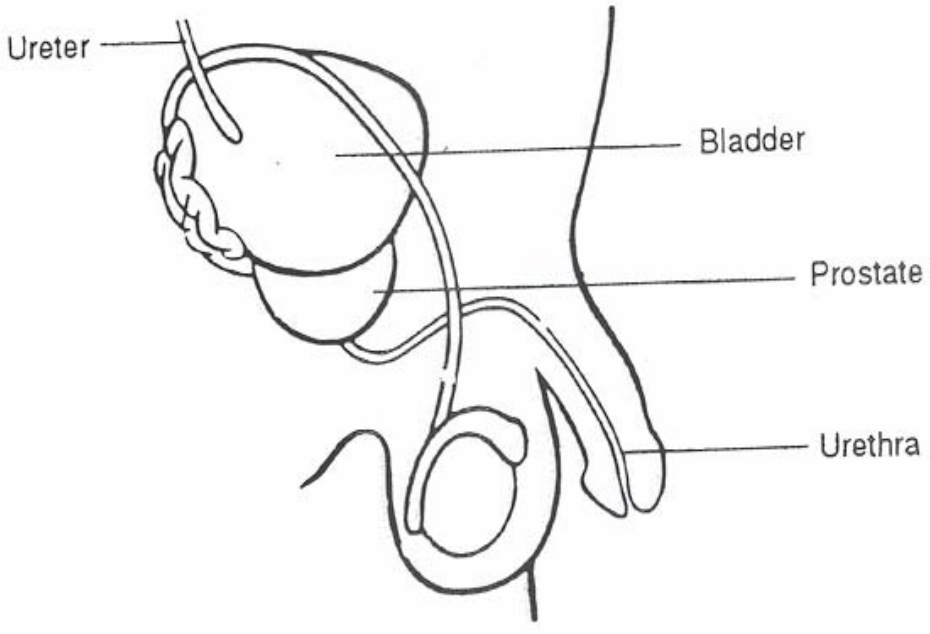
RADICAL PROSTATECTOMY PATIENT INFORMATION

The information contained in this booklet is intended to assist you in understanding your proposed surgery; some of the content may or may not apply to you. Feel free to discuss any issues and questions you may have about your surgery with the medical and nursing staff looking after you. If required, your nurse will arrange for an interpreter to assist with explaining the contents of the booklet. The interpreter can also be present for doctors' consultations. Please bring this book with you to hospital as it is a useful guide.

What is the Prostate?

The prostate gland sits just below the bladder and surrounds the neck of the bladder and the beginning of the urethra (the tube through which urine is passed). The prostate produces fluid that propels the sperm during ejaculation and provides the sperm with nourishment.

Sometimes the cells in the prostate gland become malignant (cancerous). If it is likely that the cancerous cells have not spread outside the prostate gland, the surgical option for treating the cancer is called a Radical Prostatectomy.



What is a Radical Prostatectomy?

A Radical Prostatectomy is the removal of the entire prostate gland and the seminal vesicles (two fluid storage glands near the prostate). In some cases the pelvic lymph nodes are also removed.

The pelvic lymph nodes are part of the defence system of the body and drain the prostate gland. The pelvic lymph nodes may be removed if the cancer is of a higher grade or near the edges of the prostate. This is done to reduce the risk of the cancer spreading and to help the surgeon determine the extent of the cancer at a microscopic level.

Potential Complications

All urological surgical procedures carry a small risk of bleeding and wound, chest and urinary tract infection. You will be monitored for these risks and treated promptly if they occur.

- **Excessive bleeding**
  Your wound, drain(s) and vital signs (blood pressure and pulse) will be monitored for signs of excessive bleeding.

- **Infection**
  Your chest, wound and urine will be monitored for early signs of infection and intervention will be put in place if it occurs. To reduce the risk of infection antibiotics are given directly into your bloodstream during your operation and continued post-operatively if necessary. You can also assist with the prevention of infection by maintaining good hygiene and doing your deep breathing exercises. Early mobilisation also helps.

