Gloucestershire Hospitals
NHS Foundation Trust

Patient Information

Robotic assisted laparoscopic radical prostatectomy

Introduction

You have recently had an appointment with your consultant to discuss your upcoming surgery. This leaflet aims to put into writing the information given to you at that appointment and to answer some of the commonly asked questions. If you have any other questions or concerns, please contact the Uro-oncology Nurse Specialist Team/keyworkers or speak to the doctors or nurses at the hospital when you see them. The contact details are at the end of this booklet.

What is a robotic assisted laparoscopic radical prostatectomy?

Robotic assisted laparoscopic radical prostatectomy is keyhole surgery (minimally invasive surgery) to remove the prostate gland using a robotic assisted technique. This is major surgery which is carried out under a general anaesthetic (while you are asleep) and uses a number of ‘ports’ (small incisions) which allow access to the diseased prostate gland.

Why do I need a robotic assisted laparoscopic radical prostatectomy?

Following your diagnosis of localised prostate cancer, a radical prostatectomy (removal of the prostate gland) is recommended to remove your prostate gland and seminal vesicles (sperm ducts).

Is there an alternative to this procedure?

There are alternative ways to manage the disease which may include:

- Active surveillance – taking extra care to notice any change in symptoms.
- Open radical prostatectomy – a single large cut, often known as ‘traditional’ surgery.

Reference No.
GHPI1286_01_24
Department
Urology/Uro-oncology
Review due
January 2027

- External beam radiotherapy – a course of radiotherapy given as daily outpatient sessions.
- Brachytherapy- the implant of radioactive seeds into the prostate.
- Conventional laparoscopic surgery- keyhole surgery without robotic assistance.
- HIFU (High Intensity Focused Ultrasound) and/or cryotherapy – treatments that are offered in select centres under trial control.

Your medical history will have been discussed at a specialist prostate multidisciplinary team meeting, to work out the best treatment options for you.

The Urologist or your Uro-oncology Nurse Specialist will give you information to help you make an informed decision about which treatment you feel would suit you best. The information you are given will allow you to take in to account what the procedure involves, the usual recovery period, any side effects, complications and also the long-term outcome.

If you need further guidance, please contact one of the Uro-oncology Nurse Specialists. The contact details are at the end of this leaflet.

How is the operation carried out?

The surgeon uses a robotic device to carry out the operation. Six small incisions (cuts) are made by the surgeon then the instruments are inserted. It is important to remember that the instruments and robot are controlled by the surgeon. This method allows the surgeon to operate with greater precision.

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 through your urethra to help the healing process to begin. There may be a wound drain in place, which is a narrow plastic tube draining away any fluid from the operation site.

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It is important for you to know that, on occasions during surgery, the consultant carrying out 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 does not happen often but due to a variety of reasons this may be the best and safest option for you.

What is nerve-sparing surgery?

There are 2 network bundles of nerves that run along either side of the prostate which are responsible for controlling erections.

Sometimes it is possible, during surgery, 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. There are treatments available which may help to restore erections; these can be discussed with your consultant or your Uro-oncology 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 the nerve bundles spared. Please remember that this may not be possible when they see the anatomy at the time of surgery; the prime aim of the operation is the safe removal of the cancer. If it is not possible to preserve the nerve bundles due to the position of the prostate tumour, this usually results in complete loss of your erections.

Buddy system

No matter how many booklets and leaflets you read about this operation, there is nothing quite like talking to a patient who has already had this procedure. If you would like to talk with one of our patients, before or after surgery, please ask your consultant or Uro-oncology Nurse Specialist. They will put you in contact with someone or you could attend the local Cotswold Prostate Cancer Support group or Prostate Cancer UK for men who have had this procedure.

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

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Coming into hospital

In the month before your operation, you will be asked to come into the Pre-admission Clinic where we will take your details, arrange blood tests and take heart tracings (ECG - electrocardiogram) in readiness for your surgery. Here you will have another opportunity to talk about any concerns that you may have.

