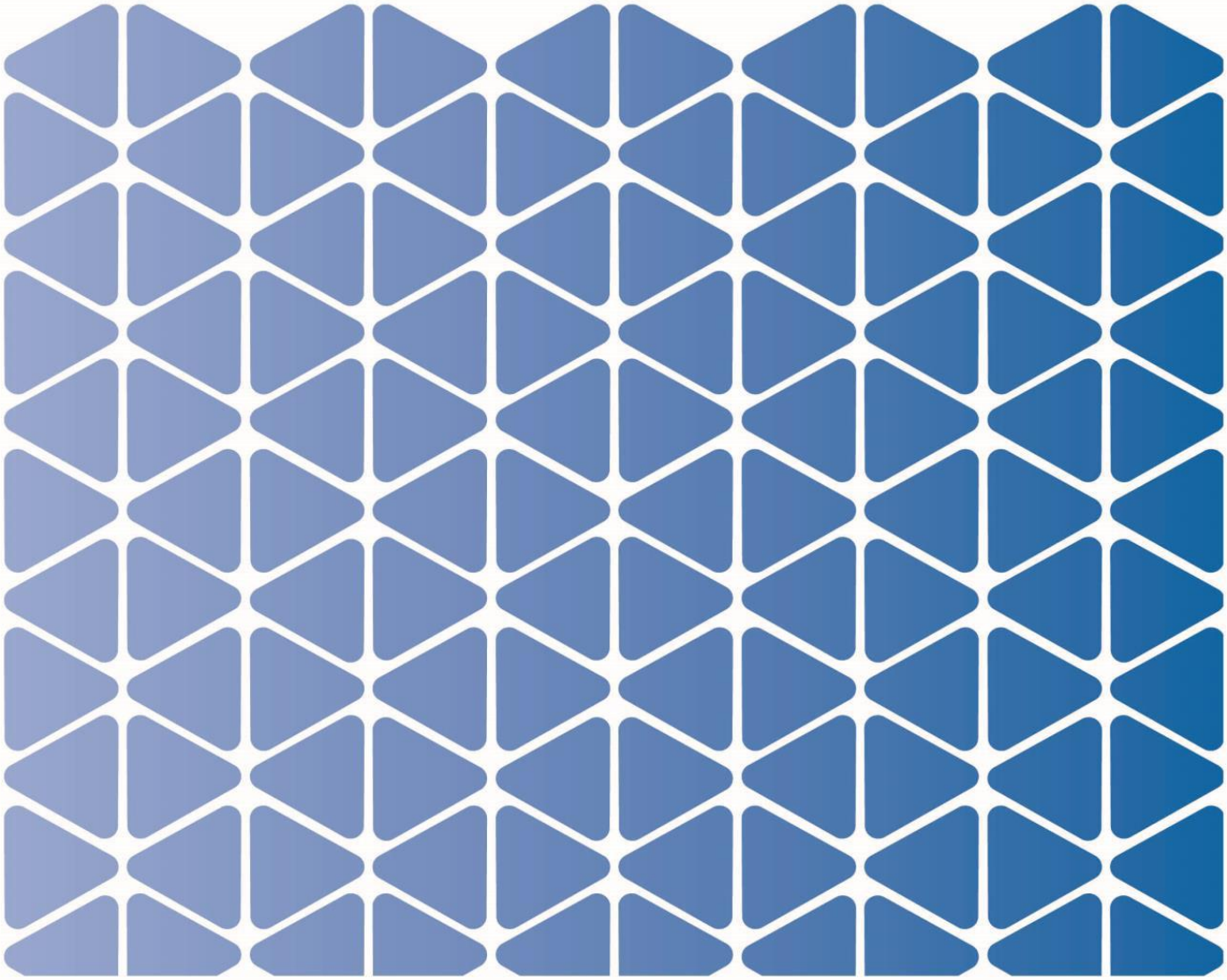
PATIENT INFORMATION

ROBOTIC-ASSISTED LAPAROSCOPIC RADICAL PROSTATECTOMY (RALP)



