



RADICAL RETROPUBIC PROSTATECTOMY FOR PROSTATE CANCER

Procedure Specific Information

What is the evidence base for this information?

This publication includes advice from consensus panels, the British Association of Urological Surgeons, the Department of Health and evidence-based sources. It is, therefore, a reflection of best urological practice in the UK. It is intended to supplement any advice you may already have been given by your GP or other healthcare professionals.

Alternative treatments are outlined below and can be discussed in more detail with your Urologist or Specialist Nurse.



What does the procedure involve?

Removal of the whole prostate gland, seminal vesicles and the draining nodes for cancer of the prostate, as well as tying of the vas deferens, through an incision in the lower half of abdomen

What are the alternatives to this procedure?

Active monitoring (watchful waiting), external beam radiotherapy, brachytherapy, hormonal therapy, the perineal or laparoscopic telescopic or minimally-invasive) approach; more recently a robotic operation (the da Vinci procedure)

What should I expect before the procedure?

You will usually be admitted on the day before your surgery although some hospitals now prefer to admit patients on the day of surgery. You will normally receive an appointment for pre-assessment to assess your general fitness, to screen for the carriage of MRSA and to perform some baseline investigations. After admission, you will be seen by members of the medical team which may include the Consultant, Specialist Registrar, House Officer and your named nurse.

You will be asked not to eat or drink for 6 hours before surgery and, immediately before the operation, you may be given a pre-medication by the anaesthetist which will make you dry-mouthed and pleasantly sleepy.

You will be given an injection under the skin of a drug (Clexane), that, along with the help of elasticated stockings provided by the ward, will help prevent thrombosis (clots) in the veins. An enema will be given a few hours before you go to the operating theatre.

Please be sure to inform your surgeon in advance of your surgery if you have any of the



following:

- an artificial heart valve
- a coronary artery stent
- a heart pacemaker or defibrillator
- an artificial joint
- an artificial blood vessel graft
- a neurosurgical shunt
- any other implanted foreign body
- a regular prescription for Warfarin, Aspirin or Clopidogrel (Plavix®)
- a previous or current MRSA infection
- a high risk of variant-CJD (if you have received a corneal transplant, a neurosurgical dural transplant or previous injections of human-derived growth hormone)

At some stage during the admission process, you will be asked to sign the second part of the consent form giving permission for your operation to take place, showing you understand what is to be done and confirming that you wish to proceed. Make sure that you are given the opportunity to discuss any concerns and to ask any questions you may still have before signing the form.

Fact File 1 • The NHS Constitution **Same-Sex Accommodation**

As a result of the new NHS constitution, the NHS is committed to providing same-sex accommodation in hospitals by April 2010. This is because feedback from patients has shown that being in mixed-sex accommodation can compromise their privacy. The NHS pledges that:

- sleeping and washing areas for men and women will be provided
- the facilities will be easy to get to and not too far from patients' beds

To help accomplish this, the Department of Health has announced specific measures designed to "all but eliminate mixed-sex accommodation" by 2010. These include:

- more money for improvements in hospital accommodation
- providing help and information to hospital staff, patients and the public
- sending improvement teams to hospitals that need extra support
- introducing measures so that the Department can see how hospitals are progressing

What happens during the procedure?

Either a full general anaesthetic (where you will be asleep throughout the procedure) or a spinal anaesthetic (where you are awake but unable to feel anything from the waist down) will be used. All methods minimise pain; your anaesthetist will explain the pros and cons of

each type of anaesthetic to you.

You will usually be given an injectable antibiotic before the procedure after checking for any drug allergies.



In this operation, the whole prostate gland and the two sacs behind the prostate (the seminal vesicles) are removed completely through an incision in the lower part of your abdomen. The bladder is then joined to the water pipe (urethra) which runs along the penis. In some circumstances, lymph glands close to the prostate may be sampled at the start of the operation; very rarely, if these obviously contain cancer, the operation may be discontinued and you will be treated in other ways..

The operation takes between 3 and 3½ hours to complete.

What happens immediately after the procedure?