You will usually come into hospital on the day of your operation. You will receive a letter explaining what time and where you need to report to when you arrive at the hospital. Occasionally, if patients have other health or social issues, they may need to be admitted the day before their surgery.

At any time during your stay, if you are concerned about anything, please speak to one of the nurses or ask to speak to the Ward Manager. We want your stay to be as worry free and as comfortable as possible.

The day of your operation

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 blood clots forming in your legs (Deep Vein Thrombosis/DVT). An anaesthetist will visit you before you go to theatre and will discuss with you the type of anaesthetic you will be receiving. This is usually a general anaesthetic.

After your operation

You will be admitted to the urology ward from theatre. You will have regular checks (known as observations) carried out by the nursing staff, as part of your postoperative care.

Please be aware that you may have swelling of your face (facial oedema), which might extend to your chest and upper arms. This can last up to 48 hours after your surgery. Please do not be worried, this is a result of the operating table being positioned so that you are tilted head down during surgery.

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

As mentioned, you will wake up with a catheter in place. 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. The catheter will need to remain in place for at least 7 days but is usually not removed until 10 to 14 days after surgery.

The nursing staff will attach a leg bag to your catheter and teach you how to look after your catheter in readiness for your discharge. It is important that you know how to look after your catheter before you leave the hospital (please read the next section).

Most patients are discharged the day after their 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 before you leave hospital. If you need pain relief, please ask as it is important that you feel comfortable. It will also help with your movement. You will be 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 about 4 hours after your operation.

Caring for your catheter

It is essential that the catheter flows and does not get blocked. The reason for the catheter is that while it is in position the anastomosis (joining together) will be able to heal. It is **important** that you ring for advice if the catheter stops draining. You can contact the Urology Nurse Practitioners, Monday to Friday, 8:00am to 4:00pm. Outside of these hours please contact the urology ward.

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

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Very rarely, the balloon that holds the catheter in place can burst, causing the catheter to 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 come to Cheltenham General Hospital to see a urology doctor who will be able to reinsert the catheter if necessary.

It is usual to have leakage around the catheter at times. This is called by-passing and usually happens when you open your bowels. This is nothing to be alarmed about.

You can also experience blood oozing from around your catheter. Again, this is normal and 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, little involuntary contractions of the bladder muscle can be troublesome and can cause the catheter to leak around the sides. If this problem continues, medication can be prescribed to reduce the symptoms.

Some blood in your urine is normal and nothing to be concerned about. You may also notice little ‘flecks’, or bits of debris in your urine. You should try to 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 contact a member of the Nurse Practitioner Team (telephone number at end of leaflet). If this happens out of hours, then please contact staff on Prescott ward, they will be able to advise or reassure you over the phone.

Hygiene

It is important to keep the area where your catheter enters your urethra (water pipe) clean. We 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 often during the day.

Fluid and diet intake

It is important to drink enough fluids on a daily basis. This will maintain hydration, keep your catheter draining well, prevent blockages and reduce the risk of infection. Drinking about 8 teacups or 5 mugs (1.5 to 2 litres) of fluid will make sure that the catheter drains well and help keep the urine clear.

It is important to follow a healthy diet and eat 5 portions of fruit or vegetables daily to avoid constipation. Constipation can cause drainage problems with the catheter.

Leakage around the catheter

The most common causes of catheter leakage are:

Blockages
Signs of a blockage are:

- No urine drainage in the bag.
- Feeling of wanting to pass urine all of the time.
- Feeling of fullness or pain.
- Distended, bloated abdomen (swelling of the lower stomach).
- Leakage around the catheter.

If you have one or more of the symptoms listed, please contact the community nurse who should then visit you 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 nearest Emergency Department.

Bladder instability spasm

Leakage usually happens if you try to 'help' the catheter to drain. It is normal to feel as if you want 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 to adjust.

