



## **METRO**UROLOGY

### **PREPARING FOR A RADICAL RETROPUBIC PROSTATECTOMY**

#### **INTRODUCTION**

Surgical removal of the prostate has been performed as a cure for prostate cancer for about 100 years. A better understanding of pelvic anatomy has led to improved techniques and reduced complications such that radical retropubic prostatectomy (RRP) has become the preferred procedure for attempted cure of prostate cancer in selected patients. The following handout will help you better understand what to expect before, during and after an RRP.

#### **BEFORE SURGERY**

Because transfusions may be required, patients may wish to donate their own blood before surgery (auto transfusion). Collecting your blood may take three or four weeks and can be done at your local hospital.

You are advised to avoid aspirin and other nonsteroidal anti-inflammatory medications for approximately ten (10) days before surgery to minimize bleeding tendencies (see-attached list). The day prior to surgery a clear liquid diet should be taken; i.e. water, clear juices, Jell-O, tea and a bowel preparation protocol will be given to you. Nothing to eat or drink after midnight unless otherwise instructed by your physician's office/hospital. No smoking for 24 hours prior to surgery. On the morning of surgery, you will be reporting to the hospital two (2) hours prior to surgery.

#### **DURING SURGERY**

You will be given either a general or epidural anesthetic. The typical radical prostatectomy takes 1 ½ - 2 hours.

A catheter is passed into the bladder and a midline incision is made from the belly button to the level of the pubic bone. Pelvic lymph nodes (spongy structures that drain the prostate gland) are removed on the right and left sides. The prostate is then carefully removed from where it lies between the bladder and the urinary control sphincter muscle.

In selected situations, the nerves and blood vessels that allow for erections are preserved (also known as a nerve-sparing modification).

The bladder is then sewn to the urethra over a temporary catheter. One or two temporary drains are then placed in the pelvis and brought out through the skin. The abdominal skin incision is closed with staples or stitches.

### **AFTER SURGERY**

Postoperative recovery is usually smooth and rapid. The average hospital stay is 2 – 4 days. Patients usually walk the day after surgery and receive intravenous fluids for about two or three days. Oral fluids are usually begun slowly on the first and second day after surgery. Drains are usually removed before discharge.

Patients are discharged home with a Foley catheter. Some urine or blood leakage around the catheter may occur and is normal. Scrotal swelling is not uncommon. Also, blood may be seen in the urine and should clear with increased fluid intake. The catheter is removed at a postoperative office visit usually 2 to 3 weeks after surgery. **Temporary urinary leakage after catheter removal is almost universal and expected. For this reason, please bring diapers for protection when you come to the office for the removal of the catheter.** Newborn diapers or adult Depends work well.

### **SOME POSSIBLE POSTOPERATIVE COMPLICATIONS**

1. Impotence, or the inability to achieve an erection, occurs to varying degrees with any treatment of prostate cancer. When a nerve-sparing operation is done, up to 50% of men may retain some ability to achieve erections. Many men do not have nerve-sparing operations because of the extent of their prostate cancer into both lobes of the prostate or because of their age being over 70. It may take erections up to a year for maximum recovery if a nerve-sparing operation has been done.
2. Incontinence, or urinary leakage, may occur. Many men may have urinary leakage when they cough, lift something heavy, etc. Less than 1% of men will have total urinary incontinence, which could require an artificial sphincter placement at some later date. It may take up to six (6) months for full recovery of urinary incontinence. Usually, it is only a few weeks.
3. Bladder neck contracture is a narrowing of the connection between the urethra and bladder. It is common for this scarring to occur and when severe enough it obstructs the urinary stream. Most bladder neck contractures are easily treated in the office with dilation.
4. Thrombophlebitis, or blood clots in veins, is a rare complication of all pelvic surgery. Precautions are taken with compression stockings and early postoperative ambulation, which helps prevent clots forming in the veins.