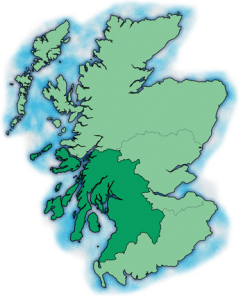


NHS
West of Scotland
Cancer Network

Robotic assisted laparoscopic prostatectomy: Patient information

Contents

1 Introduction

The aim of this booklet is to help answer some of the questions you may have about having a robotic assisted laparoscopic prostatectomy. It explains the:

- benefits
- risks
- alternatives to the surgery
- what you can expect when you come into hospital.

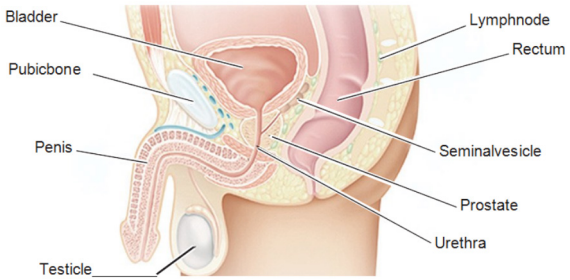
If you do have any questions and concerns, please do not hesitate to speak to your Urologist or Clinical Nurse Specialist.

2 What is the evidence base for this information?

This booklet was developed using advice from experts, the British Association of Urological Surgeons, the Department of Health and other evidence-based sources. Therefore, it is based on best practice in the UK. It is intended to supplement any advice you may already have from your GP or other healthcare professionals.

3 What and where is my prostate?

Your prostate is a small walnut sized gland that is situated at the base of your bladder. Its main function is to produce liquid which carries your sperm when you ejaculate.



4 What is a robotic assisted laparoscopic prostatectomy?

This is keyhole surgery (minimal access) where the surgeon uses a special machine (called a Da Vinci® Xi machine) which has robotic arms. This surgery is to remove the prostate, seminal vesicles (tube-like glands which make semen) and occasionally lymph nodes.

More and more we now use 'key hole' surgery which means you have smaller cuts than the traditional open large cut across the tummy.

The Da Vinci® Xi machine is a safe and effective method for surgery and is used by many cancer centres throughout the UK.

You need a general anaesthetic for a Robotic assisted laparoscopic prostatectomy which means you are asleep.

It involves the use of a number of "ports" (small cuts) which allow access to the prostate.

The length of time for the surgery is typically between 2-3 hours but varies between patients.

Your Urologist will assess and discuss your fitness for this surgery.

You should be aware that there is a small chance (about 0.5 per cent or one in 200) that your surgery may need to change to open surgery. In other words once the surgery begins the surgeon may find that it is not possible to proceed using the robot and so may decide that they need to make a cut in your tummy to successfully remove the prostate. Therefore, if you don't want open surgery at all, we would not be able to proceed with the robotic surgery.

Please be assured that you will not have to decide which surgery to have on your own. Your urologist and clinical nurse specialist will be able to offer advice.

5 Why do I need robotic assisted laparoscopic prostatectomy?

A prostatectomy (removal of the prostate gland) is surgery to remove the prostate gland in patients who have prostate cancer. We

remove the prostate, seminal vesicles and some surrounding tissues to provide the best possible chance of removing all the cancer.

You will have had a discussion with your Urologist and Clinical Nurse Specialist about prostate cancer. Please remember that we can treat early prostate cancer effectively. Most men with early prostate cancer will remain alive and healthy for many years to come.

6 What are the benefits?

This type of surgery has been shown to have the following advantages:

- **Small scars:** six small cuts in the tummy as opposed to one large one.
- **Less pain**: usually oral painkiller tablets will help manage the pain and pain rarely lasts more than three days.
- **Less blood loss:** this reduces the risk of needing a blood transfusion
- **Short length of stay:** most patients go home 24 to 48 hours after surgery.
- **Enhanced surgical 3-D vision and dexterity of instruments** gives the surgeons high levels of control within the tummy minimising risk and helping to remove all the cancer
- **Rapid return to normal:** most patients can return to work after four to six weeks.

7 Are there any risks associated with robotic assisted laparoscopic prostatectomy?

Most surgical procedures have potential risks, these are listed below.

Common (greater than 1 in 10)

- Temporary insertion of a bladder catheter (all patients will have a catheter for at least seven days after the surgery).
- Temporary difficulties with urinary control.

- Impairment of erections even if the nerves can be preserved (20 to 50 percent of men with good pre-operative sexual function).
- Inability to ejaculate or father children because the structures which produce seminal fluid have been removed (occurs in 100 per cent of patients).
- Discovery that cancer cells have already spread outside the prostate requiring further treatment.