As mentioned before in this leaflet, the best thing to do if you get the feeling of wanting to pass urine naturally is to relax and 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 may cause abdominal pain and will also 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 continual or painful, then we can give you medication to calm the bladder down. Please contact the Urology Nurse Practitioner Team 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 or pressure.

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 cause a leakage. Avoid any strain being put onto the catheter.

Removal of your catheter (Trial Without Catheter - TWOC)

You will be given a date to attend the Nurse Practitioner Clinic for the removal of your catheter. This will be about 10 to 14 days after your surgery. Once the catheter has been removed, you will be asked to remain in the clinic and to pass urine into the toilet. The nurse will then scan your bladder to make sure that you are emptying your bladder fully.

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

- **Frequency**
  It is normal to want to pass urine more often for the first few hours, sometimes as often as every half an hour. This is nothing to be concerned about. It usually settles 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, whether they have had surgery or not.

- **Urge 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 carry on, particularly if it was a problem before surgery and you may need medication to help this settle.

- **Incontinence**
  Any incontinence/loss of bladder control does tend to settle down, but can take several months to do so. Following this operation, most patients notice a gradual improvement over time. It is essential that you carry on doing the pelvic floor exercises you have been given regularly as this will help improve your bladder control.

  Most patients learn to be dry at night within the first 2 weeks. To start with, you will find that you are drier in the mornings than afternoons. The evenings are usually worst for leakages because the sphincter muscle, which controls the release of urine, is tired from the day's activity. Sometimes going back to work too early can result in more leakage for the same reason.

  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.

This tends to happen when you laugh, cough, sneeze or lift something heavy causing a small amount of urine to leak.

Sometimes men will wear a small pad to protect themselves, especially if they know they will be doing heavy work such as 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 before your 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 further on in this leaflet 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 so, you will become skilled and know exactly how to do them correctly after your surgery.

The floor of the pelvis is made up of layers of muscle and other tissues. These layers stretch like a hammock from the bottom of your spine to your pubic bone. 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 the best results, we recommend you arrange to meet the physiotherapist before your surgery and then again when your catheter has been removed. The contact details at end of this leaflet.

A physiotherapist can advise you and assess your ability to perform quality pelvic floor exercises. They may also help to stimulate your pelvic floor contractions using a mild electric current called electrotherapy.

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Electrotherapy may sound alarming but it is completely 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.

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 your 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. You should 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 5, 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 carrying out 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 surgery.

Contact details for the specialist physiotherapist are at the end of this leaflet. You can arrange to see the specialist physiotherapist to be assessed and reassured that you are performing your exercises correctly and to learn how to get the best results.

Why do 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.
- frequent heavy lifting.
- a chronic cough, bronchitis or asthma.
- being overweight.
- lack of general exercise.

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After my operation

- Avoid heavy lifting, such as shopping and carrying suitcases for at least 6 weeks.
- It is recommended that you do not drive before your catheter is removed. You need to be able to perform an emergency stop without hesitation before you return to driving. You should speak to your GP, a member of the hospital medical team or the Urology Nurse Practitioner Team/keyworker for advice about your particular suitability to drive.
- Also, it is worth contacting your insurance company to find out about their specific cover or restrictions.
- Avoid heavy gardening such as digging, for 12 weeks following surgery.
- Drink plenty of fluids while the catheter is still in position.
- Take gentle exercise such as walking and gradually increase the distance.
- Eat a healthy diet of fruit, vegetables, lean meat, fish and wholegrains.
- 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 (this can be helped by drinking plenty of fluids, eating a healthy diet and taking gentle exercise).
- **Do pelvic floor exercises regularly as instructed.**
- Avoid travelling by air for 6 weeks following surgery. After this time, you will need to ask your GP about your fitness to travel abroad. We also recommend that you speak to your travel insurance company about your policy in relation to your recent surgery to be clear about their specific cover or restrictions.

