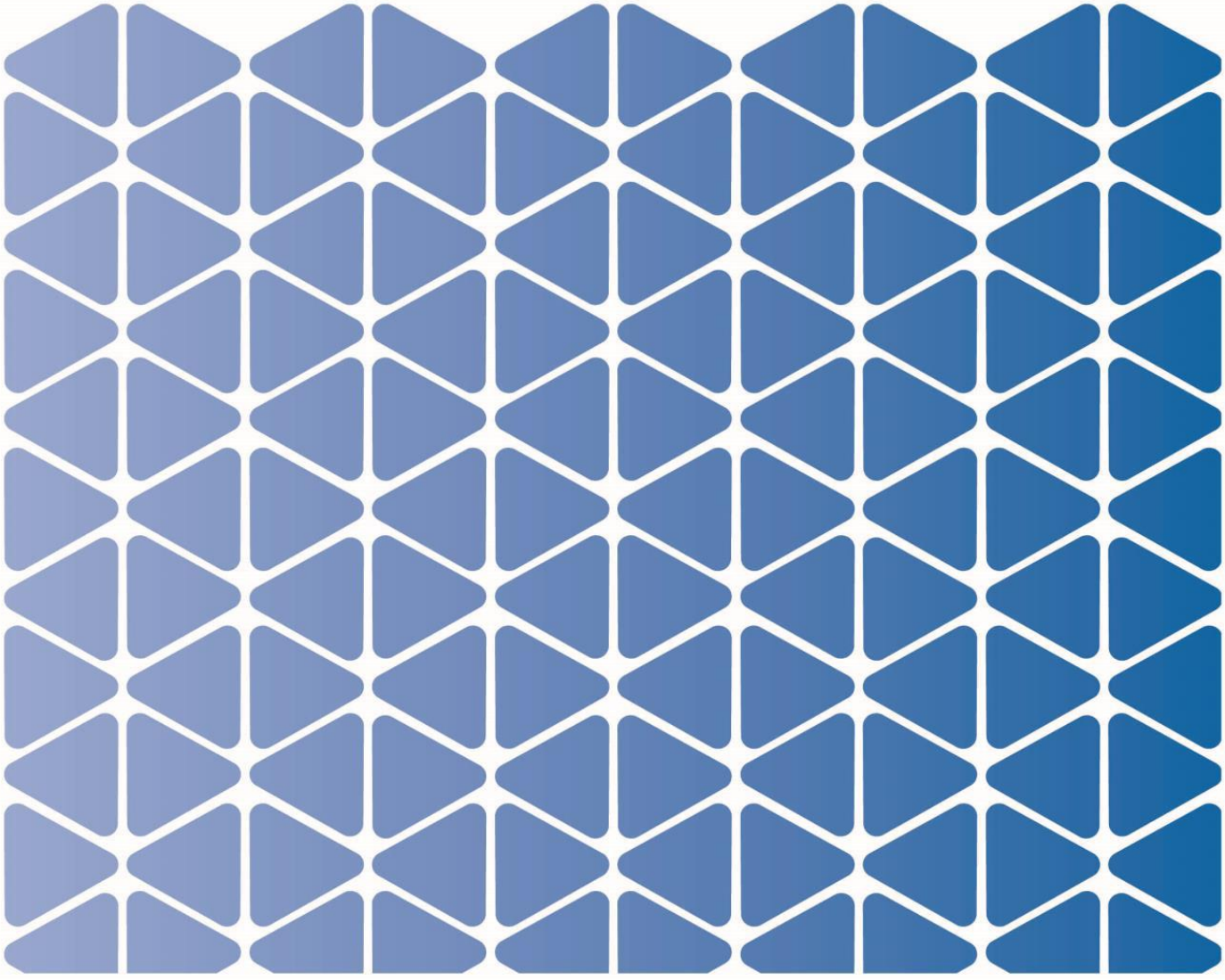
PATIENT INFORMATION

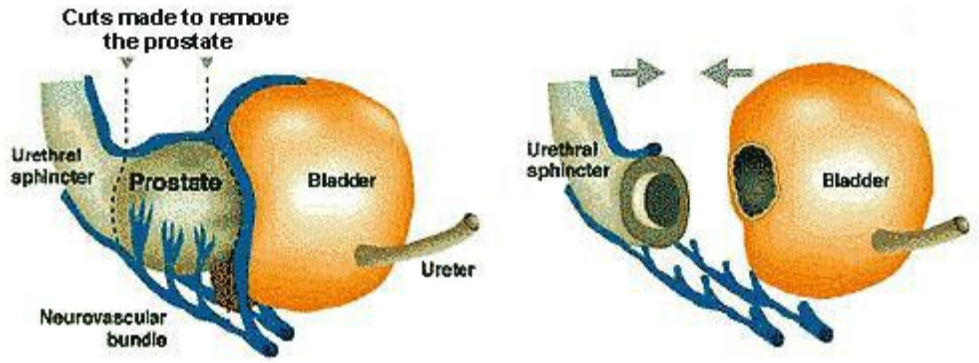
RADICAL PROSTATECTOMY WITH BILATERAL LYMPH NODE DISSECTION



Department of Urology

You have chosen to have surgery to completely remove your prostate. This operation is called a radical prostatectomy. This involves removal of your prostate gland, seminal vesicles and, sometimes, the draining lymph glands, as well as tying off your vasa deferentia (sperm-carrying tubes).

The prostate gland is situated underneath your bladder and forms a part of your urethra (water pipe). To allow us to remove your prostate we usually make a vertical incision (cut) in your abdominal (tummy) wall. Through this we can see the prostate and other associated structures, the bladder and large bowel. When the prostate gland is removed, the urethra (water pipe) is cut and reconnected to the bladder. A catheter is inserted into the bladder to drain the urine from your bladder; this also protects the wound inside allowing it time to heal.
You will also have another small tube called a 'drain' inserted into the abdomen to drain any fluid, which may gather where the prostate has been removed. This usually stays in for two to three days or until the amount drained becomes minimal.



This leaflet explains some of the benefits, risks and alternatives to the operation. We want you to have all the information you need to make the right decision. Please ask your urology team about anything you do not fully understand or want to be explained in more detail.

We recommend that you read this leaflet carefully. You and your doctor (or other appropriate health professional) will also need to record that you agree to have the procedure by signing a consent form, which your health professional will give you.

Benefits of the procedure

The aim of your surgery is to remove the diseased prostate. For most patients this will provide a cure for prostate cancer and hopefully a significant improvement in their urinary problems.

