Declaration of Disclosure and Expression of Consent to the Medical Procedure Recommended by the S.I.C.

I, the undersigned _____, born in _____, on _____, declare that I have been informed, both during the initial consultation and during hospitalization, in a clear and understandable manner by Prof./Dr. _____ that surgery is indicated for the **ADRENAL PATHOLOGY** diagnosed in me: _____.

I have been clearly informed that the adrenal mass from which I am affected is benign □ certainly or probably malignant □ hyperfunctioning □ nonfunctioning □.

I have been informed that, in light of the preoperative investigations performed, the planned procedure will consist of: **ADRENALECTOMY** Right □ Left □ Bilateral □ **Laparoscopic approach** □ **Open approach (laparotomy)** □, to be performed under **general anesthesia**. I have also been informed that it may become necessary to modify the procedure on the basis of intraoperative assessment, either by extending the resection to adjacent organs or structures (kidney, pancreas, spleen, etc.) or by converting the laparoscopic approach to laparotomy because of intraoperative findings or technical reasons.

The goals and expected benefits of the proposed treatment have been clearly explained to me, including in relation to alternative treatments such as medical therapy, together with the foreseeable risks and/or possible impairments.

I have been informed that this procedure may involve complications including:

- **injury to the spleen**, particularly in the case of left adrenalectomy, with the possible need for splenectomy; this may lead postoperatively to thrombocytosis, with a risk of thrombosis, and, especially in younger patients, immune dysfunction and increased susceptibility to infection.
- **pancreatic injury** with consequent **acute pancreatitis**, particularly in the case of left adrenalectomy;
- **postoperative bleeding and hematomas, as well as injury to major abdominal vessels**, which may require reoperation for hemostasis and/or blood transfusions, with the related infectious risk;
- the onset of **deep venous thrombosis** and possible **pulmonary embolism**.
- formation of an **incisional hernia** at the surgical wound site, which may require reconstructive abdominal wall surgery.
- **conversion to an open approach (laparotomy)**, if the procedure is started endoscopically and cannot be completed because of technical difficulties or complications not manageable endoscopically.
- formation of a **pleural effusion** and/or **pneumothorax**, with possible need for pleural drainage, whether the operation is performed laparoscopically or through a lumbotomy approach.
- onset of intraoperative blood pressure alterations (**hypertensive crises, hypotension**), with possible **cerebro-cardiovascular complications** (stroke, cardiac arrhythmias, myocardial infarction, heart failure), especially in surgery for pheochromocytoma.
- possible need for a so-called **completion reoperation**, should the final histologic examination reveal a malignant neoplastic disease not otherwise predictable.

- possible need for **extended resection involving adjacent organs** (liver, spleen, kidney, pancreas, diaphragm, bowel) if required by intraoperative findings.

- **infection** of the surgical wound(s).

- **general complications** (affecting the heart, lungs, kidneys, liver, brain, etc.), which may occur especially in elderly patients and/or in those with significant organ disease (coronary artery disease, renal, hepatic, or respiratory failure) or systemic disease (diabetes, metabolic disorders, debilitated condition), as may occur during or after any anesthetic, surgical, pharmacologic, or other medical procedure.

Other possible complications may include: _____

I have been informed that, following the operation, complete and certain resolution of arterial hypertension, if present, cannot be predicted, and that one or more surgical scars will in any case remain.

The surgeon has also adequately informed me of the incidence of these complications (including within his/her own Unit), explaining that surgery, regardless of the route of access and even when performed with meticulous technique, cannot be considered risk-free, and that the incidence of complications may be increased by the associated disease(s) from which I suffer: _____.

I have also been informed that, in the event of removal of a pathologic adrenal gland secreting corticosteroids, I may need corticosteroid hormone replacement therapy for a variable period, possibly lifelong, especially in the case of bilateral adrenalectomy, in order to prevent acute adrenal insufficiency. I have also been informed that one or more abdominal and/or lumbar scars will in any case remain.

I am also aware that, should it become necessary to save me from an imminent and otherwise unavoidable danger of serious harm, or should difficulties arise in carrying out the operation with the proposed technique, all measures deemed appropriate by the treating physicians will be undertaken to avert or limit such danger and, in any case, to complete the procedure in the safest possible manner, including modification of the treatment plan previously proposed to me. Having understood the above, I declare that I have been invited to read carefully everything set forth in this document, which corresponds to what has been fully explained to me orally.

I further declare that I have fully understood the meaning of what has been explained to me and that I have no further questions beyond those already answered. Therefore, knowingly, **I consent** □ **I do not consent** □ to the proposed surgical treatment, which will be performed by the team of this Unit.

I authorize □ **I do not authorize** □ the treating physicians, should other conditions not previously diagnosed become evident during surgery, to proceed, according to their professional judgment and conscience, with the treatment of such conditions, including modification of the therapeutic plan previously proposed to and agreed upon with me.

I authorize □ **I do not authorize** □ the use of any tissues and/or organs removed during treatment for the purpose of establishing a histopathologic diagnosis, as well as for procedures aimed at improving scientific knowledge.

Furthermore, **I consent** □ **I do not consent** □ to the taking of photographic and/or video recordings during diagnostic and/or therapeutic procedures and to their use in the medical field for the advancement of scientific knowledge, with full protection of my privacy.

Date _____

Physician's signature

Patient's signature