- **Prolonged bowel inactivity (paralytic ileus)**
  There is a small risk of paralytic ileus following any major

surgical procedure that involves handling of the bowel, prolonged anaesthetic time or large amounts of strong pain killing medication. This means the intestinal tract is very slow to return to its normal function. If a paralytic ileus occurs you are likely to experience nausea, vomiting, a bloated abdomen and/or intestinal cramps. These symptoms can be relieved by the use of a nasogastric tube to drain the stomach's normal secretions while the bowel rests and recovers.

- **Incisional hernia**
  As a wound heals, scar tissue forms creating a bond between the two sides of the incision. The scar tissue is strong but can still occasionally tear or give way. This leads to a bulge developing along the scar (incisional hernia) usually within one to five years after surgery. A hernia may not cause any discomfort but if it is troublesome it may require repair.

- **Incontinence**
  Some men may have problems with urinary control. Mostly this difficulty is only temporary and will usually improve with time. Pelvic floor exercises, described later in this booklet, are recommended to help strengthen the muscles involved with urinary control. You should practise these pelvic floor exercises prior to your surgery.

- **Impotence**
  In order to ensure complete removal of the prostate and clearance of the cancer, the nerves that enable erections may be damaged during surgery. Any damage to these nerves can result in either partial or total impotence. In some men erection difficulties may be temporary; the degree of potency that returns will depend on age, smoking and potency prior to surgery. Sexual function can continue to improve for up to two years after surgery but because of the removal of the prostate and seminal vesicles ejaculation will not return. However, you may experience a normal orgasm.

If you experience impotence that is ongoing, there are some possible solutions to this problem. Unfortunately, none of these are currently government-funded.

- tablets
- prostaglandin injections
- vacuum devices
- penile implants

- **Stricture**
  As part of this surgery, the urethra is cut and then rejoined to the bladder to enable the complete removal of the prostate. In a small number of cases this new join between the bladder and urethra forms scar tissue. This scar tissue may cause your urine stream to become weaker over time. If necessary, a simple operation can correct this at a later date.

- **Infertility**
  Infertility will occur as a result of the removal of the entire prostate gland and seminal vesicles. If infertility is a concern for you, please discuss this with your doctor.

Length of Stay

The usual length of stay is five to seven days. However, if you need to stay longer for a medical reason, this will be discussed with you.

Before Surgery

Informed consent

After consultation with the doctor you will be asked to sign a form to give written consent for the surgeon to perform the operation and for an anaesthetic to be administered. Relevant sections of the form must also be completed if you agree to a blood transfusion and/or if your particular surgery involves the

removal of a body part and you wish to have this returned. Our expectation is that you feel fully informed about all aspects of your surgery before giving written consent. The following health professionals are available to help you with this process.

Nurses

A nurse will explain what to expect before and after surgery. Please ask questions and express your concerns; your family or people close to you are welcome to be involved.

When you are discharged from hospital your nurse will arrange for you to receive ongoing support, advice and practical help, if needed.

Cancer Society

You may wish to contact the Cancer Society. This organisation can provide information, counselling and arrange help such as nursing care and involvement in support groups.

Tests

Blood samples

Samples of your blood will go the laboratory to check your general health before surgery.

Blood transfusions

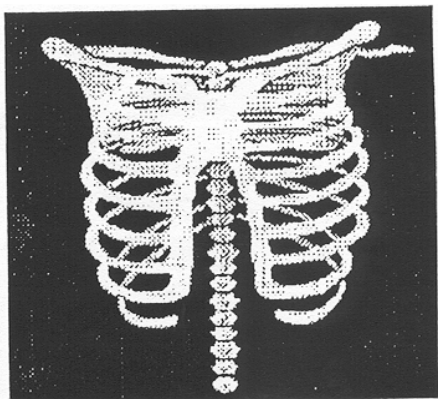
A sample of your blood will go to the blood bank to identify your blood type so this can be matched with donated blood. This donated blood is then ready for transfusion during or after surgery if required. **We will need your written consent before a transfusion is able to take place.**

Midstream urine

A sample of your urine is sent to the laboratory to check that there is no bacteria.