If you have been told that you have or probably have cancer, surgery gives the best chance of a cure, although treatment may need to be combined with radiotherapy at a later stage.

Serious or frequent risks

- Everything we do in life has risks. Surgery to remove your prostate is a major operation and there are some risks associated with it, including problems with:
  - breathing (for example, a chest infection);
  - the heart (for example, abnormal rhythm or, occasionally, a heart attack); and
  - blood clots (for example, in the legs or occasionally in the lung).
  - Stroke
  - Death

Those specifically related to a radical prostatectomy may include:

- Common risks (Greater than 1 in10):
  - Dry orgasm/no semen production, infertility (100%)
  - Impotence/erectile dysfunction and (almost 100%)
  - Penile shortening
  - swollen scrotum and penis;
  - urinary tract infection;
  - temporary urinary incontinence is not uncommon but it usually improves quickly with pelvic floor exercises.

- Occasional risks (Between 1 in 10 and 1 in 50):
  - Wound pain, hernia or infection requiring further treatment
  - Bleeding requiring blood transfusion or further surgery
  - Stricture formation (scarring as a result of the operation can cause your urethra to narrow and make your urinary flow slow).
  - Urine leakage from new joint between bladder and urethra, needing prolonged catheter
  - pathology test showing cancer outside or at the margin of the prostate needing further treatment.
  - lymph fluid collection or lymphocoele infection requiring drainage.
  - further treatment with hormones, radiotherapy or chemotherapy if PSA still shows cancer presence

- Very rare but serious complications(Less than 1 in 50):
  - Urinary incontinence requiring pads, and may need further surgery (artificial sphincter, male sling)
  - numbness and leg weakness caused by position during surgery;
  - rectal injury, needing temporary colostomy;
  - fistula (connection) between the bowel and bladder requiring further treatment.

