Robotic assisted laparoscopic radical prostatectomy
Introduction
This leaflet is produced to support the consultation you have had about your surgery and to clarify some of your queries. If you have any additional questions or concerns, please do not hesitate to contact the uro-oncology nurse specialist/keyworkers or speak to the doctors or nurse at the hospital when you see them. Contact details are at the back of this leaflet.

What is a robotic assisted laparoscopic radical prostatectomy?
Robotic assisted laparoscopic radical prostatectomy is a minimally invasive (keyhole) operation to remove the prostate gland using a robotic assisted technique. This is major surgery which is performed under a general anaesthetic and uses a number of ‘ports’ (small incisions) which allow access to the diseased organ.

Why do I need a robotic assisted laparoscopic radical prostatectomy and is there an alternative to this procedure?
Following your diagnosis of early localised prostate cancer, a radical prostatectomy (removal of the prostate gland) is recommended to remove the prostate gland and seminal vesicles (sperm ducts).

There are alternative ways to manage the disease which include active surveillance, open radical prostatectomy, external beam radiotherapy, brachytherapy, conventional
laparoscopic surgery, HIFU (high intensity focused ultrasound) and/or cryotherapy. Your case history will have been discussed at a multidisciplinary team meeting to identify the optimum treatment options for you. You will have been asked to decide on how you wish to be treated but should you require additional guidance please contact one of the uro-oncology nurse specialists. The contact details are at the end of this leaflet.

How is the operation performed?
The operation is performed by a robotic assisted laparoscopic technique. The surgeon makes 6 small incisions through which the instruments are inserted. It is important to remember that the instruments and robot are controlled by the surgeon. This procedure allows improved views and therefore precision when operating.

Your prostate, containing the cancer, seminal vesicles and surrounding tissue will be removed. The surgeon will then join (anastomose) the neck of your bladder to the Urethra (water pipe).

A catheter will be placed into your bladder via the urethra to allow for the healing process to begin and also there may be a wound drain in place.

It is important to realise that, on occasions during surgery, the consultant performing the operation may have to change the approach from robotic assisted laparoscopic to open surgery but you will not be aware of this until after the operation. This is not a regular occurrence, but can be due to various reasons.
What is nerve-sparing?

There are 2 network bundles of nerves that run along either side of the prostate and these are responsible for controlling erections. Sometimes it is possible to preserve the nerves on one or both sides. Even if the nerves are protected on both sides, it can take up to 12 to 18 months for the nerves to regenerate and recover. During this time your erections may return gradually. Treatments are available which may help to restore erections and can be discussed with your consultant or specialist nurse/nurse practitioner.

Your consultant will discuss the issue of nerve sparing with you and whether you are suitable to have one or both of these spared. Please remember that this may not be possible when they visualise the anatomy at the time of surgery and the prime aim of the operation is the safe removal of the cancer. If non-nerve sparing surgery is necessary due to position of the prostate tumour, then this usually results in complete loss of your erections. After surgery therapies are available to restore your erections.

Buddy system

No matter how many booklets and leaflets that you read discussing this operation, there is nothing quite like talking to a patient who has undergone this procedure.

If you feel that talking to one of our patients will be of help to you, before or after surgery, please ask your consultant or nurse specialist. They will put you in contact with someone or you could attend the local

Follow Up Regime

Once your surgery has been carried out and you have recovered sufficiently to be discharged from hospital an appointment will be arranged for you to attend the hospital for your trial without catheter (TWOC). In the majority of cases this is only a day visit, but a small number of cases may involve an overnight stay. About 6 weeks after your discharge, your consultant will arrange to see you in the outpatients department. This will give you the opportunity to discuss the results of the pathology report on your prostate following the review at the specialist multidisciplinary team (SMDT) made up of surgeons, radiologists, pathologists, nurse specialists and oncologists.

From then on, you will need to attend the outpatients department at regular intervals for review by a member of the Urology Team. This will include measuring your PSA (Prostate Specific Androgen) blood level. You will be asked to have this checked 1 to 2 weeks before each appointment so that when you attend clinic we have a recent result available. The PSA blood test is one way that we are able to monitor the success of the operation and your progress. You will continue to be monitored for 5 years.

If there is an increase in the PSA we will discuss further treatment options with you.
Cotswold Prostate Cancer Support group where there are men who have had this procedure.

All buddies have volunteered their services to help other patients through the process.