Occasional (between 1 in 10 and 1 in 50)

- Scarring at the bladder exit resulting in weakening of the urinary stream and requiring further surgery (2 to 5 percent).
- Severe urinary incontinence (temporary or permanent) requiring incontinence pads or further surgery (2 to 5 percent).
- Blood loss requiring transfusion or repeat surgery.
- Further cancer treatment at a later date, such as radiotherapy or hormone treatment.
- If lymph nodes are removed during surgery it can lead to fluid in the pelvis.
- Some degree of constipation can occur; we will give you medication for this. If you have a history of piles, you need to be especially careful to avoid constipation. (As straining to make a bowel movement puts pressure on your wound).
- Apparent shortening of the penis; this is due to removing the prostate gland causing upward displacement of the urethra to allow it to be re-joined to the bladder neck. The reduction in blood flow to penis also effects length.
- Development of a hernia related to the site where the port was inserted.
- Development of a hernia in the groin area at least six months after the surgery.
- Scrotal swelling, inflammation or bruising (short term).

Rare (less than 1 in 50)

- Anaesthetic or cardiovascular problems possibly requiring intensive care admission (including chest infection, blood clot in the lung, stroke, blood clot in the leg (deep vein thrombosis), heart attack and death).

- Pain or infection at the cut sites.
- Rectal injury requiring a temporary colostomy.
- Hospital-acquired infection.
- Colonisation with MRSA (0.9 percent, 1 in 110).
- Clostridium difficile bowel infection (0.2 percent; 1 in 500).
- MRSA blood stream infection (0.08 percent; 1 in 1,250).

8 What are the complications specific to having this surgery?

Your surgeon will try and perform nerve sparing surgery if appropriate. This means trying to avoid removing the nerves which affect your ability to have an erection and those to the base of the bladder which keep you continent.

Erectile problems

Depending on your erectile function before the surgery and whether it was possible or appropriate to save these nerves, problems with erection after the surgery can occur. The risk of this problem varies:

- **Very high** (more than 80 per cent; eight out of 10 men), if the erections were not good before hand or the characteristics of the tumour mean that it was not advisable to preserve the nerves.
- **Moderately high** (60 percent; six out of 10) if only one nerve could be saved.
- **Moderate** (30 to 40 percent; three to four out of 10) if both nerve bundles were saved.

We can treat erection problems using a range of treatments from tablets, injections and vacuum devices. It is highly unlikely that you will lose your sex drive (libido) as a result of the surgery.

If a nerve-sparing surgery has been performed, we will offer you medication such as Viagra or Cialis after surgery. We would recommend that you take this as prescribed in order to help

improve the blood flow into the penis. We would not expect this to result in erections immediately and, in fact, some patients may take as long as 18 to 24 months to recover erectile function.

If tablets are unsuccessful, we can then arrange for you to see a specialist nurse to discuss alternative treatments.

Please feel free to discuss this with your Urologist or Clinical Nurse Specialist.

Continence problems

It is common to experience some temporary loss of control over the passage of urine. This tends to settle within three to six months but, during this period, you may need to wear absorbent pads. A small minority of patients will experience severe incontinence after the surgery, however, we will discuss this with you before your surgery.

9 What will happen if I choose not to have robotic assisted laparoscopic prostatectomy?

The aim of robotic assisted laparoscopic prostatectomy is to remove your prostate gland, seminal vesicles and surrounding tissues while the cancer is contained within the prostate gland. This is to provide the best possible chance of removing all the cancer.

However, if you choose not to have this surgery there are many other alternative treatments (see below). The Multi Disciplinary Team (MDT) will give you a risk category which refers to the chance of your cancer getting worse and your long term survival. This can help you make a decision regarding treatment.

Low risk

Low risk localised prostate cancer within your prostate gland is very unlikely to grow or develop for many years. This is because your prostate cancer may be so slow growing that it never causes any

symptoms. Treatments for prostate cancer can cause long-term side effects, so doctors try to avoid giving treatments if it is safe to do so. If the cancer starts to develop while you are having active monitoring (where we monitor your cancer regularly), your doctor will offer you alternative treatment. Please see the section below.

Intermediate risk

In men with intermediate risk prostate cancer, the cancer may start to grow or spread within a few years and so you we are likely to offer you treatment earlier.

High risk

High risk prostate cancer may start to grow or spread within a couple of years. If the cancer has broken through the capsule surrounding the prostate gland, this is called locally advanced prostate cancer.

For locally advanced prostate cancer, you may have surgery to remove the prostate gland or external radiotherapy to the prostate. This may be combined with a course of hormone treatment. You may have hormone therapy before surgery or radiotherapy, or afterwards for up to three years. Men who cannot have surgery or radiotherapy because they are not fit enough may have a course of hormone therapy as a treatment on its own.