The rates for hospital-acquired infection may be greater in high-risk patients, for example those patients

- with long-term drainage tubes;
- who have had their bladder removed due to cancer;
- who have had a long stay in hospital; or
- who have been admitted to hospital many times.

Sometimes, more surgery is needed to put right these types of complications.

- Most people will not experience any serious complications from their surgery. The risks increase for elderly people, those who are overweight and people who already have heart, chest or other medical conditions such as diabetes or kidney failure. As with all surgery, there is a very small risk you may die.

- You will be cared for by a skilled team of doctors, nurses and other health-care workers who are involved in this type of surgery every day. If problems arise, we will be able to assess them and deal with them appropriately.

Other options for treatment that are available

Deciding which treatment to have is not something you will do alone and may depend on the level of expertise available at your hospital. If you need further information, please contact your specialist nurse, surgical care practitioner or urologist.

- **Active surveillance** – no active treatment but careful monitoring of your PSA levels with repeated biopsies and further intervention only if there is definite evidence of cancer progression
- **Robotic-assisted laparoscopic radical prostatectomy**– performed using a keyhole technique with robotic assistance
- **Laparoscopic (keyhole) radical prostatectomy**– performed using the standard keyhole technique without robotic assistance
- **External beam radiotherapy**– giving an intensive course of external irradiation to your prostate gland

- **Permanent seed brachytherapy**– implanting radio-active seeds under ultrasound control into your prostate gland
- **High intensity focused ultrasound (HIFU)** – external beamed ultrasound; only available in a few specialist centres and, because we do not have long-term results, needs to be given as part of a clinical trial
- **Cryotherapy**– freezing & thawing the prostate with fine needles passed into the gland; only available in a few specialist centres and, because we do not have long-term results, needs to be given as part of a clinical trial

Your pre-surgery assessment visit

We will ask you to go to a pre-surgery assessment clinic where you will be seen by members of the medical and nursing teams of the urology unit. The aim of this visit is to record your current symptoms and past medical history, including any medication you are taking. Your heart and lungs will be examined to check that you are well enough for surgery. Blood tests and x-rays will usually be taken or arranged during this clinic.

The members of the surgical team will check that you agree to have the planned surgery. Please bring your operation consent form (which you were given in Outpatients), making sure that you have read and understood the form before you visit the clinic. If you have not understood any part of the information, you will be able to ask any questions you may have about your planned surgery.

Being admitted to the ward

You will usually be admitted on the day of your surgery so you and we can prepare for the surgery. We will welcome you to the ward and check your details. We will fasten an armband containing your hospital information to your wrist.

To reduce your risk of blood clots in your legs after surgery, we will usually give you heparin injections and ask you to wear support stockings before and after your surgery. We will usually ask you to continue with your normal medication during your stay in hospital, so please bring it with you.

Your anaesthetic

We will carry out your surgery under a general anaesthetic. This means that you will be asleep during your operation and you will feel nothing.

Before you come into hospital

There are some things you can do to prepare yourself for your operation and reduce the chance of difficulties with the anaesthetic.

- If you smoke, consider giving up for several weeks before the operation. Smoking reduces the amount of oxygen in your blood and increases the risks of breathing problems during and after an operation.
- If you are overweight, many of the risks of anaesthesia are increased. Reducing your weight will help.
- If you have loose or broken teeth or crowns that are not secure, you may want to visit your dentist for treatment. The anaesthetist will usually want to put a tube in your throat to help you breathe. If your teeth are not secure, they may be damaged.
- If you have long-standing medical problems, such as diabetes, hypertension (high blood pressure), asthma or epilepsy, you should consider asking your GP to give you a check-up.

