



You have been booked for a

# Radical prostatectomy



ROCKHAMPTON  
**Urology**

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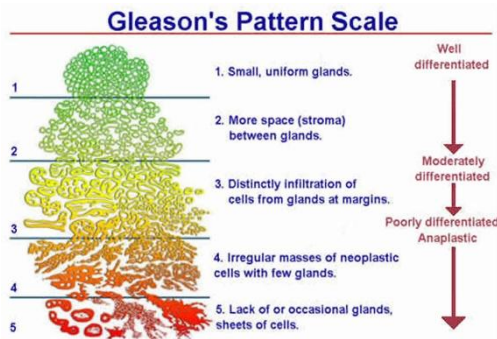
**Urologist**

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You have been diagnosed of prostate cancer

It is not good news for you to have cancer but is a good thing to know that you have prostate cancer and you can fight against it.

First of all, you have to know about how we score prostate cancer to know about your prognosis Prostate cancer is graded in Gleason Score, this is related to the architectural pattern of your cancer, it is the sum of the most prevalent cancer in your biopsy. It goes from 1 to 5, 1 means almost normal pattern and 5 means very desestructured pattern, more aggressive.



We only treat cancer which score is more than 7, (the sum of the most prevalent cancers in the biopsy), it can be 3 + 4, or above, if the number increases means that it is more aggressive.

Prostate cancer is not an aggressive cancer, we discuss about your prognosis in 10 years, most of the cancers are about 2 to 5 years prognosis, meaning that we have more chances to treat the cancer and stop the cancer affecting your life

There are multiple options of treatment, but if you are suggested to have radical prostatectomy it means that this treatment can cure you in more than 90% of the cases without any extra treatment, no need for further radiotherapy or chemotherapy in most cases

Just to remind you of the possible options discussed I go through them briefly in the next sections

**Active surveillance:** The aim of this approach is to avoid over treatment of potentially non-significant cancers. However, if your cancer is a Gleason score of 7 or more, I would not recommend active surveillance as he likely has clinically significant disease.

**Low-dose Brachytherapy:** at the moment this therapy is not a very well established as the treatment of choice of moderate grade cancer, prostate cancer with good results are low grade tumours. I discussed all the possible complications of the procedure (urethral stricture, dysuria, impotence in a long term, difficult to treat if therapy fails).

**External Beam Radiotherapy** could be an option for this patient. It is recommended to have hormonal therapy before radiotherapy and radiotherapy requires approximately 8 weeks of treatment. I have also discussed the risks of rectal and urinary toxicity, risk of urinary retention and that salvage surgery is generally recommended in cases of failure, a surgery with high risk of complications. Another factor against this treatment is age; young people have time to develop secondary tumours related to radiotherapy.

**Surgery** can be laparoscopic, laparoscopic robotic assisted and open surgical options. All these types of surgeries has the same oncologic outcome. Open radical prostatectomy offers the same proven benefits of cancer control, continence and potency as its robotic or laparoscopic counter-part.

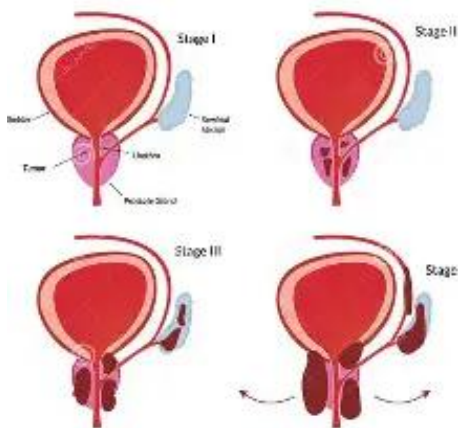
Laparoscopic and robotic approach both offer a moderated rapid convalescence with one or two days of shorter hospital stay, 2 days

admission compared to three days with open prostatectomy. The inconvenience of robotic is that needs to be done in Brisbane and the cost involved in the procedure. It is recommended to stay in Brisbane some days, around 2 weeks, the time you are having the indwelling catheter, after the operation to avoid complications. Now we are discussing the results of my patients after surgery.