10 Are there any alternatives to robotic assisted laparoscopic prostatectomy?

Your surgeon will have discussed all the suitable alternatives with you when you were deciding on which course of treatment to choose from. The full list of alternative treatments is given below:

- Active monitoring (watchful waiting)
- Open radical prostatectomy

- External beam radiotherapy
- Brachytherapy (implantation of radioactive seeds)
- Other treatment options under investigation include HIFU (high intensity focused ultrasound) and Cryotherapy

You may not be suitable for some of these treatments. However, if you wish to discuss any of these treatment options further please ask your Urologist, or Specialist Nurse.

11 What do I need to do to prepare for robotic assisted laparoscopic prostatectomy?

You will normally receive an appointment to attend the pre-assessment clinic, approximately seven days before your admission to hospital. This is to make sure you are well enough and fully prepared for coming into hospital, your treatment and then going home. While at the clinic you may have several other tests. For example blood tests, ECG (heart tracing) or chest x-ray.

We will usually admit you on the day of your surgery.

Please do not eat from midnight the night before your surgery (please refer to the "Your stay in hospital and discharge information" Booklet for further information).

Please try to empty your bowels the morning of surgery. You may need to have a small suppository before surgery to help you empty your bowels.

Please have a shower on the morning of surgery before leaving home. You do not need to shave any areas of your body. If this is required we will do this in the anaesthetic room once you are asleep.

Admission

After admission, you will see members of the medical team which may include the Consultant, Specialist Registrar or your Clinical Nurse Specialist.

Please be sure to tell them 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 prescription for warfarin, aspirin or clopidogrel (plavix®)
- A previous or current MRSA infection
- High risk of variant CJD (if you have received a corneal transplant, a neurosurgical dural transplant or previous injections of human-derived growth hormone)

Before your surgery, the anaesthetic team will visit you please ask them questions if you have concerns or issues about the anaesthetic.

We will ask you to change into a surgical gown.

We will give you an injection under the skin of a drug (Clexane®) which, together with the elasticated stockings, will help prevent thrombosis (blood clots) in the veins of your legs.

12 Asking for your consent

We want to involve you in all the decisions about your care and treatment. If you decide to go ahead, by law we must ask you to sign a consent form. This confirms that you agree to have the surgery and understand what it involves. Staff will explain all the risks, benefits and alternatives again before they ask you to sign a consent form. If you are unsure about any aspect of your proposed surgery, please do not hesitate to speak to your Urologist or Clinical Nurse Specialist.

The Recovery Area

Once your surgery is complete, we will take you to the recovery area. You will wake up with an oxygen mask on your face, a catheter in your bladder (to drain urine) and six small cuts where the robotic port sites have been closed. You may also have a wound drain in your abdomen.

We find that nursing our patients in a sitting position immediately after surgery gives us the best results. If you find this uncomfortable please let the staff know and we can change your position.

Some patients have a slight swelling of the face and eyes when they first wake up after the anaesthetic. This reduces quickly if we nurse you sitting up right. Please do not rub your eyes as this can cause pain while they are swollen. The nurses will remind you about this.

We will give you clear fluids to drink and you can start to eat as soon as you feel able to do so. Once the anaesthetic staff, surgeons and nursing staff agree that your condition is stable, we will transfer you back to the ward.

13 Will I feel any pain?

Although you have had keyhole surgery, it is still possible that you may have some pain and we will give you painkillers if you need them. It is very important that, whilst you are in the recovery ward area, you let the staff know if you feel any pain or become nauseous so that they can give you the appropriate medication.

Your abdomen is filled with gas throughout the surgery to give us the space to operate in. This can cause the abdomen to feel stretched and bloated afterwards. All the gas is let out at the end of the surgery but some people complain of pain in their shoulders - this is due to the diaphragm being stretched by gas.

Local anaesthetic is injected into the wounds and your anaesthetist will inject you with a large dose of painkillers before waking you. We

try to change your painkillers to oral tablets rather than continue to use injections. This helps speed up your recovery and aids you getting out of bed and mobilising. Taking regular painkillers will help you remain pain free and you will be able to go home quicker.

The wounds themselves are small (five to ten millimeters) apart from the one on the right hand side as this is larger to allow the removal of the prostate at the end of surgery. The size of this wound depends on the size of your prostate. Since the surgery is performed through small cuts, most patients experience much less pain than with open surgery. Patients tend to need less pain medication and, after three days, most men do not take any painkillers at all. We will give you painkillers home with you and we advise you to make sure that you have a supply of paracetamol at home before going home.

Occasionally people complain of a sore throat after surgery and this is due to the anaesthetic tube that helps you breathe during the surgery. This will soon settle.

Very rarely patients suffer from numbness over the knee or in the fingers but this should settle after two weeks.

It is not unusual to experience bruising across the abdomen and in the scrotum. The scrotum can become swollen and occasionally dark purple in colour - if you experience pain or scrotum feels excessively hot please contact your GP for advice.