Your pre-surgery visit by the anaesthetist

- After you go into hospital, the anaesthetist will come to see you and ask you questions about:
  - your general health and fitness;
  - any serious illnesses you have had;
  - any problems with previous anaesthetics;
  - medicines you are taking;
  - allergies you have;
  - chest pain;
  - shortness of breath;
  - heartburn;
  - problems with moving your neck or opening your mouth; and
  - any loose teeth, caps, crowns or bridges.

- Your anaesthetist will discuss with you the different methods of anaesthesia they can use. After talking about the benefits, risks and your preferences, you can then decide together what is best for you.

- Also, before your operation a member of the theatre nursing staff may visit you. He or she will be able to answer any questions you may have about what to expect when you go to theatre.

On the day of your operation

Nothing to eat and drink (nil by mouth)

It is important that you follow the instructions we give you about eating and drinking. We will ask you not to eat or drink anything (including chewing gum or sucking sweets) for six hours before your operation. This is because any food or liquid in your stomach

could come up into the back of your throat and go into your lungs while you are being anaesthetised. You may take a few sips of plain water up to two hours before your operation so you can take any medication tablets.

Your normal medicines

Continue to take your normal medicines up to and including the day of your surgery. If we do not want you to take your normal medication, your surgeon or anaesthetist will explain what you should do. It is important to let us know, before you are admitted, if you are taking anticoagulant drugs (for example, warfarin, aspirin, dabigatran, apixaban or clopidogrel).

We will need to know if you do not feel well and have a cough, a cold or any other illness when you are due to come into hospital for your operation. Depending on your illness and how urgent your surgery is, we may need to delay your operation as it may be better for you to recover from this illness before your surgery.

Your anaesthetic

When it is time for your operation, a member of staff will take you from the ward to the operating theatre. They will take you into the anaesthetic room and the anaesthetist will make you ready for your anaesthetic.

To monitor you during your operation, your anaesthetist will attach you to a machine to watch your heart, your blood pressure and the oxygen level in your blood. General anaesthesia usually starts with an injection of medicine into a vein. A fine tube (venflon) will be placed in a vein in your arm or hand and the medicines will be injected through the tube. Sometimes you will be asked to breathe a mixture of gases and oxygen through a mask to give the same effect.

Once you are anaesthetised, the anaesthetist will place a tube down your airway and use a machine to ‘breathe’ for you. You will be unconscious for the whole of the operation and we will continuously monitor you. Your anaesthetist will give you painkilling drugs and fluids during your operation. At the end of the operation, the anaesthetist will stop giving you the anaesthetic drugs. Once you are waking up normally, they will take you to the recovery room.

Pain relief after surgery

Pain relief is important as it stops suffering and helps you recover more quickly. Your anaesthetist may suggest that you have an epidural. The nerves from your spine to your lower body pass through an area in your back close to your spine called the ‘epidural space’. An epidural injects local anaesthetic drugs into the epidural space using a fine plastic tube placed between the bones of the lower spine. This means that

the nerve messages are blocked. This causes numbness and removes the pain. Epidurals may be used during and after surgery for pain relief. They can be inserted when you are conscious, sedated or during your general anaesthetic. The benefits of an epidural are:

- better pain relief than other methods;
- reduced complications of major surgery; and
- you may recover more quickly.

Following an epidural, you may experience some side effects. Side effects are common but are normally minor and easy to treat. Serious complications are rare.

Common side effects include itching from the drugs used and headache. There is a small risk of having a bad headache (1 in 100) and of temporary nerve damage (1 in 10,000). Permanent nerve damage and paralysis are very rare indeed. Your anaesthetist will discuss these issues with you.

Another alternative for pain relief is to have a PCA (patient-controlled analgesia). This allows you to control your pain relief yourself. Morphine is the drug normally used, and the PCA machine allows you to press a button and give yourself a small amount of pain medication. Some side effects are sickness, constipation and drowsiness. Larger doses can cause breathing problems and low blood pressure. However, you can never give yourself too much medicine by this method.

We may also give you tablets or injections to make sure you have enough pain relief. Once you are comfortable and have recovered safely from your anaesthetic, we will take you back to the ward. The ward staff will continue to monitor you and assess your pain relief. They will ask you to describe any pain you have using the following scale.