Admittance to hospital

Within the month prior to your operation you will be asked to attend the Pre Admission Clinic where we will take your details, arrange blood tests and heart tracings (ECG - electrocardiogram) in readiness for your surgery. Here you will have another opportunity to discuss any concerns that you may have.

Admission to hospital is in most cases on the day of your operation. You will receive a letter explaining where you need to go on arrival at the hospital. Occasionally, individuals may need to be admitted the day prior to surgery if they have other health or social issues.

On the day of your operation, you will be helped into a hospital gown and prepared for theatre. Anti-embolic support stockings will be given to you to wear to reduce the chance of clots forming in your legs (Deep Vein Thrombosis/DVT). An anaesthetist will visit you prior to theatre and discuss with you the type of anaesthetic you will be receiving, usually a general anaesthetic.

On the urology ward, pre or post operation, you will meet the nursing staff who will be looking after you during your stay. If you are concerned about anything during your stay, then do speak to one of the nurses or ask to speak to the Ward Manager. We want your stay to be as smooth and comfortable as possible for you.

This is serious and can be life threatening. To try and prevent any clots forming, the nursing staff will fit you with support stockings called anti-embolic stockings before surgery. These will support your veins while you are in theatre and following your operation. You will be encouraged to get out of bed the day after your operation, as this again can prevent clots forming.

It is important that while you are in bed after your operation, you move your legs and wriggle your toes as much as possible. This will keep your circulation going. It is recommended that patients who undergo major surgery are treated with a medication that is injected to assist in reducing the risk of clot formation. It is important that you continue this medication after you have been discharged from hospital and you will be taught to administer it yourself.

- **Severe incontinence**
  In men who have severe long term incontinence (1 year post-operative), a referral will be made to another unit for consideration of an artificial sphincter operation. This would be discussed in more detail with you by your consultant.

- **Other side effects**
  With any major operation, there is always a risk that the unlikely will happen, so it is possible that some patients will have a heart attack or stroke under the anaesthetic or afterwards. If you have a history of either of these, we normally arrange for an anaesthetic opinion to make sure it is safe for you to have your surgery. Although very rare, any of the above secondary complications can result in death.
After your operation
When you return to the ward, you will need to have regular observations performed by the nursing staff.

Please be aware that you will have facial oedema (swelling) which can last up to 48 hours post operatively. This is a result of the operating table being positioned so that you are tilted head down.

You may have an intravenous infusion (drip) which will provide you with the fluids and in some cases nutrients and medicines. Occasionally, it may be necessary to give patients a blood transfusion during or after the operation.

As previously mentioned, you will wake up with a catheter. This is a tube draining the bladder so that the anastomosis (surgical join) can begin healing. It is important that the catheter flows freely at all times. This catheter will need to remain sited for a minimum for 1 week after surgery, and is removed on average 10 to 14 days after surgery.

The nursing staff will attach a leg bag to your catheter and teach you how to start to look after your catheter in preparation for your discharge. It is important that you know how to look after your catheter before you leave the hospital. (See section on catheter care later in the booklet) Usually, patients are discharged the day after the surgery.

You may also have a wound drain in your abdomen. This is used to drain any excess fluid away from the wound area. The wound drain will be removed prior to discharge.

If you require pain relief, please ask as it is important that you feel comfortable to aid movement. You will be given 3 litres per 24 hours. This keeps the catheter draining and the urine clear and can flush away debris before it has time to develop into an infection. If you have very cloudy or offensive smelling urine, please contact your GP, as you may need a course of antibiotics.

Rare side effects (less than one in 50)

- Hospital acquired infection
  - MRSA, you will have been screened for this at pre-admission
  - Clostridium difficile bowel infection.

- Rectal injury
  If this occurs you may require an operation for a temporary colostomy.

- Ureteric injury
  If this happens and is recognised at the time of your operation, it will be repaired immediately. If it becomes apparent after the operation, then you will require a second operation to reconnect the ureter to the bladder.

- Clots
  Any major pelvic operation carries a risk of developing clots. These usually take the form of a DVT (Deep Vein Thrombosis). This is where a clot forms in the deep veins of the leg, usually the calf, resulting in pain and swelling. Although this can be treated, there is always the possibility that part of the clot can break free and travel to other parts of the body. If this happens, a PE (Pulmonary Embolism) can occur where the clot travels to the lungs.
encouraged to get up and move about as soon as possible after the surgery to reduce the risk of complications.