14 What happens after the surgery?

On the evening after your surgery we will encourage you to get out of bed. You begin by sitting in your chair for short periods and slowly progress to moving around your bed, going for a wash and being able to walk the length of the ward area.
The day after surgery we will:

- review your drain and remove it if appropriate

- change your urinary drainage bag to a smaller leg bag
- ask you to get dressed.

You will be able to go home when you:

- are eating and drinking,
- are mobilising safely (i.e. as well as you did before your admission)
- are able to care for your catheter and leg bags

Occasionally your surgeon may make a decision to keep you in hospital a little longer on medical grounds. This is nothing to worry about and the decision is made with your best interests in mind.

It is important that someone is available to take you home when you are discharged (e.g. to help carry your bag etc). It is also important that there is someone at home to help look after you once you go home from hospital.

Patients travelling long distances to the hospital may be required to stay slightly longer.

17 What happens when I am discharged home?

You will go home with your catheter in place. We will teach you how to look after your catheter before you go home.

We will give you an appointment to come back to clinic to have your catheter removed 7-14 days after surgery. **Please make sure you have your appointment booked before you leave hospital.**

When your catheter is removed you may experience some degree of incontinence. It is common to experience some temporary loss of urine control. This tends to settle within three to six months but, during this period, you may need to continue to wear absorbent pads.

To be prepared for your catheter removal and any potential temporary urine leakage, you should make sure that you have

a supply of absorbent pads (e.g. those specially designed for male underwear) at home before your appointment to have your catheter removed. **You will need to bring two pads with you to your appointment.** You can buy these pads from:

- Your local pharmacy or supermarket – you may need to order these.
- All of the major suppliers have telephone and on line ordering facilities if you prefer. The Bladder and Bowel Foundation website also has a list of contact information (www.bladderandbowelfoundation.org).

Do not buy too many until you know what your needs are.

As discussed before your surgery, a small minority of patients will experience severe incontinence after the surgery. If this is the case, we can arrange additional support and follow-up.

Pelvic Floor Exercises

After your catheter is removed , you will need to continue pelvic floor exercises To improve urinary control, pelvic floor exercises are helpful. You will need to continue these exercises after the catheter has been removed for up to a year, but not while your catheter is in place.

Your wounds

Your wounds are closed with absorbable stitches that will dissolve in 2-4 weeks. You may shower and bathe as normal.

It is important to stay active after you surgery as this minimises the risk of complications such as chest infection and deep vein thrombosis (blood clots). We recommend a little gentle exercise each day - walking is ideal. After two weeks you can start gentle jogging and aerobic exercise. After four weeks, you may resume light lifting e.g. small bag of shopping.

Driving

You can start to drive again when you are comfortable to do so (usually about two weeks after surgery) and when you feel able to make an emergency stop. You should, however, check with your insurance company before returning to driving.

Returning to Work

Please allow at least two weeks before returning to work. Everyone recovers at a different rate and some people may require longer but most people are able to return to work after six weeks.

18 When should I expect to have a follow-up appointment?

Your first appointment will be 7-10 days after surgery to remove the catheter (unless your consultant tells you otherwise).

Following your surgery the Multi Disciplinary Team (MDT) made up of Surgeons, Radiographers, Oncologists and Nurses will review the results of the histology (i.e. the results of the examination of the tissue that was removed). About 6 weeks after your surgery you will have an outpatient appointment to discuss the results and what happens next (the care pathway).

We will check your prostate specific antigen (PSA) every 3 months for the first year and then every six months for a further year. After this we will review you as appropriate.

19 Useful Contact Numbers

Before your surgery, please make a note of your named specialist nurse, and before discharge, the phone numbers for Ward 11C and your Consultant's secretary.

Before your catheter removal, please contact the ward directly if you have any issues. If there are any issues, requiring admission, we will admit you straight back to the Urology Ward.

After your catheter removal, the Specialist Nurses should be your first point of contact and you can contact them during normal working hours. Please leave a message if you cannot get through to them directly. If you are worried about your health please contact your GP practice.

Ward 11C, QEUH
Tel: 0141 452 2770

Robotic Secretary
Julie Clyde
Telephone: 0141 451 5997
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Robotic Nurse Specialist and Co-cordinator
Sister Alison Obeidallah
Telephone: 07812 767491
Email: alison.obeidallah@ggc.scot.nhs.uk

20 Where can I find more information?

Prostate Scotland
Telephone: 0131 603 8660
Website: www.prostatescotland.org.uk

Macmillian Cancer Support
Freephone: 0808 808 0000
Monday to Friday09:00 to 20:00
Website: www.macmillan.org.uk

Cancer Research UK
Telephone: 0808 800 4040
Website: www.cancerresearchuk.org.uk

Bladder and Bowel Foundation
Telephone: 0845 345 0165
Website: www.bladderandbowelfoundation.org

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