

Laparoscopic nephrectomy (including nephroureterectomy)

HealthTech guidance

Published: 24 August 2005

www.nice.org.uk/guidance/htg84

Your responsibility

This guidance represents the view of NICE, arrived at after careful consideration of the evidence available. When exercising their judgement, healthcare professionals are expected to take this guidance fully into account, and specifically any special arrangements relating to the introduction of new interventional procedures. The guidance does not override the individual responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or guardian or carer.

All problems (adverse events) related to a medicine or medical device used for treatment or in a procedure should be reported to the Medicines and Healthcare products Regulatory Agency using the [Yellow Card Scheme](#).

Commissioners and/or providers have a responsibility to implement the guidance, in their local context, in light of their duties to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity, and foster good relations. Nothing in this guidance should be interpreted in a way that would be inconsistent with compliance with those duties. Providers should ensure that governance structures are in place to review, authorise and monitor the introduction of new devices and procedures.

Commissioners and providers have a responsibility to promote an environmentally sustainable health and care system and should [assess and reduce the environmental impact of implementing NICE recommendations](#) wherever possible.

Contents

1 Recommendations	4
2 The procedure	5
2.1 Indications	5
2.2 Outline of the procedure	5
2.3 Efficacy	6
2.4 Safety	6
2.5 Other comments	7
3 Further information	8
Sources of evidence	8
Information for patients	8
Update information	9

This guidance replaces IPG136.

1 Recommendations

- 1.1 Current evidence on the safety and efficacy of laparoscopic nephrectomy (including nephroureterectomy) appears adequate to support the use of this procedure provided that the normal arrangements are in place for consent, audit and clinical governance.
- 1.2 Patient selection is important when this procedure is being considered for the treatment of malignant disease. Long-term follow-up data are lacking, and clinicians are encouraged to collect data on rates of recurrence in patients with malignant disease.

2 The procedure

2.1 Indications

- 2.1.1 Indications for nephrectomy (including nephroureterectomy) include renal cell or urethral cancer and benign conditions that lead to a poorly functioning or non-functioning kidney. These benign conditions may be due to or associated with symptomatic hydronephrosis, chronic infection, polycystic kidney disease, dysplastic kidney, hypertension and renal calculus.
- 2.1.2 The standard treatment for an irreversibly damaged kidney or localised kidney cancer is an open nephrectomy. Under general anaesthesia, the kidney is removed through an incision in the loin or the front of the abdomen.

2.2 Outline of the procedure

- 2.2.1 A transperitoneal or retroperitoneal approach may be used for laparoscopic nephrectomy. In the transperitoneal approach, the abdomen is insufflated with carbon dioxide through a trocar and then three or four small abdominal incisions are made. In the retroperitoneal approach, a small incision is made in the back and a dissecting balloon is inserted to create a retroperitoneal space. After the balloon is removed, the space is insufflated with carbon dioxide and two or three additional small incisions are made in the back for the laparoscopic instruments. The kidney is freed by laparoscopic dissection, and is then enclosed in a bag and removed through an appropriate incision or placed in an impermeable sac, morcellated and removed through one of the port sites. The ureter is sometimes removed along with the kidney (laparoscopic radical nephroureterectomy).
- 2.2.2 Hand-assisted laparoscopic nephrectomy allows the surgeon to place one hand in the abdomen while maintaining the pneumoperitoneum required for laparoscopy. An additional small incision is made which is just large enough for the surgeon's hand, and an airtight 'sleeve' device is used to form a seal around the incision.

2.3 Efficacy

- 2.3.1 One non-randomised comparative study of 100 patients with renal cell carcinoma reported that there was no statistically significant difference in the estimated 5-year disease-free survival rate for laparoscopic and open nephrectomy (95.5% versus 97.5%, respectively). A case series of 157 patients with renal cell carcinoma who had the laparoscopic procedure reported an estimated 5-year disease-free survival rate of 91%.
- 2.3.2 Two non-randomised comparative studies, including 209 patients with upper urinary tract transitional cell carcinoma, reported no difference in recurrence rates between laparoscopic and open nephroureterectomy.
- 2.3.3 Two non-randomised comparative studies found that significantly less analgesia was required after laparoscopic nephrectomy than after open surgery. In a further two non-randomised comparative studies, the mean hospital stay ranged from 5.2 days to 8.9 days for open surgery, compared with 3.4 days to 6.8 days for laparoscopic surgery ($p < 0.001$). In one study, the mean convalescence period was also significantly shorter for laparoscopic surgery: 23 days compared with 57 days for open surgery ($p < 0.001$). For more details, refer to the [overview](#).
- 2.3.4 The Specialist Advisors did not express any concerns about the efficacy of this procedure when performed by trained operators. However, they noted that there was a lack of data from randomised controlled trials.

2.4 Safety

- 2.4.1 Three non-randomised comparative studies reported complication rates for laparoscopic nephrectomy that were not significantly different from those for open nephrectomy. Six studies reported rates of conversion to open surgery: this occurred in 0% (0/54) to 10% (46/482) of procedures.
- 2.4.2 The complications reported in a large case series of 482 procedures (461 patients) included bleeding in 5% (22/482), re-intervention in 3% (15/482) and bowel injury in less than 1% (3/482). Other complications reported in the studies included paralytic ileus in 3% (2/60) of patients; injury to arteries in 3% (2/60), the

spleen in 2% (1/60) and the adrenal gland in 2% (1/60); and urinary tract infection in 1% (2/157). Two case series reported mortality rates of less than 1% (2/263) and 1% (2/157). For more details, refer to the [overview](#).

- 2.4.3 The Specialist Advisors stated that potential adverse events included major haemorrhage from renal vessels, bowel injury and the need for conversion to open surgery.

2.5 Other comments

- 2.5.1 It was noted that training and competence in laparoscopic techniques were important for surgeons undertaking this procedure.

3 Further information

Sources of evidence

The evidence considered by the committee is in the [overview](#).

Information for patients

NICE has produced [information on this procedure for patients and carers](#). It explains the nature of the procedure and the guidance issued by NICE, and has been written with patient consent in mind.

Update information

Minor changes since publication

January 2026: Interventional procedures guidance 136 has been migrated to HealthTech guidance 84. The recommendations and accompanying content remain unchanged.

ISBN: 978-1-4731-9080-1

Endorsing organisation

This guidance has been endorsed by [Healthcare Improvement Scotland](#).