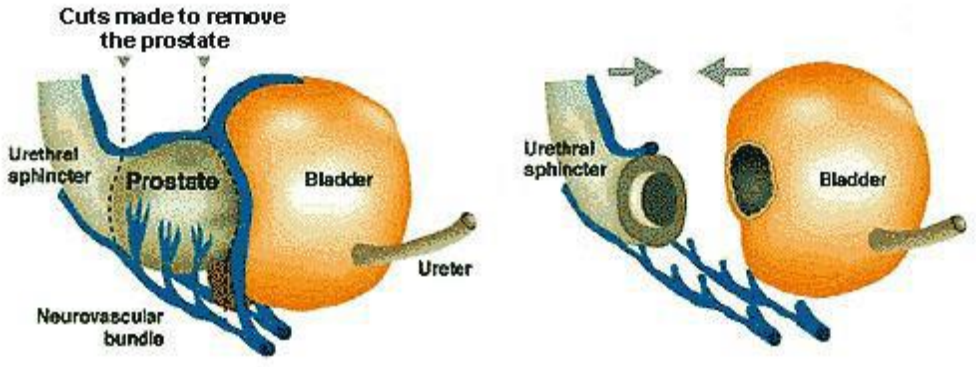
Department of Urology

You have chosen to have Robotic-assisted Laparoscopic surgery to completely remove your prostate. This involves very precise removal of the whole prostate gland, seminal vesicles (sperm sac) and, sometimes, the draining lymph glands, as well as tying off your vasa deferentia (sperm-carrying tubes). It is performed through several small puncture (keyhole) incision in your lower abdomen, using robotic instruments.

Our aims in men with cancer confined to the prostate gland are:

- to remove the cancer;
- to achieve a clear margin away from the tumour;
- to drop the PSA blood level below 0.1 ng per ml;
- to reduce the need for any further treatment (e.g. radiotherapy or hormone treatment);
- to preserve your continence; and
- if possible and appropriate, to preserve the erection nerves to your penis.

The prostate gland is situated underneath your bladder and forms a part of your urethra (water pipe). 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.



Robotic surgery uses sophisticated mini-instruments which are totally under the control of the surgeon. The robot mimics and assists the surgeon’s movements; it does **not** do the operation. This technique is now widely used because of its high degree of surgical accuracy, and because recovery is much faster than it is for open surgery.

Your surgeon will try to preserve the muscle fibres and nerves that control continence. If you still leak some urine after a year (as 1 in 20 to 1 in 33 patients do), this can be corrected by another procedure such as an artificial urinary sphincter or a male sling.

The erection nerves lie very close to your prostate, forming a cobweb of delicate strands over its surface. If your erections were normal before the procedure, it is usually possible to preserve them (called nerve-sparing prostatectomy). It can be very successful in maintaining your erections after the procedure although they may take some time to recover. We can only preserve these nerves if the cancer has not reached the layer where they lie. Your team will explain how you can enjoy a healthy sex life after surgery, even if the nerves do not recover or need to be removed.

You should be aware that there is a small chance (one in 100 or 1%) that we might have to convert a laparoscopic ("keyhole") procedure to open surgery. Because of this, we are not able to proceed with a robotic (keyhole) procedure if you are not willing to have open surgery under any circumstances.

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.

Details of the procedure

- we normally perform the procedure under a general anaesthetic
- we will give you an injection of antibiotics before the procedure, after carefully checking for any allergies
- we make five or six keyhole incisions (cuts) in your abdomen (tummy, pictured) that allow the robotic instruments to be put in
- these instruments allow the surgeon to free your prostate from the bladder and urethra (waterpipe) so it can be removed, whilst sparing the muscles and nerves that control continence and trying to preserve your erection nerves
- we then re-join your urethra to your bladder using absorbable stitches
- we use local anaesthetic to numb the keyhole incisions and minimise your discomfort when you wake up

- all the keyhole incisions are closed with absorbable stitches
- we put a catheter in your bladder to drain the urine while the new join heals
- the procedure usually takes two to three hours to perform

After the procedure, you often get some bruising and swelling around the keyhole incisions together with some swelling or puffiness in your scrotum. You may also get some facial puffiness for a day or two (because you lie slightly “head down” during the surgery). You may feel some shoulder pain and bloating until your bowel starts working again (normally after 24 hours). Most patients can go home after a day or two.