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

If you are concerned, please contact your GP or Uro-oncology 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 worrying to find, but usually it is nothing to be alarmed about. If you are concerned, please see your GP or speak to your consultant or Uro-oncology Nurse Specialist at your next appointment.

Some patients become depressed after major surgery, feeling low and even tearful. This can be a natural reaction but be assured that 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 stress strongly enough that if you are concerned, you should not hesitate to speak to one of your health professionals.

Pads and sheaths

Pads

After the 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.

When you attend for your catheter removal, the Urology Nurse Practitioner team will provide you with a supply of pads to take home. If your GP practice has a Gloucestershire postcode and you have ongoing incontinence, further pads can be obtained via the Gloucestershire Continence Team. Please contact the Nurse Practitioner Team who removed your catheter and they will refer you to the Gloucestershire Bladder & Bowel Health (Adult) Service.

A member of the continence team will telephone you to make an assessment of your needs.

If you require further pads then a new order will be placed by the continence team for the correct absorbency pad. This may be for the same as you have been using or a lower or higher absorbency according to your needs. If you have any difficulty with your pad delivery, please contact:

Gloucestershire Bladder & Bowel Health (Adult)
Tel: 0300 422 5303
Monday to Friday, 9:00am to 5:00pm

Unfortunately, if your GP practice does not have a Gloucestershire postcode, this service may not be available on the NHS - this is outside of our control. We apologise to our patients from Herefordshire, Worcestershire and Gwent as we are unable to provide pad provision after your initial supply. Please speak to your local continence advisor service or your GP about this.

Conveen/sheaths
It is preferred that conveens and sheaths are not used for incontinence, but some patients can have quite a lot of leakage in the early days after surgery, so in a few circumstances a sheath condom attached to a catheter leg bag may be necessary. It is advisable if you are having a large amount of leakage that you talk to the Urology Nurse Practitioner team – the telephone number is at the end of this leaflet.

Side effects

The potential side effects of the prostatectomy surgery are listed below:

Common side effects (greater than 1 in 10)

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

  It is rare that a patient needs to wear protection in their underwear long term.

  About 1 in every 100 patients who have had this operation will have severe incontinence where continual protection is needed and about 10 in every 100 patients will have mild/moderate incontinence; where a few drops of urine leak on coughing, laughing, sneezing or getting up quickly.

  It can take 3 to 6 months before a patient gains full bladder control, although most men find they have complete control before this. It is common for men to experience ‘stress incontinence’ (as mentioned earlier in this booklet), where a little urine may leak when the patient is doing physical activities such as digging the garden or lifting heavy objects.

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This small amount of leakage can happen even when the patient coughs, laughs or sneezes. Stress incontinence can be a long standing/permanent situation, it happens because the surgery has changed the natural anatomy at the neck of the bladder.

- **Impotence**
  Impotence is the inability to achieve or maintain an erection firm enough for satisfactory sexual intercourse. As mentioned earlier in this booklet, the nerves that enable a man to achieve an erection run along the outside of the prostate and can be damaged or removed to clear the cancer during surgery. If these nerves are damaged then erection failure will happen.

  With nerve-sparing operations where the surgeon tries to spare the nerves that enable men to get an erection there is usually a delay of up to 12 months before they notice erections returning. It is possible that the erections do not return to full strength. If the remaining potency nerves are saved on both sides there is a chance of maintaining potency in 70 out of every 100 men with full potency before surgery.

  There are treatments available to restore or improve erections which will be explained to you by the doctor or Uro-oncology Specialist Nurse. During your follow up period, you will be asked about your erections and if you want to restore your activity, you can start treatment when you feel ready.

  It is probable that you will be prescribed a medication that will either be taken twice a week or daily. This will depend on the medication and the dose given to you once the catheter is removed. You may be referred to the andrology vacuum pump therapy clinic. Research suggests that this will help with erectile rehabilitation and 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 your Uro-oncology Nurse Specialist.