You should be able to eat and drink around 4 hours after the operation.

Caring for your catheter

It is essential that the catheter flows and does not block. The reason for the catheter is that whilst it is in position the anastomosis (joining together) will heal. It is essential that you ring the urology ward for advice if the catheter stops draining.

Do not allow anyone to change the catheter other than urology personnel.

Occasionally, and this is a very rare occurrence, the balloon that holds the catheter in position can burst and the catheter fall out. If this happens please ring the urology ward immediately for advice (the number is at the end of the booklet). You will be asked to attend the hospital to see a urology doctor who will be able to reinsert the catheter if necessary.

It is usual to experience leakage around the catheter at times. This is called by-passing. This usually occurs when you have your bowels opened and this is nothing to be alarmed about. You can also experience blood oozing from around your catheter. This is normal and is nothing to be alarmed about. Sometimes, you will get normal sensations of wanting to pass urine even when the catheter is in place. When the feeling of wanting to pass urine comes on, just relax; do not push or try to pass urine, let the catheter do the work for you.

Sometimes, these little involuntary contractions of the

- **Hernia**
  A hernia may develop at the site of the port insertion or in the groin area at least 6 months after the operation. This does not require urgent treatment but please mention it to your GP or consultant.

- **Scrotal swelling**
  Scrotal swelling, inflammation or bruising can occur. This is a short term side effect which will resolve naturally.

- **Infection**
  The infection may be a wound infection or a urine infection

  - **Wound infection.** This is always a possibility when you undergo any surgery. If infection occurs, you will be prescribed antibiotics these may be either tablets or injection form. You may experience a discharge from the wound although this can be unpleasant for you it is better for the infection to drain away. If you develop a wound infection after discharge from hospital contact your own doctor who will arrange for antibiotic therapy and for the district nurse to visit or review at the surgery with the practice nurse.

  - **Urine Infection.** Patients undergoing any type of surgery to their urinary tract (kidneys, bladder or prostate) are susceptible to developing a urine infection. After Radical Prostatectomy, you will need to have a catheter for approximately 10 to 14 days. Whilst the catheter is sited, the possibility of a urine infection is quite high. It is therefore important that during this time you drink plenty of fluids. You need to have a fluid intake of about 2 to
bladder muscle can be troublesome and can cause the catheter to leak around the sides. If this is a persistent problem, then we can give you some medication to quieten these muscles down.

Some blood in your urine is expected and is nothing to be alarmed about. You may also notice little bits of debris in your urine. If either of these situations occur, try and drink plenty of fluids to keep the catheter draining and to prevent blockages and infection. If you are unsure or concerned about your catheter, then please do not hesitate to ring the Nurse Practitioner Team or out of hours then Bibury ward staff will be able to advise or reassure you over the phone or advise you to attend the hospital.

Hygiene
It is important to keep the area where your catheter enters your urethra (water pipe) clean. It is therefore recommended that you have a daily shower or bath (shower is preferable). Wash around this area with soap and water using a cloth for this purpose only. Dry thoroughly with a towel. Some patients do experience a little discharge around the catheter which then can dry and crust on the outside. This is nothing to be concerned about and is caused by the catheter rubbing the inside of the urethra. If you have a discharge, you must clean this area more frequently during the day.

If this occurs, your consultant will arrange for you to come into hospital and have a small procedure, performed via the urethra, to open the neck of the bladder up again. This will be done under general anaesthetic and you may need to stay in hospital for 24 hours.

- **Urinary anastomosis leak**
  This is where the anastomosis (join) between the bladder and the urethra has not quite healed. If this happens, then we would leave your wound drain in position longer than normal to allow the area to drain. Sometimes, we need to arrange an x-ray of the bladder called a cystogram. This involves inserting some dye through your catheter and x-raying the bladder and anastomosis. If this issue occurs the catheter may have to remain in your bladder for longer.

- **Blood loss**
  This may lead to you requiring a transfusion or repeat surgery. If you are opposed to transfusions, then a special consent form is used to record this, so please inform staff at the time of consent.

- **Lymph collection**
  If lymph node sampling is performed then you may develop a collection of lymph fluid in the pelvis. This usually resolves naturally with time.