In terms of incontinence, after the surgery 67% of patients are pad free within 1-2 months, however, 5-10% may require pad at 1 year and 2-4% have server incontinence at 1 year requiring further intervention by way of an artificial sphincter or sling. In term of erectile dysfunction if both nerves are sacrificed, spontaneous erections are generally not achievable. With bilateral nerve sparing, potency rates are up to around 80% but depends on age and pre-existing erectile function. This decreases to 20% with unilateral nerve spearing. He is aware that if erection is not achieved, spontaneously or with PDE5 inhibitors, then, his option is a vacuum device, intracavernosal injection or possible prosthesis. I have explained that erectile dysfunction may take 12-24 months to recover.

There are other associated risks after the surgery including mortality, DVT, PE, MI, CVA, urine leak, urinary retention, anastomotic stricture,

STAGES OF PROSTATE CANCER



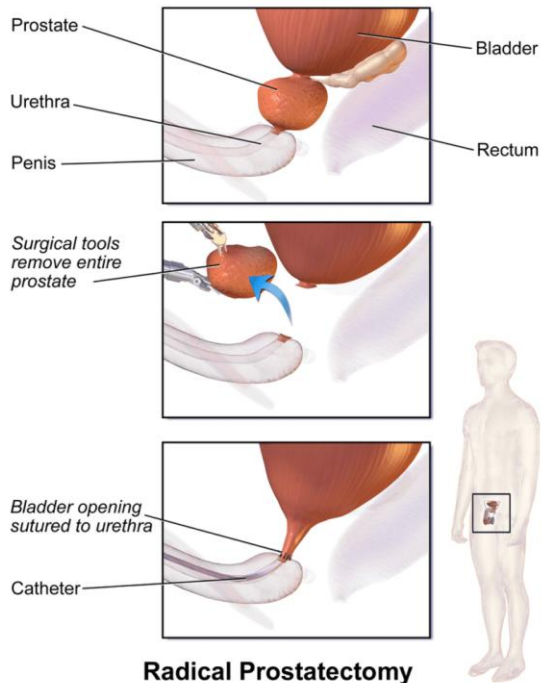
ureteric injury, fistula formation, prolonged catheterization positive margins and the possible need for adjuvant radiotherapy and cancer recurrence. All these complications are extensively explained in the clinic to the patients.

We get into detail about the surgery:

## **THE SURGERY**

A radical prostatectomy involves the surgical removal of the prostate gland and seminal vesicles to eradicate the cancer, occasionally is needed to remove also the lymphatic tissues in the area. During the open prostatectomy the prostate is accessed through a 10 cm incision in the lower abdomen. Most of the patients remain in hospital of a period of 3 day after the operation

The surgery takes around 3 hours, the prostate is removed, the nerves are spared if possible and if the cancer is localized, the bladder neck is reconstructed and anastomosed to the urethra. A catheter is left for 2 weeks to let the anastomosis heal during this period. The catheter is removed after a test to check that there is no leakage in the anastomosis. Your recovery to fully continence starts once the catheter is removed.



## CONSENT AND RISKS

Your doctor is explaining your surgery, possible complications, and other possible treatment options till you are fully informed to decide if you want to go ahead with the surgery.

A consent form is a legal document, recognizing your willingness to proceed with the intended treatment. You are required to sign a consent form for the operation once you fully understand the reason for the operation and the risk involved.

