

Informed Consent Radical and Simple Orchiectomy

This information is given to you so that you can make an informed decision about having **Radical and Simple Orchiectomy**.

Reason and Purpose of the Procedure

Orchiectomy means “removal of a testicle”. Most often this procedure is presumed to be a diagnosis of testicular cancer, and referred to as a radical orchiectomy. In this operation, the testicle and the majority of the spermatic cord is removed through the groin region. In a simple orchiectomy, the testicle and just a short segment of the spermatic cord is removed, simple orchiectomies are performed for reasons of infection or chronic pain. Both testicles can be removed to temporarily help in the treatment of prostate cancer.

Benefits of this surgery

You might receive the following benefits. Your doctor cannot promise you will receive any of these benefits. Only you can decide if the benefits are worth the risk.

- Removal of cancerous organ.
- Decreased Pain
- Decreased testosterone production to slow prostate cancer.

Risks of Surgery

No procedure is completely risk free. Some risks are well known. There may be risks not included in the list that your doctor cannot expect.

General risks of surgery

- **Small areas of the lungs may collapse.** This would increase the risk of infection. This may need antibiotics and breathing treatments
- **Clots may form in the legs, with pain and swelling.** These are called DVTs or deep vein thrombosis. Rarely, part of the clot may break off and go to the lungs. This can be fatal
- **A strain on the heart or a stroke may occur**
- **Bleeding may occur.** If bleeding is excessive, you may need a transfusion
- **Reaction to the anesthetic may occur.** The most common reactions are nausea and vomiting. In rare cases, death may occur. The anesthesiologist will discuss this with you

Risks of this surgery

- **Infection:** Infection is possible as a result of any procedure.
- **Persistence of Infection:** In patients who undergo simple orchiectomy for reasons of infection, there is a chance that further surgery may be required to control the infection; this is more common in patients who are diabetic.
- **Hematoma:** This is when small blood vessels continue to ooze or bleed after the procedure is over. Further procedures may be needed.
- **Chronic Pain:** As with any procedure, a patient can develop chronic pain in an area that has undergone surgery.
- **Paresthesia:** There are small nerves that run alongside of the spermatic cord. If damaged it is possible to have numbness in the area. In most cases the sensation comes back over time. Rarely does the area stay numb forever.
- **Excessive blood loss:** These procedures are usually associated with minimal bleeding. There are very rare cases in which one of the arteries in the spermatic cord can open after the incision is closed. If this happens blood loss can be significant, and may require a transfusion, and require a further surgery to stop the bleeding.

Risks associated with smoking

Smoking is linked to an increased risk of infections. It can also lead to heart and lung complications and clot formation.

Risks Associated with Obesity

Obesity is linked to an increased risk of infections. It can also lead to heart and lung complications and clot formation.

Risks Specific to You

Alternative Treatments**Other choices:**

- Do nothing. You can decide not to have the procedure.

If you choose not to have this treatment

- Cancerous tissue may continue to grow and spread throughout the body.
- Pain may continue
- Infection may continue.

General Information

- During this procedure, the doctor may need to perform more or different procedures than I agreed to.
- During the procedure the doctor may need to do more tests or treatment.
- Tissues or organs taken from the body may be tested. They may be kept for research or teaching. I agree the hospital may discard these in a proper way.
- Students, technical sales people and other staff may be present during the procedure. My doctor will supervise them.
- Pictures and videos may be done during the procedure. These may be added to my medical record. These may be published for teaching purposes. My identity will be protected.

Patient Name: _____

DOB: _____

By signing this form I agree

- I have read this form or had it explained to me in words I can understand.
 - I understand its contents.
 - I have had time to speak with the doctor. My questions have been answered.
 - I want to have this procedure: Right Left **Radical and Simple Orchiectomy**
-
- I understand that my doctor may ask a partner to do the surgery.
 - I understand that other doctors, including medical residents or other staff may help with surgery. The tasks will be based on their skill level. My doctor will supervise them.

Provider: This patient may require a type and screen or type and cross prior to surgery. IF so, please obtain consent for blood/product.

Patient Signature _____ Date: _____ Time: _____

Relationship: Patient Closest relative (relationship) _____ Guardian

Interpreter's Statement: I have translated this consent form and the doctor's explanation to the patient, a parent, closest relative or legal guardian.

Interpreter: _____ Date _____ Time _____

Interpreter (if applicable)

For Provider Use ONLY:

I have explained the nature, purpose, risks, benefits, possible consequences of non-treatment, alternative options, and possibility of complications and side effects of the intended intervention, I have answered questions, and patient has agreed to procedure.

Provider signature: _____ Date: _____ Time: _____

Teach Back

I have explained the nature, purpose, risks, benefits, possible consequences of non-treatment, alternative options, and possibility of complications and side effects of the intended intervention, I have answered questions, and patient has agreed to procedure.

Patient shows understanding by stating in his or her own words:

____ Reason(s) for the treatment/procedure: _____

____ Area(s) of the body that will be affected: _____

____ Benefit(s) of the procedure: _____

____ Risk(s) of the procedure: _____

____ Alternative(s) to the procedure: _____

OR

____ Patient elects not to proceed: _____ Date: _____ Time: _____

(patient signature)

Validated/Witness: _____ Date: _____ Time: _____