- **Constipation**
  Some degree of constipation can occur. You will be prescribed medication if you experience constipation or if you have problems due to piles. It is also important to consider your diet to aid improvement.
Fluid and diet intake

It is important to drink an adequate amount of fluids on a daily basis; in order to maintain hydration, keep your catheter draining well, prevent blockages and reduce risk of infection. Drinking approximately 8 teacups or 5 mugs (1.5 to 2 litres) of fluid will ensure that the catheter drains well and helps keep the urine clear. Following a healthy diet and eating 5 fruit or vegetable portions daily, as recommended by the department of health, is important to avoid constipation. Constipation can cause drainage problems with the catheter.

Leakage around the catheter

The most common causes of catheter leakage are:

- **Blockages**
  - No urine drainage in the bag
  - Feeling of wanting to pass urine all of the time
  - Feeling of fullness or pain
  - Distended, bloated abdomen
  - Leakage around the catheter.

  If one or several of the above occur then contact the community nurse who will then visit to flush out the catheter. The catheter must not be removed.

  If the community nurse cannot unblock the catheter, they will need to contact the Urology Team for advice or if out of hours then you should be sent to the emergency department at the hospital.

- **Bladder instability spasm**

  Leakage mainly occurs if you try to ‘help’ the catheter to drain. It is normal to experience feelings of wanting

Occasional side effects (between one in 10 and one in 50)

- **Internal Scarring (bladder neck stenosis)**
  
  Some men will have problems emptying their bladder due to scarring at the anastomosis (joining together) of the urethra (water pipe) to the neck of the bladder. If this occurs, then you will notice that your flow becomes poor and you have difficulty in emptying your bladder. It is important to mention this when you attend your review clinic.

either be taken twice a week or daily, depending on which drug and dose is given to you once the catheter is removed, as research suggests that this will aid erectile recovery. However, ejaculation is ‘dry’ or there may only be minimal or no seminal fluid on ejaculation. This situation is permanent and is due to the removal of the structures which produce seminal fluid. You will still have the sensation of orgasm. If you wish to discuss this issue at any time before or after surgery, please mention it to your consultant or nurse specialist.

If you wish to explore the possibility of sperm banking then speak to your consultant or specialist nurse before surgery. This is only necessary if you want (more) children.
to pass urine naturally. Remember you have been controlling your bladder since the day you were potty trained and now we are saying ‘let the catheter control your bladder’. It will be difficult for you adjust. The best thing to do if you get the feeling of wanting to pass urine naturally is to relax, let the catheter do all of the work for you. Do not try and push as this will increase the pressure in your abdomen which will then push onto your bladder and cause a leak around the catheter and onto your clothing. As long as the catheter is draining, there is no need to be concerned. If you find that these ‘bladder spasms’ are persistent or painful, then we can give you medication to calm the bladder down. Please ring your Specialist Nurse for advice if you are unsure.

• **Securing the catheter**
  It is important that the catheter bag is secured firmly to your leg. This will keep the catheter in the correct position and prevent any pulling. There should be a nice straight line from the catheter onto the tubing and into the drainage bag. There should be no kinks in the tubing as this can cause the catheter not to drain properly and therefore cause leakage. Avoid any strain being put onto the catheter.

**Removal of catheter (Trial Without Catheter - TWOC)**

This usually occurs 10 to 14 days after your surgery. You will be given a date to attend the Nurse Practitioner clinic for the removal of the catheter. Once the catheter has been removed, you will be asked to remain in the clinic It can take 3 to 6 months before full bladder control has been achieved, although most men find they have complete control before this. It is common for men to experience what is described as ‘stress incontinence’ where a little urine may leak when the patient is doing physical activities e.g. digging the garden lifting heavy objects. This small amount of leakage can occur even when the patient coughs, laughs or sneezes. This can be a long standing/permanent situation. This occurs because the surgery has altered the natural anatomy at the neck of the bladder.

- **Impotence**
  Impotence is the inability to achieve or maintain an erection sufficient for satisfactory sexual intercourse. The nerves that enable a man to achieve an erection run along the outside of the prostate and can be damage or removed to clear the cancer during surgery. If these nerves are damaged then erection failure will occur. With nerve-sparing operations where the surgeon tries to spare the nerves that enable you to get an erection, there is usually a delay of up to 12 months before men notice erections returning and it is possible that the erections do not return to full strength. If the remaining potency nerves are saved on both sides there is up to a 70% chance of maintaining potency in those men with full potency before surgery. It is possible to restore or improve the erections with treatment and there are treatments available to assist with erections. During your follow up period, the doctor or specialist nurse will ask you about your erections, and if you want to restore your activity, then all treatments will be explained to you and you can then start treatment when you feel ready. It is probable that you will be prescribed a medication that will
and to pass urine into the toilet. The nurse will then scan your bladder to ensure that you are emptying your bladder fully.

