WIDE LOCAL EXCISION OF A PENILE LESION

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 this leaflet online, scan the QR code (right) or type the shortened URL below it into your browser.

https://shorturl.at/4hhba

KEY POINTS

- The aim of this operation is to remove an abnormal area on your penis for diagnosis (if not already known) or treatment
- The procedure may be carried out under local or general anaesthesia
- Occasionally, a skin graft may be needed to cover the excision site if there is not sufficient skin available
- You may require further treatment, depending on the results

What does this procedure involve?

A wide local excision involves removing an abnormal area on your penis as treatment and/or for diagnosis. It is usually performed in an operating theatre under local or general anaesthetic. You may require a skin graft to cover the excision site. You may also be required to stay in hospital overnight and need a bladder catheter inserted after surgery.

What are the alternatives?

Alternatives to wide local excision are largely dependent on the diagnosis.

In pre-cancerous changes, chemotherapy cream or laser treatment can be used. If there is a cancer involving the foreskin, circumcision may be indicated. If there is a cancer in the glans (head) of the penis, glansectomy (removal of the head of your penis) may be required.

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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.

If you are not having local anaesthetic, an anaesthetist will see you to discuss the options of a general anaesthetic or spinal anaesthetic. The anaesthetist will also discuss pain relief after the procedure with you.

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

Details of the procedure

The length of the operation depends on the extent of the excision and whether a skin graft has been performed.

If a skin graft is needed, we usually take a partial thickness graft from your thigh (although other areas may be used). All the wounds are closed with absorbable sutures. We usually apply a dressing at the end of the procedure, and this may be stitched in place. You may also require a bladder catheter; if so, it will be put in through your urethra (waterpipe) at the end of the procedure, before you leave the operating room.

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
Discomfort & temporary bleeding from the operative site	 Almost all patients
Altered appearance & sensation in the area of the penis where surgery has been performed	 Almost all patients

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Further treatment may be required if cancer is diagnosed		Between 1 in 10 & 1 in 50 patients
Wound infection requiring treatment with antibiotics		Between 1 in 10 & 1 in 50 patients
Skin graft failure (if a graft has been used)		Between 1 in 50 & 1 in 250 patients
Negative impact on sexual function (from reduced sensation) and/or altered urinary function (spraying of your urinary stream)		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 and death) if a general anaesthetic is used		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. Individual hospitals may have different rates, and the medical staff can tell you the risk for your hospital. You have a higher risk if you have had:

- long-term drainage tubes (e.g. catheters);
- long hospital stays;
- multiple hospital admissions; or
- a compromised immune system (e.g. diabetes)

What can I expect when I get home?

You can expect some discomfort and blood from the surgical site. Sometimes, the dressing does not stay in place; do not worry about this. If you have a skin graft, or the dressing is stitched in place, you will be given contact details and a follow-up for wound review on discharge.

It usually takes up to 14 days until the results of the pathology analysis 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.

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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 Smoke-Free National Helpline on **0300 123 1044**.

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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.

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.

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