In general terms, you should expect to be told how the procedure went and you should:

- ask if what was planned to be done was achieved
- let the medical staff know if you are in any discomfort
- ask what you can and cannot do
- feel free to ask any questions or discuss any concerns with the ward staff and members of the surgical team
- ensure that you are clear about what has been done and what is the next move

After the procedure, you will have a tube coming out of your abdomen which drains fluid away from the operation site and is removed after 48-72 hours. You will also have a catheter draining urine from the bladder which is removed 2-3 weeks after surgery.

You will usually be able to go home after 5-7 days and arrangements will be made for you to be re-admitted for removal of your catheter.

The average hospital stay is 5-7 days.

Are there any side-effects?

Most procedures have a potential for side-effects. You should be reassured that, although all these complications are well-recognised, the majority of patients do not suffer any problems after a urological procedure.

Common (greater than 1 in 10)

- Temporary insertion of a bladder catheter and wound drain
- High chance of impotence due to unavoidable nerve damage (60-90%).
The risk of this happening will depend on your previous erections and also



on whether the surgeon has decided to remove one or both nerves because the tumour was extending into them. This will have been discussed with you beforehand.

- Inability to ejaculate or father children because the structures which produce seminal fluid have been removed (occurs in 100% of patients)
- Urinary incontinence (temporary or permanent) requiring pads or further surgery (3-30%)
- Minor problems with urinary leakage

Occasional (between 1 in 10 and 1 in 50)

- Scarring at the bladder exit resulting in weakening of the urinary stream requiring further surgery (approximately 14%)
- Serious urinary incontinence (temporary or permanent) requiring pads or further surgery (2-5%)
- Blood loss requiring transfusion or repeat surgery
- Discovery that cancer cells have already spread outside prostate needing observation or further treatment
- Apparent shortening of the penis; this is the result of prostate gland removal causing upward movement of the urethra to allow re-joining to the bladder neck
- Further treatment at a later date, if required, including radiotherapy or hormonal therapy
- Lymphatic collection in the pelvis if lymph node sampling is performed
- Development of a hernia in the groin at least 6 months after the operation

Rare (less than 1 in 50)

- Anaesthetic or cardiovascular problems possibly requiring intensive care admission (including chest infection, pulmonary embolus, stroke, deep vein thrombosis, heart attack and death)
- Pain, infection or hernia in the area of the incision
- Rectal injury needing temporary colostomy

Hospital-acquired infection

- Colonisation with MRSA (0.9% - 1 in 110)
- Clostridium difficile bowel infection (0.2% - 1 in 500)
- MRSA bloodstream infection (0.08% - 1 in 1250)

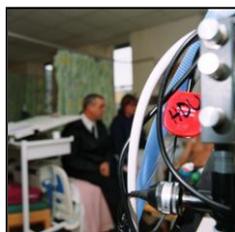
The rates for hospital-acquired infection may be greater in high-risk patients e.g. with long-term drainage tubes, after removal of the bladder for cancer, after previous infections, after prolonged hospitalisation or after multiple admissions.

What should I expect when I get home?

By the time of your discharge from hospital, you should:



- be given advice about your recovery at home
- ask when to resume normal activities such as work, exercise, driving, housework and sexual intimacy
- ask for a contact number if you have any concerns once you return home
- ask when your follow-up will be and who will do this (the hospital or your GP)
- ensure that you know when you will be told the results of any tests done on tissues or organs which have been removed



When you leave hospital, you will be given a “draft” discharge summary of your admission. This holds important information about your inpatient stay and your operation. If you need to call your GP for any reason or to attend another hospital, please take this summary with you to allow the doctors to see details of your treatment. This is particularly important if you need to consult another doctor within a few days of your discharge.

A 6-week convalescent period is usually necessary after surgery. Patients often feel tired and weak for several months.

What else should I look out for?

If you develop a temperature, increased redness, throbbing or drainage at the site of the operation, please contact your GP.

If you have problems with your catheter (especially if it falls out), ask your GP to contact the on-call urologist as soon as possible. If you become unable to pass urine once the catheter has been removed, you should return immediately to the Hospital for further treatment.

Are there any other important points?

After this procedure, there is about a 50% chance that you will lose your erections (see above) and, even if these are preserved, the ability to ejaculate is lost. You will not, of course, be able to father children.