Chest x-ray

If requested by the doctor or anaesthetist, a chest x-ray will be performed to check on the health of your lungs.



ECG

An electrocardiogram (ECG) of your heart may be required depending on your age and any diagnosed heart conditions.

Other measures

Nil by mouth

As your stomach should be empty before an anaesthetic, you must not eat anything or drink milk products six hours prior to surgery. You may, however, be able to drink clear fluids up to two hours before surgery - the Pre-Admission Clinic or ward nurse will clarify this with you.

Bowels

You will have been given an enema to use at home. This empties the lower bowel and helps to prevent constipation after surgery.

Breathing exercises

Breathing exercises will be taught to you by your nurse or physiotherapist pre-operatively. They are important as they help to keep your lungs clear of fluid and prevent chest infection. They should be carried out regularly after surgery by

supporting your abdomen with a soft pillow, taking four to five deep, slow breaths, then one deep cough.

Leg exercises

Leg exercises help keep muscle tone and promote the return of blood in your leg veins to your heart. These include pedalling the feet, bending the knees and pressing the knees down into the mattress.

Do not cross your legs - this squashes your veins causing obstruction to the blood circulation

Anti-embolus stockings

These are special stockings that help prevent clotting of the blood in your veins while you are less mobile. The stockings are used in combination with leg exercises and are fitted by your nurse before your surgery. If you currently have leg ulcers, please let your nurse know as the stockings may not be suitable for you.

Wound site – What to expect

Your wound will be abdominal and the suture line (staples or stitches) will extend from below your naval to the pubic bone. Sutures are usually removed seven to ten days after surgery.

After Surgery

You are transferred to the Recovery Room next to the theatre. Your condition is monitored and when you are awake and comfortable a nurse and an orderly will escort you back to the ward on your bed.

On the ward

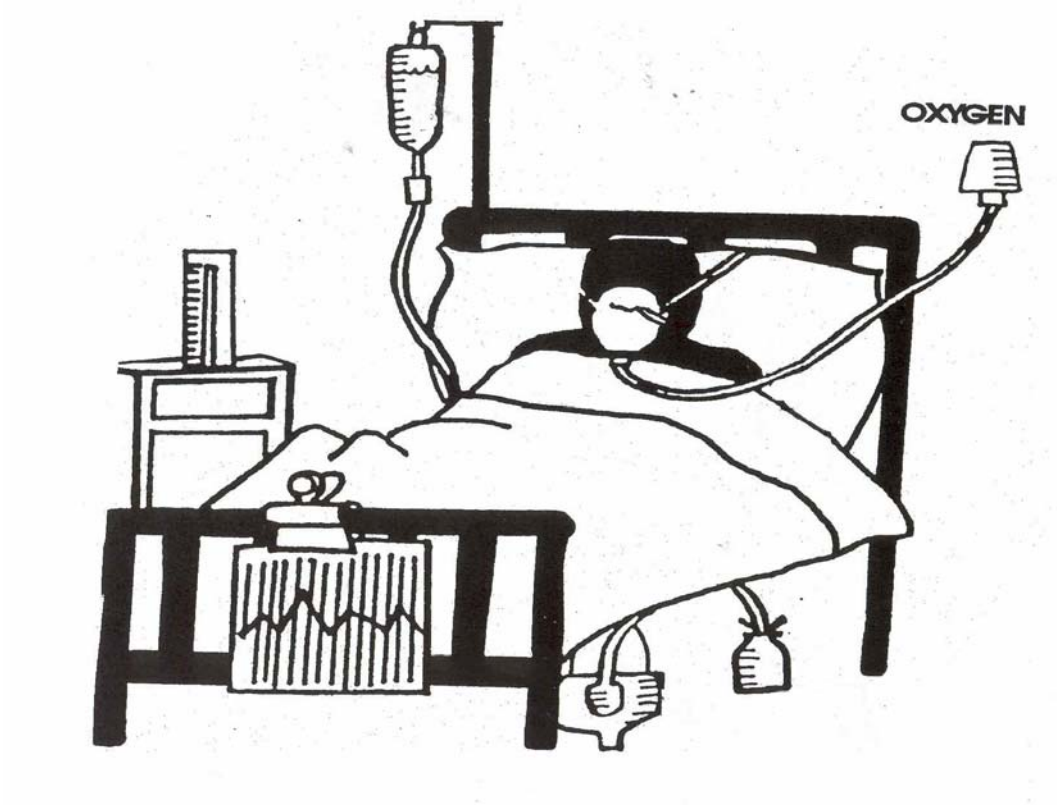
Your nurse will check the following regularly:

