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Patient ID label

Laparoscopic (±Open) Oesophago-Gastrectomy Consent Sheet (LOG1)

**Patient
Initials**

I am requesting that **laparoscopic (±open) oesophago-gastrectomy** (keyhole ±open surgery to remove part of my gullet and stomach) be performed on me as a form of therapy to treat my cancer. I have had explained to me the alternatives, benefits and risks of this procedure as listed below and during my preoperative appointments.

I understand that my treatment options for cancer of the oesophagus include supportive treatment (which aims only to treat my symptoms and not cure my cancer), palliative chemotherapy (which aims to slow down the growth of my cancer and prolong my life expectance by a few months), or curative treatment. I understand the option of curative treatment may include receiving chemotherapy medication before and/or after surgery. I understand surgery entails major abdominal and chest surgery aiming to remove the cancer and associated lymph glands.

I understand that this surgical procedure has the risk of different types of complications, which may require elective or emergency medical or surgical (reoperation) treatment. I also understand that there are things the surgeon can do to reduce the risks of surgery but not eliminate the risks of surgery or prevent all complications. I understand some of these complications may occur many years down the line following surgery.

I understand that **potential GENERAL complications of this surgery may include (but not limited to):**

- Wound infection that may require drainage and/or antibiotics. Future wound hernias that may require another operation to treat.
- Bleeding that may require blood transfusion and/or re-operation.
- Blood clots which may form in the legs causing pain and swelling or, rarely, blockage of veins in the lungs leading to breathing problems which may be life threatening or fatal (pulmonary embolism).
- Injury to internal organs that may require re-operation. These organs include the heart, lung, oesophagus (gullet), stomach, liver, spleen, intestines, bowel and blood vessels.
- (If keyhole surgery) the need to convert to an open operation if the surgeon cannot remove my cancer safely by the keyhole technique.
- Future bowel blockage (obstruction) due to scar tissue “adhesions” or future internal hernias that may require further surgery to treat.
- Death that may result from any severe complication despite maximal medical or surgical therapy.

I understand that **potential complications SPECIFIC to this type of operation may include (but not limited to):**

- Occurrence of chest infection (pneumonia) or fluid on the lung that may require treatment with antibiotics/insertion of chest drains. This may prolong my hospital stay and delay my recovery.
- Occurrence of anastomotic leak (leak from the joins between my bowel) or chyle (fatty fluid) leak that may require a drain to be inserted or major reoperation, followed by prolonged hospital stay.
- Occurrence of narrowing at the anastomosis which may cause difficult swallowing and poor nutrition. This may require further treatment with repeat endoscopic dilatations or (rarely) further surgery.
- Nutritional deficiencies after my surgery which may require treatment with supplements.
- Occurrence of dumping syndrome (abdominal cramps, light-headedness and diarrhoea) after eating certain foods. This may reduce my quality of life.
- I understand it may be months after surgery before I regain my quality of life.
- I understand that even despite surgical and chemotherapy treatment, my cancer may recur in future.

Patient Name: _____ **Patient Signature:** _____

Staff Name: _____ **Staff Signature:** _____ **Designation:** _____

Date: _____