If you wish to explore the possibility of sperm banking, then speak to your consultant or Uro-oncology Nurse Specialist **before** surgery. This is only necessary if you want (more) children.

- **Local spread of tumour**
  On analysis of the removed gland, it **may** be identified that the cancer cells have already spread outside the prostate. If this is the case, then following a review of the report and tissue samples, it may be recommended that you have further treatment, which is usually radiotherapy.

Occasional side effects (between 1 in 10 and 1 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 happens, then you will notice that your flow becomes poor and you have difficulty emptying your bladder. If you experience this, it is important to mention it when you attend your review clinic appointment.

  If you do have internal scarring, your consultant will arrange for you to come into hospital and have a small procedure, carried out through the urethra, to open the neck of the bladder up again.

  This will be done under general anaesthetic (while you are asleep). You may need to stay in hospital for 24 hours.

- **Pain in tip of penis and/or perineum**
  Occasionally you may experience a pain in the tip of the penis or the perineum (the area between your scrotum and rectum). This will settle but you may find that paracetamol or an anti-inflammatory medication will help if taken regularly. Please follow the directions on the pack. Mention any pain that you have had to your Uro-oncology Nurse Specialist or consultant, do not be concerned that something is going wrong.

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- **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 taking images of the bladder and anastomosis. If this issue happens then the catheter may have to remain in your bladder for longer.

- **Blood loss**
  If you have a lot of blood loss, you may need to have a blood transfusion or repeat surgery. If you are opposed to transfusions, then a special consent form is used to record this, please let staff know at the time of consent, before surgery.

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

- **Constipation**
  Some degree of constipation can happen. You will be prescribed medication if you have constipation or if you have problems due to piles. It is important to consider eating at least 5 portions of fruit and vegetables and drink 1.5 to 2 litres of fluid daily. Taking gentle exercise such as walking will also help.

- **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 happen. This is a short-term side effect which will resolve naturally.

- **Wound infection**
  This is always a possibility when you have any surgery. You will be prescribed antibiotics in either tablets or injection form. You may have a discharge from the wound and although this can be unpleasant for you, it is better for the infection to drain away freely. If you develop a wound infection after discharge from hospital, please contact your GP who will prescribe a course of antibiotics and arrange for the district nurse to visit you at home, or for a review at the surgery with the practice nurse.

- **Urine infection**
  Patients having any type of surgery to their urinary tract (kidneys, bladder or prostate) are open to developing a urine infection. After radical prostatectomy you will need to have a catheter for about 10 to 14 days. While you have a catheter, the possibility of a urine infection is quite high. It is very important during this time that you drink plenty of fluids, about 2 to 3 litres in every 24 hours. This will keep the catheter draining and the urine clear. It can also 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 for advice as you may need a course of antibiotics.**

Rare side effects (less than 1 in 50)

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

- **Rectal injury**
  If this happens you may need an operation for a temporary colostomy.

- **Ureteric injury**
  If this happens and is recognised during surgery, it will be repaired immediately. If it becomes apparent after the operation, then you will need a second operation to reconnect the ureter to the bladder.

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- **Blood clots**
  Any major pelvic operation carries a risk of developing blood clots. These usually take the form of a DVT (Deep Vein Thrombosis). This is where a clot forms in the deep veins in the leg, usually the calf, causing 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. This can cause a PE (Pulmonary Embolism) where the clot travels to the lungs.

  Blood clots are serious and can be life threatening. To try and prevent any clots forming, the nursing staff will fit you with anti-embolic (support) stockings before surgery. These will support your veins while you are in theatre and after your operation. You will be encouraged to get out of bed the day after your operation, as this will help to 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 to keep your circulation going.

  It is recommended that patients who have major surgery are treated with a blood-thinning medication. This is injected and will help in reducing the risk of a blood clot forming.