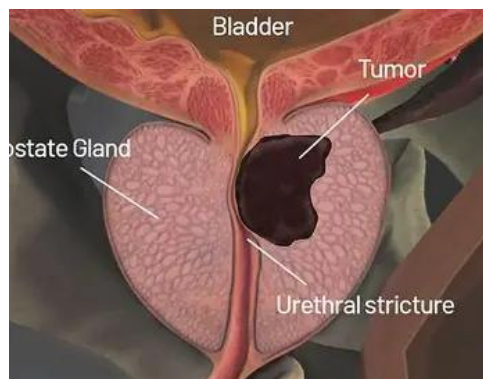
All the operations have risks associated with them. All risks should be discussed with your doctor. You should understand the procedure and discuss alternative treatment.

Your local doctor may be also available to answer your questions

Once you decide about having the surgery to treat your prostate cancer, some more information about the surgery

The radical prostatectomy can be done open or laparoscopic assisted

We go through the main differences between these 2 types of surgery;  
Both surgeries remove the prostate and seminal vesicles



## Differences

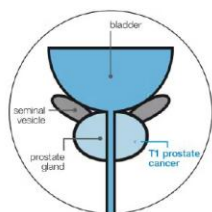
|   | <b>Open protatectomy</b>                                     | <b>Robotic prostatectomy</b>                                |
|---|--|---|
| <b>Oncology outcome</b>                         | <b>Similar or a little bit better<br/>but no significant</b> | <b>similar</b>  |
| <b>Potency</b>                                  | <b>No difference</b>   | <b>No difference</b>  |
| <b>continence</b>                               | <b>No difference</b>   | <b>No difference</b>  |
| <b>Nerve sparing</b>                            | <b>similar</b>   | <b>similar</b>  |
| <b>Length of admission</b>                      | <b>3 days</b>  | <b>2 days</b>   |
| <b>Catheter time</b>                            | <b>2 weeks</b>   | <b>2 weeks</b>  |
| <b>cost</b>                                     | <b>cheaper</b>   | <b>10 to 20 times more<br/>expensive</b>                    |
| <b>Site of surgery</b>                          | <b>Rockhampton</b>   | <b>Brisbane</b>   |
| <b>Stay in place of surgery</b>                 | <b>Back home after DC</b>                                    | <b>Stay in Brisbane for 2<br/>weeks till removal of IDC</b> |
| <b>Follow up</b>                                | <b>Local Rockhampton</b>                                     | <b>Brisbane, telehealth or<br/>FYO doctors</b>              |
| <b>Location of surgeon if<br/>complications</b> | <b>Rockhampton</b>   | <b>Brisbane</b>   |
| <b>Removal IDC</b>                              | <b>2 weeks</b>   | <b>2 weeks</b>  |

Basically, both surgeries are very similar in the outcome of the surgery, and both can have complications, the recommendations are that choose a surgeon with experience that you trust to have your surgery, we facilitate your choice

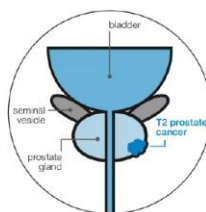
I, dr Vega Vega, facilitate your surgery to happen in Rockhampton if you want to be close to your family, in your own environment and having your doctor accessible any time. I've been urologist for almost 30 years, have a large experience in this type of surgery with far more than a thousand of radical prostatectomies, I was the first surgeon to perform this surgery in

Rockhampton, almost 20 years ago. My complication rate is very low, with a transfusion rate below 5 per cent. my statistics of incontinence and erectile dysfunction after surgery are comparable to the best outcomes. I am very proud of my oncology outcome with most of my patients, above 80-90 per cent free of cancer after the surgery.

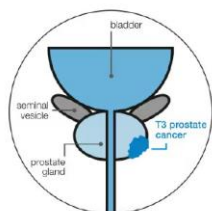
If you decide to have an open radical prostatectomy in Rockhampton, these are some useful information for you.