- Vital signs - your blood pressure, pulse, respiration rate and temperature
- The severity and location of any pain or discomfort
- The amount of urine you are producing
- The wound site and wound drain(s)
- The effectiveness of pain relief
- The amount of oxygen in your blood

You may have

Intravenous fluids

A small tube (leur) is placed into a vein in the forearm to give you fluids and medications.



Oxygen

Oxygen is often given for the first 24 hours after surgery via nasal prongs or a facemask to help with breathing and healing.

Urinary catheter
You will have a tube in the urethra that drains urine from your bladder. This tube must be secured to your leg for comfort and to prevent any tugging that may damage the newly rejoined urethra. Please inform your nurse if your catheter is not secure.

Wound drain
You will have a wound drain that drains blood and fluids from the operation site. The drain also enables early detection of any urine leakage that may occur at the urethra/bladder join.

Pain relief after your surgery
Your nurse will work alongside your doctors and the anaesthetist to keep your pain at a minimum.

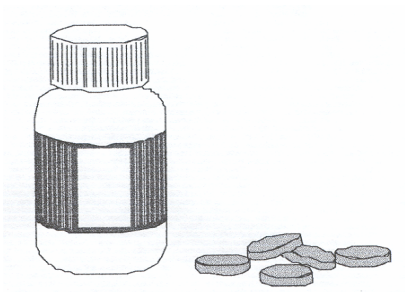
The **PAIN SCORE** is a way of your nurse establishing how much pain you are experiencing by asking you to grade your pain from 0 to 10 where 0 = no pain and 10 = the worst pain you can imagine.

The following methods of pain relief may be used singly or in combination with each other.

Patient controlled analgesia (PCA)
This infusion machine has a button you press each time you need pain relief. It will help your pain by immediately delivering a specific amount of pain relief into your blood stream. The pump is programmed according to your anaesthetist's instructions.

Intravenous (IV) pain relief
Intravenous pain relief can be administered to supplement a PCA or epidural or on its own to manage pain that is not controlled by tablets or suppositories alone.

Rectal pain relief
Pain may also be controlled by the insertion of suppositories whilst you are not able to take tablets orally.



Oral pain relief
When you are able to drink, you may have tablets by mouth (orally).

Comfort cares after your surge.,

To help keep you comfortable your nurse will give you bed washes, linen changes and move you around in the bed regularly.

Medications are available for the relief of nausea and vomiting, if they occur. You will be given mouthwashes and ice to suck while you are not eating or drinking.

You will be reminded about and assisted with deep breathing exercises. These should be performed every hour while you are awake.

Food and fluids

Progress to a full diet should be gradual starting with sips and over a day or so and graduating to full meals. It is important to eat a balanced diet and chew thoroughly and eat slowly. If your bowel is slow to return to normal or you have special dietary needs, a dietician will be involved to assist your recovery.

Mobility

You will usually be up in a chair for a short time and assisted to walk a short distance within a day or two of your surgery. Your level of activity will increase as you recover.

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Removal of drips and drains

Intravenous fluids

This is removed when you are drinking normally. The leur (plastic tube) is removed when you are no longer requiring intravenous medications.

Wound drain

This is removed when the amount of drainage is minimal and the operation area is healing.