0 = No pain
1 = Mild pain
2 = Moderate pain
3 = Severe pain

It is important that you report any pain you have as soon as you experience it.

What are the risks of anaesthetic?

Your anaesthetist will care for all aspects of your health and safety over the period of your operation and immediately afterwards. Risks depend on your overall health, the nature of your operation and how serious it is. Anaesthesia is safer than it has ever been. If you are normally fit and well, your risk of dying from any cause related to anaesthetic is very small. Side effects of having an anaesthetic include drowsiness,

nausea (feeling sick), muscle pain, sore throat and headache. We will discuss with you the risks of your anaesthetic.

After your surgery

- Once the medical team are happy with your progress, we may take you from the recovery room to the intensive care unit, or on to a ward. You will need to rest until the effects of the anaesthetic have passed.
- You will have a drip in your arm to keep you well hydrated.
- You will have a tube (catheter) to drain urine from your bladder into a bag next to your bed. This will be removed approximately 10 to 15 days after your operation.
- You may also have a fine tube in your neck (a central venous pressure line – CVP) to help measure accurately the amount of fluids that you are being given. We will remove it when you no longer need it.
- Your anaesthetist will arrange for you to have painkillers for the first few days after the operation, as we mentioned earlier.
- We will encourage you to get out of bed and move around as soon as possible, as this helps prevent chest infections and blood clots. Usually, the physiotherapy or nursing team will help you with this.

Leaving hospital

❖ **Length of stay**

How long you will be in hospital varies from patient to patient and depends on how quickly you recover from the operation and the anaesthetic. Most patients having this type of surgery will be in hospital for five to seven days.

❖ **Medication when you leave hospital**

Before you leave hospital, the pharmacy will give you any extra medication that you need to take when you are at home.

❖ **Convalescence**

How long it takes you to recover from your surgery varies from person to person. It can take up to 12 weeks. You should consider who is going to look after you during the early part of this time. You may have family or close friends nearby who are able to support you or care for you in your home during the early part of your recovery period. You might consider going to stay with relatives or you may want to make your own arrangements to stay in a convalescent home while you recover. After you return home, you will need to take it easy and should expect to get tired to begin with.

❖ Stitches

We will take out any clips or non-dissolving stitches that seal the wound after about 10 days. If you have left hospital before this time, we will arrange for a community nurse to do this.

❖ Personal hygiene

You will normally bathe or shower while you are in hospital, and this can continue as normal after you leave hospital.

❖ Diet

You do not usually need to follow a special diet. If you need to change what you eat, we will give you advice before you go home.

❖ Exercise

We recommend that you avoid strenuous exercise and heavy lifting for 12 weeks after surgery. You should do lighter exercise, such as walking and light housework, as soon as you feel well enough.

❖ Sex

You can continue your usual sexual activity as soon as you feel comfortable. You may have difficulty achieving an erection as a result of this surgery. Erectile rehabilitation treatment will be discussed with you at your follow up appointment.

❖ Driving

You should not drive until you feel confident that you could perform an emergency stop without discomfort – probably at least four weeks after your operation. It is your responsibility to check with your insurance company.

❖ Work

How long you will need to be away from work varies depending on:

- how quickly you recover;
- whether or not your work is physical; and
- whether you need any extra treatment after surgery.

Most people will not be fully back to work for 12 weeks. Please ask us if you need a medical sick note for the time you are in hospital and for the first three to four weeks after you leave.

Specific Instructions

❖ Care of you catheter

Prior to leaving hospital you will be taught how to care for your catheter. A District nurse will be arranged to make sure you are coping well. This will involve emptying the bag and connecting a larger drainage bag for the night. You should keep the area around the catheter clean and dry, wash around the tube at least once per day, and dry thoroughly.

You should seek further advice if you experience any of the following:

- If you have prolonged pain
- If urine has not drained after two hours
- If large amounts of urine keep leaking around the catheter

❖ Fluid intake and urine output

Usually drinking two litres of water a day will be sufficient. You should aim to keep your urine a pale yellow. If it becomes dark you need to increase your fluid intake.

