

# Laparoscopic deroofing of simple renal cysts

Interventional procedures guidance

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[www.nice.org.uk/guidance/ipg226](https://www.nice.org.uk/guidance/ipg226)

## 1 Guidance

- 1.1 Current evidence on the safety and efficacy of laparoscopic deroofing of simple renal cysts is adequate to support the use of this procedure provided that normal arrangements are in place for consent, audit and clinical governance.
- 1.2 Patient selection for this procedure is important because most renal cysts do not cause symptoms and do not require treatment. Clinicians should take steps to predict whether deroofing is likely to relieve symptoms, usually by observing the effect of cyst aspiration. Laparoscopic deroofing should not be performed for renal cysts that are asymptomatic.

## 2 The procedure

### 2.1 Indications

- 2.1.1 Simple renal cysts typically have thin walls with no calcification, septation or enhancement shown on contrast studies. Solitary simple cysts are common and are often diagnosed incidentally. In the minority of patients who are symptomatic, pain is the most frequent complaint.
- 2.1.2 Symptomatic renal cysts can be managed with analgesic medication, needle aspiration (with or without administration of a sclerosant) and open surgical cyst deroofing if aspiration is unsuccessful at relieving symptoms in the long term. In some patients, a nephrectomy may be necessary. Asymptomatic cysts do not usually require any treatment.
- 2.1.3 Laparoscopic deroofing is not used if there is any suspicion of malignancy. The management of polycystic kidney disease is different from that of simple renal cysts and is therefore not addressed in this guidance.

### 2.2 Outline of the procedure

- 2.2.1 Laparoscopic deroofing of renal cysts is usually performed under general anaesthesia, using a retroperitoneal or transperitoneal approach. In the former, a small incision is made in the back and a dissecting balloon is inserted to create a space in the retroperitoneal tissues. In both approaches, carbon dioxide insufflation is used and small incisions are made to provide access for the laparoscope and surgical instruments. Ultrasonography may be used to help locate the cyst, which is usually aspirated, and part of the cyst wall is then excised. Fat or omentum may be interposed to prevent recurrence.

### 2.3 Efficacy

- 2.3.1 In a non-randomised controlled trial of patients with symptomatic simple renal cysts, pain recurred in all 5 patients treated with cyst aspiration and

sclerotherapy at a mean follow-up of 17 months, whereas all 7 patients treated with laparoscopic deroofing were pain-free at a mean follow-up of 18 months.

- 2.3.2 In five case series of patients with symptomatic simple renal cysts (155 patients in total), the proportion of patients who were symptom-free ranged from 91% (41/45) after a mean follow-up of 52 months to 100% (20/20) after a mean follow-up of 6 months.
- 2.3.3 Four of these case series reported rates of cyst recurrence as 0% (0/13) after 6 months, 13% (3/23) after 34 months, 4% (2/45) after 39 months and 19% (7/36) after 67 months. For more details, refer to the 'Sources of evidence' section.
- 2.3.4 Some Specialist Advisers expressed no concerns about efficacy. Others stated that there is a possibility that cysts may refill after the procedure. The Advisers considered patient selection to be important because not all cysts cause symptoms.

## 2.4 Safety

- 2.4.1 Four studies of patients with simple renal cysts (91 patients in total) each reported one case of haemorrhage (overall incidence 4%). In two patients the cyst excision margin bled excessively; one case required conversion to open surgery but the other was controlled by an intracorporeal suture. Self-limited retroperitoneal bleeding occurred in one patient (in whom a retroperitoneal approach was used) and reactionary haemorrhage occurred in another. One study reported that 1 of 9 patients had prolonged ileus. One study reported wound infection in 8% (2/24) of patients and urine leakage in 4% (1/24).
- 2.4.2 In a case series of 17 patients, a cyst wall carcinoma was identified during one procedure and an open nephrectomy was performed immediately. No findings of malignancy were reported in three other case series (of 29, 20 and 36 patients, respectively). For more details, refer to the 'Sources of evidence' section.
- 2.4.3 The Specialist Advisers stated that theoretical adverse outcomes include

haematuria, urinary tract infection, port site infection, urine leakage (from a parapelvic cyst), intraoperative bleeding, conversion to open surgery or nephrectomy, and injury to other internal organs or major blood vessels.

## 3 Further information

- 3.1 The Institute has published interventional procedures guidance on [laparoscopic nephrectomy \(including nephroureterectomy\)](#) and is developing a clinical guideline on chronic kidney disease [Now published as ['Early identification and management of chronic kidney disease in adults in primary and secondary care'](#)].

Andrew Dillon  
Chief Executive  
July 2007

## Sources of evidence

The evidence considered by the Interventional Procedures Advisory Committee is described in the following document.

['Interventional procedure overview of laparoscopic deroofing of simple renal cysts'](#), December 2006.

## Information for patients

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

## 4 About this guidance

NICE interventional procedure guidance makes recommendations on the safety and efficacy of the procedure. It does not cover whether or not the NHS should fund a procedure. Funding decisions are taken by local NHS bodies after considering the clinical effectiveness of the procedure and whether it represents value for money for the NHS. It is

for healthcare professionals and people using the NHS in England, Wales, Scotland and Northern Ireland, and is endorsed by Healthcare Improvement Scotland for implementation by NHSScotland.

This guidance was developed using the NICE [interventional procedure guidance](#) process.

We have produced a [summary of this guidance for patients and carers](#). Information about the evidence it is based on is also [available](#).

## **Changes since publication**

14 January 2012: minor maintenance.

## **Your responsibility**

This guidance represents the views of NICE and was arrived at after careful consideration of the available evidence. Healthcare professionals are expected to take it fully into account when exercising their clinical judgement. This guidance does not, however, override the individual responsibility of healthcare professionals to make appropriate decisions in the circumstances of the individual patient, in consultation with the patient and/or guardian or carer.

Implementation of this guidance is the responsibility of local commissioners and/or providers. Commissioners and providers are reminded that it is their responsibility to implement the guidance, in their local context, in light of their duties to avoid unlawful discrimination and to have regard to promoting equality of opportunity. Nothing in this guidance should be interpreted in a way which would be inconsistent with compliance with those duties.

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## Endorsing organisation

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