Sutures (stitches or staples)

Sutures are usually removed seven to ten days after surgery. If you are not going to be in hospital at this time, you will be given a date for you to arrange for your GP or practice nurse to remove them.

Urinary catheter

The timing of the removal of the urinary catheter varies according your doctor. If you go home with a catheter, you will be taught how to manage it prior to discharge. Please ensure that have a copy of the information book “Going home with your catheter” to refer to at home. Usually after approximately ten days a District Nurse will remove your catheter at home.

What happens when the catheter comes out?

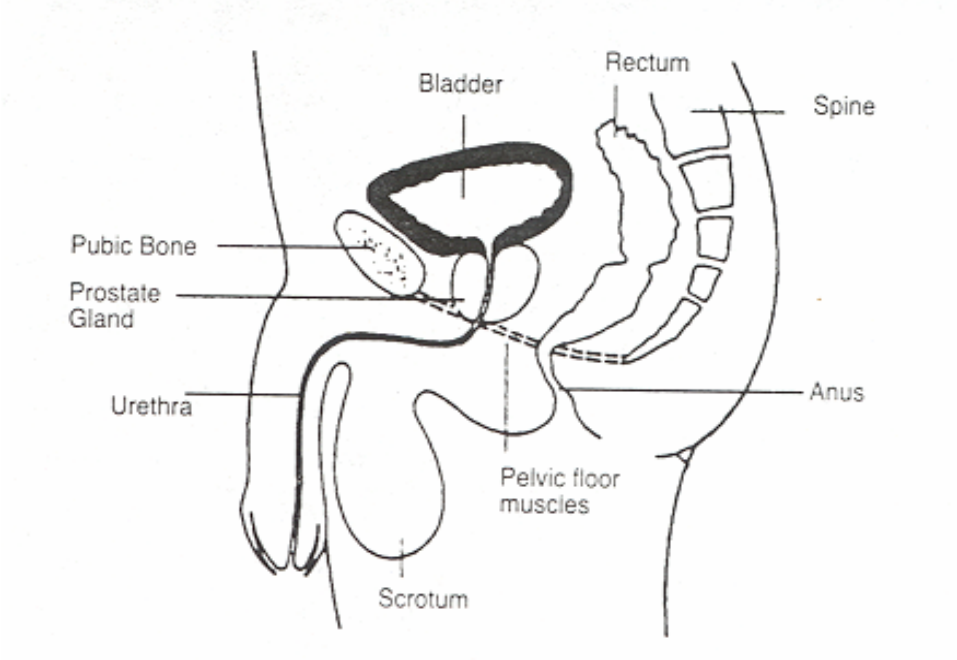
At first you may experience a burning sensation when you pass urine and have difficulty with control of urine flow. Sometimes these symptoms can continue for a prolonged period. The pelvic floor muscle information below should be helpful as will the support of the District Nurse.

What is the pelvic floor?

The pelvic floor is the layer of muscle stretching from the pubic bone in the front to the tailbone at the back and forming the

floor of the pelvis. It is the main support structure for the pelvic organs.

- A toned pelvic floor supports the bladder and bowel.
- A toned pelvic floor helps close off the bladder and bowel outlets to help prevent leakage.
- Relaxation of the pelvic floor allows effective bladder and bowel emptying.
- A functional pelvic floor may enhance the ability to maintain an erection.



Factors contributing to pelvic floor muscle weakness are:

- Some prostate surgery
- Persistent straining to empty the bladder or bowel with or without constipation
- Constipation
- Persistent heavy lifting
- A chronic cough (from smoking, chronic bronchitis or asthma)
- Being overweight
- Lack of regular exercise

Once the pelvic floor muscles become weak your ability to hold urine and/or wind during physical activity is compromised. Like

any other muscles of the body, the more you exercise them, the better they will function.

Pelvic floor muscle training for men

The first step is to correctly identify the muscles. Sit or lie down comfortably – your thighs, buttocks, tummy muscles should be relaxed. Lift and squeeze inside as if you are trying to hold back urine and wind from the back passage. If you are unable to feel a definite squeeze and lift action of your pelvic floor don't worry – even people with very weak muscles can be taught these exercises.