  It is important that you continue this medication after you have been discharged from hospital. You will be taught how to give yourself the injections.

- **Severe incontinence**
  In men who have severe long-term incontinence (1 year following surgery), a referral will be made to discuss the option of an artificial sphincter. If considered, your consultant would discuss this in more detail.

- **Other side effects**
  With any major operation, there is always a slight risk that unlikely side effects could happen, such as having a heart attack or stroke while under anaesthetic or afterwards.

  If you have a history of either of these, we normally arrange for an anaesthetist's 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.

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Follow up

Once your surgery has been carried out and you have recovered well enough to be discharged from hospital an appointment will be arranged for you to attend hospital for your Trial Without Catheter (TWOC). In most cases this is only an outpatient 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 outpatient department.

Please arrange for a PSA blood test to be taken at your GP's surgery, 1 week before the appointment with the consultant.

The appointment with the consultant will give you the opportunity to discuss the results of the pathology report on your prostate following the review by the Specialist Multidisciplinary Team (SMDT). The SMDT is made up of surgeons, radiologists, pathologists, Uro-oncology Nurse Specialists and oncologists.

Further appointments will be needed at regular intervals for review by a member of the Urology Team. This will include monitoring your PSA blood level. You will be asked to have the PSA blood test 1 to 2 weeks **before** each appointment so that a recent result is 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 in this way for about
2 years. We will discuss registration onto the Self-management remote monitoring system which will allow you to be discharged from the hospital outpatient follow-up appointments.

We will continue to observe your PSA readings on the Self-management system. If there is an increase in the PSA readings, we will bring you back into the hospital appointment system, without delay, for further assessment and to discuss further treatment options with you.

Please remember once you have your prostate removed your PSA should always be undetectable at less than 0.1 (<0.1).

Patient Information

Contact information

Urology Ward via Switchboard
Tel: 0300 422 2222
When prompted, ask for the operator, then the Urology Ward.

Urology Nurse Practitioner Team
Tel: 0300 422 5193 / 3640 / 6691
Monday to Friday, 8:00am to 5:00pm

Pelvic Floor Physiotherapist
Tel: 0300 422 2345
Monday to Friday, 8:30am to 4:30pm
Email: ghn-tr.physiotherapy@nhs.net

Physiotherapy self-referral
Website: www.gloshospitals.nhs.uk/our-services/services-we-offer/physiotherapy/womens-and-mens-health-physiotherapy/

Physiotherapy self help
Website: www.gloshospitals.nhs.uk/our-services/services-we-offer/physiotherapy/how-can-i-help-myself/

Gloucestershire Bladder & Bowel Health (Adult)
Tel: 0300 422 5303
Monday to Friday, 9:00am to 5:00pm

Uro-oncology Nurse Specialist Team

Zoe Eastman
Tel: 0300 422 4334
Email: zoe.eastman@nhs.net
Monday to Thursday, 8:30am to 4:30pm
Friday: 8:30am to 2:00pm

Hannah Hamblin
Tel: 0300 422 4951
Email: Hannah.hamblin@nhs.net
Monday, Tuesday and Thursday: 8:30am to 4:30pm
Friday: 8:30am to 2:00pm

Patient Information

Amanda Morss
Tel: 0300 422 2950
Email: amanda.morss@nhs.net
Tuesday to Thursday, 9:30am to 4:30pm
Friday: 9:30am to 2:00pm

Lucinda Poulton
Tel: 0300 422 6913
Email: lucinda.poulton1@nhs.net
Monday to Thursday, 8:30am to 4.30pm
Friday: 8.30am to 2.00pm

Jo Shaw
Tel: 0300 422 4339
Email: joanne.shaw8@nhs.net
Monday to Thursday, 8:30am to 4:30pm
Friday, 8:30am to 2:00pm

Content reviewed: January 2024

Making a choice