You may experience any of the following once the catheter has been removed:

- **Frequency**
  It is normal to want to pass urine frequently for the first few hours, sometimes as often as every half an hour. This is nothing to be concerned about and it does settle down over a period of a day or two.

- **Urgency**
  This is extremely common after catheter removal and means that you get little warning when you want to pass urine. You may have to dash to the toilet. This is normal and takes a few days to settle. All patients experience these symptoms when their catheter has been removed whether they have had surgery or not.

- **Urges incontinence**
  This is when the urgency catches you and you cannot make it to the toilet in time. This is quite common and does settle down. Very occasionally the urgency can persist particularly if it was a problem before surgery and you may need medication to help this settle.

- **Incontinence**
  Any incontinence does tend to settle down, but can take several months to do so. Following this operation, most patients notice a gradual improvement over this time. It is essential that you carry on doing your pelvic floor exercises regularly as this will help your control. Most patients learn to be dry at night within the first

A supply of pads and instructions on how to obtain a further supply will be ordered for you. If you have any difficulty obtaining pads at home, please contact the Continence Team Office at Cheltenham General Hospital Tel: 0300 422 5303.

**Conveen/Sheaths**

It is preferred that Conveens and Sheaths are not used for the incontinence, however in some patients, the leakage can be quite a lot initially, and a sheath condom attached to a catheter leg bag may be necessary. It is advisable if you are having this amount of leakage that you talk to your Nurse specialist at the hospital.

**Side effects**

The potential side effects for this procedure are listed below:

**Common side effects (greater than one in 10)**

- **Incontinence**
  Most men find that they have little warning that they want to pass urine, and are incontinent, especially when the catheter is first removed. This generally improves rapidly with time and it is important that you perform pelvic floor exercises regularly to improve control.

It is rare that a patient needs to wear any protection in their underwear long term. About 1% of patients who have undergone this operation will have severe incontinence where continual protection is needed and about 10% will have mild/moderate incontinence, i.e. a few drops of urine leak on coughing, laughing, sneezing or getting up rapidly.

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1 to 2 weeks. Mornings are also dryer than afternoons to start with. The evenings are usually worst for leakages because the sphincter muscle is tired by the day’s activity. Sometimes going back to work too early can result in more leakage for the same reasons. Over a period of months most patients regain full control of their bladder, but some can be left with what is called stress incontinence. This happens when the neck of the bladder is put under pressure and that generally happens when you laugh, cough, sneeze or lift anything heavy. A small drop of urine then leaks into your clothing. Sometimes men will wear a small pad to protect themselves, especially if they know they will be doing heavy work, e.g. gardening. Stress incontinence can be permanent after a radical prostatectomy.

If your GP practice has a Gloucestershire postcode, a supply of pads will be ordered for you prior to the operation in preparation for the catheter removal. Unfortunately, if your GP practice does not have a Gloucestershire postcode, this service may not be available on the NHS and is outside of our control. Please see the section on pads for further information.

Pelvic floor exercises

Pelvic floor exercises should be practiced as soon as you have decided to have the radical prostatectomy. By doing them before surgery, you will become proficient at them so that after surgery, you will know exactly how to do the exercises correctly. The floor of the pelvis is made up of layers of muscle and other tissues. These layers stretch like a hammock from the tail bone at the back to

A lot of patients experience aches and twinges during their recovery period of approximately 3 months. These can be frightening, as with each twinge, you feel that something is going wrong. Generally, the twinges are normal and are due to tissue and muscle inside healing together.

If you are concerned, please do not hesitate to ring either your GP or nurse specialist for advice, we do not want you to worry unnecessarily.

As the wound heals, some patients may develop scar tissue along the wound. This can feel like a lump and may be frightening to find but generally it is nothing to be alarmed about, but if you are concerned, either see your GP or speak to your consultant or specialist nurse at your next appointment.

Some patients can get depressed following major surgery and feel low and even tearful. This is a natural reaction and patients, as they recover, do begin to feel better emotionally. It is natural after your operation to feel frightened and concerned during your recovery. We cannot emphasis enough that if you are concerned, you should not hesitate to ask one of your health professionals.