Up to 30% of patients develop some small degree of urinary leakage (often leaking a drop or two when standing from a seated position with a full bladder). This is usually only a small amount of leakage when you cough, strain or are active. To improve urinary control, pelvic floor exercises are helpful; you will have been instructed in how to do these prior to your surgery and it is beneficial to start the exercises in the period between your initial discharge and your re-admission for catheter removal. The control steadily improves over the first year after surgery but a small proportion (3-5%) have long-lasting poor control.

It will be at least 14-21 days before the final pathology results on your prostate become available. It is normal practice for the results of all biopsies to be discussed in detail at a multi-disciplinary meeting before any further treatment decisions are made. You and your GP will be informed of the results after this discussion.

You will be followed up closely after your operation, chiefly by means of the prostate blood test (PSA). If this level rises, it indicates a return of the cancer and will require further treatment in the form of radiotherapy or drugs.

Driving after surgery

It is your responsibility to ensure that you are fit to drive following your surgery. You do not normally need to notify the DVLA unless you have a medical condition that will last for longer than 3 months after your surgery and may affect your ability to drive. You should, however, check with your insurance company before returning to driving. Your doctors will be happy to provide you with advice on request.

Is there any research being carried out in this area?



Before your operation, your surgeon or Specialist Nurse will inform you about any relevant research studies taking place, and, in particular, if any surgically-removed tissue may be stored for future study. If this is the case, you will be asked if you wish to participate and, if you agree, to sign a special form to consent to this.

All surgical procedures, even those not currently the subject of active research, are subjected to rigorous clinical audit so that we can analyse our results and compare them with those of other surgeons. In this way, we can learn how to improve our techniques and our results; this means that our patients will get the best treatment available.

Who can I contact for more help or information?

For further information on the internet, here are some useful sites to explore:

[Best Health](#) (prepared by the British Medical Association)

[NHS Clinical Knowledge Summaries](#) (formerly known as Prodigy)

[NHS Direct](#)

[Patient UK](#)

[Royal College of Anaesthetists](#) (for information about anaesthetics)

[Royal College of Surgeons](#) (patient information section)

What should I do with this information?

Thank you for taking the trouble to read this publication. If you wish to sign it and retain a copy for your own records, please do so below.

If you would like a copy of this publication to be filed in your hospital records for future reference, please let your Urologist or Specialist Nurse know. However, if you do agree to proceed with the scheduled procedure, you will be asked to sign a separate consent form which will be filed in your hospital record. You will, if you wish, be provided with a copy of this consent form.

I have read this publication and I accept the information it provides.



The British Association
of Urological Surgeons

Signature.....

Date.....



How can I get information in alternative formats?

Please ask your local NHS Trust or PALS network if you require this information in other languages, large print, Braille or audio format.



Most hospitals are smoke-free. Smoking increases the severity of some urological conditions and increases the risk of post-operative complications. For advice on quitting, contact your GP or the **NHS Smoking Helpline** free on **0800 169 0 169**

Disclaimer

While every effort has been made to ensure the accuracy of the information contained in this publication, no guarantee can be given that all errors and omissions have been excluded. No responsibility for loss occasioned by any person acting or refraining from action as a result of the material in this publication can be accepted by the British Association of Urological Surgeons Limited.

Fact File 2 • The NHS Constitution Patients' Rights & Responsibilities

The constitution, as a result of extensive discussions with staff and the public, sets out new rights for patients which will help improve their experience within the NHS. These new rights include:

- a right to choice and a right to information that will help them make that choice
- a right to drugs and treatments approved by NICE when it is considered clinically appropriate
- a right to certain services such as an NHS dentist and access to recommended vaccinations
- the right that any official complaint will be properly and efficiently investigated, and that they be told the outcome of the investigations
- the right to compensation and an apology if they have been harmed by poor treatment

The constitution also lists patient responsibilities, including:

- providing accurate information about their health
- taking positive action to keep themselves and their family healthy
- trying to keep appointments
- treating NHS staff and other patients with respect
- following the course of treatment that they are given
- giving feedback, both positive and negative, after treatment