in place for 10 days and the district nurse will remove these after you go home.

As well as a dressing on your wound, you will also have a drain (a small plastic tube) from your abdomen which drains away fluid from inside your wound. This will normally stay in place for 4 – 5 days.

Eating and Drinking

The amount of fluids that you can drink immediately after the surgery will be restricted. This is to prevent you from being sick. You will gradually be able to eat and drink, starting with a light diet and fluids 2-3 days after your surgery. You will be drinking and eating normally around 4 days after the surgery.

Going home

Most people are in hospital for 7 to10 days after this surgery. By the time you are ready to go home you will be looking after yourself without the need for help from others. You will feel tired when you get home and it is important that you rest. However, you should take some gradual and gentle exercise such as walking. For a few weeks after surgery you will appreciate some time to recuperate and gradually get back to normal. This may take between 6 and 12 weeks.

We will give you a letter for the district nurses and any necessary medication, such as painkillers to take home.

General advice after the surgery

Getting back to work – This depends on the type of work that you do but as a general rule you will probably need about 6 weeks off work. If your job involves manual work such as lifting then you will need about 12 weeks off work. If you are unsure about it please ask the team looking after you for advice. You can get a medical certificate for the time that you are in hospital from the ward staff. Your GP can give you a further certificate for the rest of the time you need to have off.

By 12 weeks after the surgery we would expect you to have made a 95% recovery. It will probably take 6 months for you to make a full recovery.

If taking this amount of time off work will cause any financial problems for you, we suggest that you contact your specialist nurse who can refer you to a MacMillan Benefits Advisor. This advisor can give you information on any benefits you maybe eligible for and assist you with the application forms.

Lifting – be careful about what you lift such as sport and carrier bags and small children! For the first 6 weeks, try not to lift anything.

Driving – Until you can safely carry out an emergency stop without it causing pain you should not drive. This will take about 4-6 weeks.

Follow up

You do not routinely need surgical follow up after you surgery. Further follow up will normally be under the care of your Oncologist (the consultant who treated you with chemotherapy). The results from your surgery are normally available before you go home and your consultant will discuss these with you. This includes letting you know the type of tissue found in the removed lymph nodes (pathology report). Occasionally you may be ready to go home before the results are available. In this case we will give you an out patient appointment with your Oncologist to discuss them.

Contacts:

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Out of hours:

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For further information

Macmillan Cancer Support has information on many aspects of cancer.

Freephone: **0808 808 00 00**

website: **www.macmillan.org.uk.**

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