If you feel unsure whether you have identified the correct muscles, try to stop your flow when passing urine, then restart it. Only do this to identify the correct muscles to use – this is a test NOT an exercise.

If you are unable to feel a definite tighten and lift action in your pelvic floor muscles, you should seek professional advice.

If you can feel the muscles working exercises them by:

1. Squeezing/tightening and drawing in and up around both your anus (back passage) and urethra (bladder outlet). LIFT UP inside and try to **HOLD** this contraction **STRONGLY** for as long as you can (1-10 seconds). **KEEP BREATHING!** Now release and RELAX. You should have a definite feeling of letting go.
2. Rest 10-20 seconds. Repeat Step 1 and remember it is important to rest. If you find it easy to hold, try to hold longer and repeat as many as you are able. Work towards 12 long, strong holds.
3. Now try 5-10 short, fast, **STRONG** contractions.
   - **Do NOT** hold your breath
   - **Do NOT** push down instead of squeezing and lifting
   - **Do NOT** pull your tummy in tightly

- **Do NOT** tighten your buttocks and thighs

Try to set aside 5-10 minutes in your day for this exercise routine and remember **QUALITY** is important.

A few **GOOD** contractions are more beneficial than many half-hearted ones and good results take **TIME** and **EFFORT**. Remember to use the muscles when you need them most. That is, always tighten before you cough, sneeze, lift, bend, get up out of a chair, etc.

Progressing your programme

Increase the length of and number of holds you do in succession before experiencing muscle fatigue. Work towards 12 long, strong holds. Increase the number of short, fast contractions – always do your maximum number of **QUALITY** contractions (Pelvic Floor Muscle Training for Men information reproduced with the permission of the New Zealand Continence Association).

Discharge Advice

- See your GP promptly if you experience chills, fever or pain in your bladder or back, or your urine is cloudy and offensive smelling. These symptoms may be indicative of a urinary tract infection and require treatment.
- The majority of wound strength is reached within the first six weeks after surgery so it is important to avoid strenuous activity, heavy lifting and straining during this period. This includes such things as contact sports, mowing lawns, gardening, vacuuming and lifting heavy washing baskets.
- Sexual activity may be resumed after six weeks or when you feel comfortable to do so.
- It is important to maintain a regular bowel habit. If you experience a tendency towards constipation, a mild laxative combined with a good daily fluid intake and a high fibre diet

will help to alleviate this problem. If you have not moved your bowels since your operation, please tell the District Nurse.

- Approximately 10-14 days after surgery you may pass slightly bloodstained urine again. This is normal and should stop within a day or two – just continue to drink plenty.
- Continue to practise the pelvic floor exercises outlined in this book to assist with the recovery of your normal urinary control. If you are having problems with urinary control, the District Nurse will be able to provide support and information. Also, your urinary function will be assessed as part of your follow-up appointment approximately six weeks after surgery. If necessary, you may be referred to the Continence Service for additional support at this time.
- Your hospital doctor will provide your first sickness benefit certificate/medical certificate and will advise you when you are able to return to work.

Follow-up

Discharge letter

You and your GP will receive a copy of a letter outlining the treatment you received during your hospital stay. This will be posted to you if it is not completed by the time you leave hospital.

GP

When you are discharged from hospital you will be under the care of your GP who will look after your general health and monitor your progress.

Outpatients appointments

You will receive an appointment to attend Urology Outpatients approximately six weeks after discharge. This will be posted to you.

District Nurse

When you are discharged from hospital you will be visited by the District Nurse. The District Nurse is also the person to contact if you have any problems with your catheter or urinary control.

3 References: Mosby's Genitourinary Disorders, Clinical Nursing, Mikel Gray 1992
Urological Nursing 3rd Edition, Urological Nursing' 2004
Campbell's Urology 7th Edition, Urology, 1998