Radical Retropubic Prostatectomy

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

This patient information leaflet is drawn from the consensus panels of many worldwide urological societies, as a supplement to any advice that you may already have been given. Alternative treatments are outlined below and can be discussed in more detail with Dr Campbell.

What are the alternatives to this procedure?

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

Before the procedure

Please be sure to inform Dr Campbell in advance of your procedure if you have any of the following:

- An artificial heart valve
- A coronary artery stent
- A heart pacemaker or defibrillator
- An artificial blood vessel graft
- A neurosurgical shunt
- Any other implanted foreign body
- Blood thinning medications, particularly:
  - Asasantim
  - Aspirin
  - Fish Oil
  - Iscover
  - Persantin
  - Plavix
  - Warfarin
- Mesh hernia repair
- Previous abdominal surgery
- Angina
- Hypertension
- Diabetes

You will usually be admitted on the day of surgery. You may be asked to attend a pre-admission clinic 5–10 days before the procedure to assess your general fitness and to perform some baseline investigations.

If you are taking warfarin, Clopidogrel, iscover, asaantin, or persantin on a regular basis, you must discuss this with Dr Campbell because these drugs can cause increased bleeding after surgery. There may be a balance of risk where stopping them will reduce the chances of bleeding but this can result in increased clotting, which may also carry a risk to your health. This will, therefore, need careful discussion with regard to risks and benefits.

You will be asked not to eat or drink for 6 hours before surgery. 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 (heparin), that along with the help of elasticated stockings fitted on admission, will help prevent thrombosis (clots) in the veins of the legs.

After admission, you will be seen by members of the urological team which may include not only Dr Campbell, but the specialist registrar, the intern, your named nurse, and the physiotherapist. The specialist registrar may perform the operation in conjunction with Dr Campbell and with your permission.
Radical Retropubic Prostatectomy continued...

Where do I go for my procedure?
The admissions section of the hospital at the appointed time, on the appointed day. The admissions section of the particular hospital will give you instructions well in advance of the operation.

If no contact has been made telephone Dr Campbell’s secretary on (07) 3367 1608, and the problem will be addressed.

Do I need to do anything special before my procedure?
Apart from a sip of water with your medicine, we ask you to fast (both food & drink) for 6 hours. You may be asked to have an enema at least 2 hours prior to the operation.

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. Both methods minimize pain—your anaesthetist will explain the pros and cons of each type of anaesthetic to you.

In this operation, the whole prostate gland and the two sacs behind the prostate (the seminal vesicles) are removed 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 approximately 2–4 hours to complete.

Immediately after the procedure
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 hrs. you will also have a catheter draining urine from the bladder which is removed approximately 2 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 on approximately the 10th post-operative day. The average hospital stay is 5–7 days.

Are there any side-effects?
Most procedures have a potential for side-effects and these are outlined below. Please tick off individual items when you are happy that they have been discussed to your satisfaction:

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 one or both nerves are removed because the tumour was extending into them. This will have been discussed with you beforehand.
~ No semen is produced during an orgasm causing infertility
~ Urinary incontinence (temporary or permanent) requiring pads or further surgery. All patients have some urinary leakage after the operation. The degree of leakage varies. This improves over the coming year. At the end of the year some men will still have some degree of incontinence (5%). Some men will need another procedure to treat this problem (2.5%). This will have been discussed with you beforehand.
~ Minor problems with urinary leakage

Occasional (between 1 in 10 & 1 in 50)
~ Scarring at the bladder exit resulting in weakening of the urinary stream requiring further surgery (5–10%)
~ 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 the prostate needing observation or further treatment
~ Further treatment at a later date, if required, including radiotherapy or hormonal therapy
~ Lymphatic collection in the pelvis if lymph node sampling is performed

Rare (less than 1 in 50)
~ Anaesthetic or cardiovascular problems possibly requiring intensive care admission (including chest infection, pulmonary embolus, stroke, deep vein thrombus, heart attack and death
~ Pain, infection or hernia in the area of the incision
~ Rectal injury needing temporary colostomy
Radical Retropubic Prostatectomy continued...