It is quite common to have a slight leakage around the catheter. If it should become offensive and smell or if it is in large amounts, you should report this to the district nurse or GP.

❖ Removal of the catheter

Approximately two weeks after your operation you will admitted for removal of you catheter. This is organised individually with each patient and will be done at clinic nearest to your home address.

Please note:

- Initially may have little or no control of your urine (you will initially be incontinent);
- You will need to recommence your pelvic floor exercises to help regain control of your urine. Please see pelvic floor exercise sheet that you should have had preoperatively.

❖ Heparin Injections

During your stay you will have had daily injection into your abdomen. You will need to continue these for four weeks or until you are readmitted for removal of your catheter. We will give you instructions on how to do the injections, but should you not feel comfortable we can arrange a district nurse to see you.

❖ Outpatient appointment

Before you leave hospital we may give you a follow-up appointment to come to the outpatient department, or we will send it to you in the post.

This appointment is usually about 10 weeks after your operation and you should have your PSA blood test done during the 10th post operative week (and before your post operative appointment).

Contact details

If you have any specific concerns that you feel have not been answered and need explaining, please contact the following.

- Alexandra Hospital:
  - Secretaries: 01527 512155
  - Ward 10 Nursing Staff: 01527 512101 or 01527 503030 ext: 42101 or 44072
  - Ward 18 Nursing Staff: 01527 512106 or 01527 503030 ext: 42106/ 44050
  - Sharon Banyard, Urology Nurse Specialist: 01527 503030 ext: 45746
  - Jackie Askew, Uro-oncology Macmillan Nurse Specialist: 01527 503030 ext: 44150
- Kidderminster Hospital and Treatment Centre:
  - Secretaries: 01562 513097
  - Penny Templey, Urology Nurse Specialist: 01562 512328
  - Sarah Holloway and Kerry Holden, Nurse Specialist – Survivorship Programme: 01562 512328
- Worcestershire Royal Hospital:
  - Secretaries: 01905 760766
  - Helen Worth and Lisa Hammond, Urology Nurse Specialists: 01905 760875

Other information

The following internet websites contain information that you may find useful.

- www.worcsacute.nhs.uk
  Worcestershire Acute Hospitals NHS Trust
- www.patient.co.uk
  Information fact sheets on health and disease.
- www.nhsdirect.nhs.uk
  On-line Health Encyclopaedia and Best Treatments website.
- www.baus.org.uk
  Information from The British Association of Urological Surgeons

If your symptoms or condition worsens, or if you are concerned about anything, please call your GP, 111, or 999.

Patient Experience

We know that being admitted to hospital can be a difficult and unsettling time for you and your loved ones. If you have any questions or concerns, please do speak with a member of staff on the ward or in the relevant department who will do their best to answer your questions and reassure you.

Feedback

Feedback is really important and useful to us – it can tell us where we are working well and where improvements can be made. There are lots of ways you can share your experience with us including completing our Friends and Family Test – cards are available and can be posted on all wards, departments and clinics at our hospitals. We value your comments and feedback and thank you for taking the time to share this with us.

Patient Advice and Liaison Service (PALS)

If you have any concerns or questions about your care, we advise you to talk with the nurse in charge or the department manager in the first instance as they are best placed to answer any questions or resolve concerns quickly. If the relevant member of staff is unable to help resolve your concern, you can contact the PALS Team. We offer informal help, advice or support about any aspect of hospital services & experiences.

Our PALS team will liaise with the various departments in our hospitals on your behalf, if you feel unable to do so, to resolve your problems and where appropriate refer to outside help.

If you are still unhappy you can contact the Complaints Department, who can investigate your concerns. You can make a complaint orally, electronically or in writing and we can advise and guide you through the complaints procedure.

How to contact PALS:

Telephone Patient Services: 0300 123 1732 or via email at: wah-tr.PET@nhs.net

Opening times:

The PALS telephone lines are open Monday to Thursday from 8.30am to 4.30pm and Friday: 8.30am to 4.00pm. Please be aware that a voicemail service is in use at busy times, but messages will be returned as quickly as possible.

If you are unable to understand this leaflet, please communicate with a member of staff.