Pads and sheaths

Pads

After removal of your catheter, it may take a little while for you to gain complete control of your bladder. During this time it may be necessary for you to wear a pad in your underwear.
the pubic bone at the front. A man’s pelvic floor supports the bladder and the bowel. The urethra (water pipe) and the rectum (back passage) pass through the pelvic floor muscles. The pelvic floor muscles play an important part in bladder and bowel control.

You can improve control of your bladder by doing exercises to strengthen your pelvic floor muscles.

To achieve your best results, you may need to seek help from the specialist nurse who may advise that you see a physiotherapist. A physiotherapist can help you to stimulate your pelvic floor contractions using a mild electric current called electrotherapy. Electrotherapy is entirely safe and does not hurt, merely giving a tingling sensation. Electrotherapy is only necessary in a few patients who have difficulty in doing pelvic floor exercises correctly.

**What can I do after my operation?**

- Avoid heavy lifting for a minimum of 6 weeks after surgery for example suitcases, shopping
- It is recommended that you do not drive a car before your catheter is removed. You need to be able to perform an emergency stop without hesitation before you drive. It is recommended that you speak to your GP, a member of the hospital medical team or the CNS/Keyworker for advice on your particular suitability to drive. Also, it is worth contacting your insurance company to confirm their specific cover or restrictions
- Avoid heavy gardening for 12 weeks after surgery
- Drink plenty of fluids while the catheter is still in position
- Take gentle exercise for example walking and gradually increasing the distance
- Eat a healthy diet
- Avoid playing golf for 4 weeks after surgery and then introduce it gradually
- Avoid any contact sports such as football for 12 weeks after surgery
- Avoid constipation
- **Do pelvic floor exercises regularly**
- Avoid travelling by air for 6 weeks after surgery.

After this time, you need to consult your GP about your fitness to travel abroad. We recommend that you speak to your travel insurance company about your policy in relation to your recent surgery to confirm their specific cover or restrictions.

**How to contract the pelvic floor muscles**

The first thing to do is to correctly identify the muscles that need to be exercised:

1. Sit or lie comfortably with the muscles of your thigh, buttocks and abdomen relaxed
2. Tighten the ring of muscle around the back passage as if you are trying to control diarrhoea or wind. Then, relax it. Practice this movement several times until you are sure you are exercising the correct muscle. Try not to squeeze your buttocks (pelvic thrusts) or tighten your thighs or tummy muscles
3. Imagine you are passing urine, then trying to stop the flow mid-stream and then restarting it. (You can do
this for real if you wish, but do so only to learn which muscles are the correct ones to use and then do it no more than once a week to check your progress, otherwise it may interfere with normal bladder emptying). If your technique is correct, then each time you tighten your pelvic floor muscles you may feel the base of your penis move slightly towards your abdomen.

Exercises

When you can feel the muscles working, you can start to exercise them:

1. Tighten and draw the muscles around the anus and the urethra in strongly all at once. Lift them up inside. Try and hold this contraction strongly as you count to five, then release slowly and relax for a few seconds. You should definitely have a feeling of 'letting go'.

2. Repeat (squeeze and lift) and relax. It is important to rest in between each contraction. If you find it easy to hold the contraction for the count of 5, then try and hold for the count of 10.

3. Repeat this as many times, as you are able, up to a maximum of 8 to 10 squeezes. Make each tightening a strong, slow and controlled contraction.

4. Now repeat 5 to 10 short but strong contractions, pulling up and immediately letting go.

5. Complete this whole exercise routine 3 times every day. You can do it in a variety of positions: sitting, lying, standing, or walking.

While doing the exercises do not:

- Hold your breath
- Push down instead of squeezing and lifting up
- Tighten your tummy, buttocks or thighs.

Good results take time. In order to build up your pelvic floor muscles to the maximum strength, you will need to work hard at these exercises. You will probably not notice an improvement for several weeks.

These exercises are important and can help you to gain control of your bladder soon after your surgery.

Contact details for the specialist physiotherapist will be given to you and are at the back of this leaflet. You can arrange to see the specialist physiotherapist to confirm that you are performing your exercises correctly and to advise you how to get the best outcome from your pelvic floor exercises.

Why the pelvic floor muscles get weak

The pelvic floor muscles can be weakened by:

- Some operations on the bladder, prostate and bowel
- Continual straining to empty your bowels, usually due to constipation
- Persistent heavy lifting
- A chronic cough, bronchitis or asthma
- Being overweight
- Lack of general exercise.

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