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:

After-effect	Risk
No semen is produced during an orgasm, effectively making you infertile	 All patients
A high chance of erectile dysfunction (impotence) if a nerve-sparing operation is not possible or nerve damage is unavoidable, together with some shortening of your penis	 Almost all patients
Urinary incontinence which be temporary and require pads, but may need further surgery if it lasts for more than a year (e.g. an artificial urinary sphincter or a synthetic male sling)	 Between 1 in 20 & 1 in 33 patients (3 to 5%)
Pathology tests that show cancer outside or at the margin of the prostate (positive margins) requiring observation & possible further treatment	 Between 1 in 10 & 1 in 50 patients
Further treatment with hormones, radiotherapy or chemotherapy may be needed at a later date if your PSA blood test still shows that cancer is present	 Between 1 in 10 & 1 in 50 patients
Leakage of urine from the new join between bladder & urethra, delaying discharge or needing longer catheter time	 Between 1 in 10 & 1 in 50 patients
Bleeding requiring transfusion or further surgery	 Between 1 in 10 & 1 in 50 patients

Pain, infection or hernia in any of the port incisions requiring further treatment		Between 1 in 10 & 1 in 50 patients
Lymph fluid collection (if the pelvic lymph nodes were removed or biopsied during surgery)		Between 1 in 10 & 1 in 50 patients
Anaesthetic or cardiovascular problems possibly requiring intensive care admission (including chest infection, pulmonary embolus, stroke, deep vein thrombosis, compartment syndrome, heart attack)		Between 1 in 50 & 1 in 250 patients (your anaesthetist can estimate your individual risk)
Need for conversion to open surgery due to operative difficulty or failure to progress		1 in 100 patients (1%)
Rectal injury or fistula requiring temporary colostomy to allow healing		Between 1 in 50 & 1 in 250 patients
Eye problems, or numbness & weakness due to nerve compression caused by your "head-down" position during surgery		Between 1 in 50 & 1 in 250 patients

Your risk of getting infection in hospital is approximately 8 in 100 (8%); this includes getting MRSA, Covid and Clostridium difficile bowel infection. 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
- **Open radical retropubic prostatectomy**– performed through an incision in your lower abdomen
- **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 one to two 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 your 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

Please do not use a catheter flip-flow valve attachment. Also if there are drainage problems with the catheter DO NOT allow anyone other than the Urology team to deal with it. This should be done with cystoscopy guidance. You should be provided with a catheter passport and enough supplies for the duration that the catheter stays in. The catheter will be in for 2 weeks. DO NOT do pelvic floor exercises with the catheter in situ.

❖ 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 your 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.

- Urology Nurse Specialist Helpline 01905760809
  (Monday - Thursday 08.30 - 16.30 and Friday 08.30 - 13.00)
- Alexandra Hospital:
  - Secretaries: 01527 512155
  - Ward 17 Nursing Staff: 01527 512045 or 01527 503030 ext: 44045 or 44046
  - Ward 14 Nursing Staff: 01527 507967 or 01527 503030 ext: 44032 or 47967
  - Sharon Banyard, Laura Grazier Urology Nurse Specialist
  - Jackie Askew, Uro-oncology Macmillan Nurse Specialist
- Kidderminster Hospital and Treatment Centre:
  - Secretaries: 01562 513097
  - Penny Templey, Aimee England, Urology Nurse Specialist
  - Sarah Holloway and Kerry Holden, Nurse Specialist – Survivorship Programme: 01562 512328
- Worcestershire Royal Hospital:
  - Secretaries: 01905 760766
  - Helen Worth, Emma Hurton, Lisa Hammond, Urology Nurse Specialists

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.PALS@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.