What should I expect when I get home?
A 6–week convalescent period is usually necessary after surgery. Patients often feel tired and weak for several months.

When you leave hospital, a discharge summary of your admission will be sent to your family doctor. This holds important information about your inpatient stay and your operation.

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 family doctor.

If you have problems with your catheter (especially if it falls out), contact Dr Campbell 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.

For after hours emergencies Dr Campbell can be contacted on (07) 3367 1608.

The Wesley Hospital Emergency Centre (07) 3232 7333, and The Greenslopes Private Hospital Emergency Centre (07) 3394 7111 are other resources that are also available.

Are there any other specific points?
After this procedure there is a 60–90% chance that you will lose your erections (see above). Erectile function can be restored in most cases with oral medications, injectable agents or in some cases the insertion of an artificial penile device. The ability to ejaculate is lost, you will of course not be able to father children.

All patients develop some degree of urinary leakage (often leakage is a drop or two when standing from a seated position with a full bladder, or 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 (5–10%) do not regain control.

Half of these patients (2–5%) will require another procedure to cure their problem. The other half (2–5%) are able to manage the small degree of leakage with pads alone.

After the surgery, patients will need to embark on a continence and sexual function rehabilitation programme. This programme will involve pelvic floor exercises and the use of oral or injectable erectile inducing medications. The programme requires motivation to obtain results and it may take the patient an entire year before the best continence results are achieved and two years before the best sexual function results are achieved.

It will be at least 7–10 days before the final pathology results on your prostate become available. Your family doctor will also be informed of the final results.

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.

Is there any research being carried out in this field?
Yes. As part of your operation, various specimens of tissue could be sent to a tissue bank, where it can be used in research on prostate disease. Normally, this tissue is disposed of or simply stored. What we would like to do is to store samples of the tissue, both frozen and after it has been processed.

Please note that we are not asking you to provide any tissue apart from that which would normally be removed during the operation.

A number of research projects are being carried out which involve studying the genes and proteins produced by normal and diseased tissues. The reason for doing this is to try to discover differences between diseased and normal tissue to help develop new tests or treatments that might benefit future generations. This research is being carried out here in Brisbane but sometimes the research scientists work with other universities or with industry to move the research forwards more quickly than it would if everything was done here.

If you would like any further information, please ask Dr Campbell.

All operative procedures performed are subject to rigorous audit at monthly Audit & Clinical Governance meetings.
Radical Retropubic Prostatectomy continued...

Who can I contact for more help or information?

Dr Peter Campbell
Suite 9, level 9, Evan Thomson Building, The Wesley Hospital, Chasely St, Auchenflower, QLD 4066

The Wesley Hospital, Urology Ward
451 Coronation Drive, Auchenflower, QLD 4066

The Wesley Emergency Centre
451 Coronation Drive, Auchenflower, QLD 4066
(07) 3232 7333

Greenslopes Private Hospital, Continence Advisor
Newdgate St, Greenslopes, QLD 4120
(07) 3394 7978, www.greenslopesprivate.com.au

Greenslopes Private Hospital Urology Ward
Newdgate St, Greenslopes, QLD 4120
(07) 3394 7261, www.greenslopesprivate.com.au

Greenslopes Private Hospital Emergency Centre
Newdgate St, Greenslopes, QLD 4120
(07) 3394 6777, www.greenslopesprivate.com.au

The Queen Elizabeth II Jubilee Hospital, Urodynamics Department
Kessels Rd, Coopers plains, QLD 4108
(07) 3275 6346

American Urological Association Foundation
1000 Corporate Blvd, Suite 410, Linthicum, MD 21090

Thank you for taking the trouble to read this information sheet. If you are satisfied with the explanation of the test, please sign below and this leaflet will be filed in your chart.

If you wish to retain a copy for your own records, one will be provided.

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

Signature  Date
Radical Retropubic Prostatectomy continued...