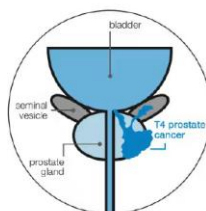
**T1 prostate cancer**  
The cancer cannot be felt and can only be seen under a microscope – **localised prostate cancer.**



**T2 prostate cancer**  
The cancer can be felt or seen but it is contained within the prostate gland – **localised prostate cancer.**



**T3 prostate cancer**  
The cancer can be felt or seen breaking through the capsule of the prostate gland – **locally advanced prostate cancer.**



**T4 prostate cancer**  
The tumour has spread to nearby organs, such as the bladder neck, back passage or pelvic wall – **locally advanced prostate cancer.**

## PREAMMISSION

During this clinic you will receive the assessment you require before your operation

The anaesthetic will explain his role during your operation and will also assess your general health

In all big surgery we recommend organising a workout to check your general health and specifically to have a cardiac stress test to check your risks of cardiac complications during the surgery.

You are asked to have bloods some days before the surgery; we also get your group and hold just in case you need to have blood after the surgery. The risk of transfusion is around 1% due to bleeding during the surgery but better be prepared.

### **DISCHARGE PREPARATIONS**

The usual length of stay for your surgery is 3 days. You usually are very independent to take care of yourself after discharge, but your family should be aware that you will require some assistance with daily household activities for a few weeks after your surgery.

### **YOUR MEDICATION**

Some medication can increase the risk of bleeding from surgery. Most of these medications are used for pain relief. Please discuss your medications with your doctors as some may need to be stopped for 1-2 weeks before your procedure:

Aspirin, Persantin, Iscover, Plavix, warfarin, Eliquis, Pradaxa or Xarelto.

If you need to continue on anticoagulants you have to discuss with your doctor the option of bridging with Clexane before surgery

All supplements like fish oil, ginkgo or glucosamine usually needs to be ceased for at least several weeks before surgery for the increased risk of bleeding.

If you are diabetic, you need to discuss with your doctor about your diabetes medication, usually needs to be ceased for 2 days before surgery

All the rest of your medication you need to continue before the surgery, you don't need to stop your regular medication, only blood thinners and diabetic medication as indicated.

## **THE DAY OF THE OPERATION**

You need to fast for more than 6 hours to avoid aspiration during the surgery

The morning of your surgery you will be admitted the day of your surgery.

On arrival in theatre, you will be introduced to theatre staff who will ask you some questions to confirm your identity and the operation you are to have.

## **AFTER THE OPERATION**

After your operation you will be transferred to the recovery room where you will be monitored until you are awake. You will then be escorted back to the ward.

After the operation you may have the following

- an IV tube drip in your arm for hydration
- an oxygen mask for the first few hours to assist with your breathing.
- A dressing will have been placed over your wound. The dressing will be waterproof allowing you to shower.

-you may have 1-2 wound drains to prevent fluid and blood from accumulating inside the wound. This will be removed in a few days and causes minor discomfort.

- a fine tube called a catheter will be inserted into your bladder to drain urine. This allows us to monitor the urine produced by your kidney and most important, relax your bladder to allow the anastomosis with the urethra to heal. This catheter needs to be in your bladder till the healing of the anastomosis is completed. Please take care of the tube and if any problem consults with your doctor. Don't let anyone remove your catheter before your doctor consider the anastomosis is fully healed.

- A pain buster pump that releases periodically local anaesthesia in the wound to keep the pain under control.

- a sequential pumping compression stocking to decrease the risk of clotting in your legs during the first day. Once they are removed, you also be fitted with a pair of compression stockings to wear for the duration of the hospital stay to help your circulation and assist in preventing clots.

A nurse will monitor your temperature, pulse, blood pressure and wound. This will continue regular basis and throughout the night.

Pain relief is very important for to your recovery. Your nurse will ask you to score your pain out of 10 (0 = no pain, 10 = worst pain imaginable), this helps your nurse to assess you pain relief needs.

You may have a device called PCA (patient-controlled analgesia) connected to your drip for pain relief. This has a regulated button you can press each time you need pain relief.

For good circulation, leg exercises, deep breathing and change of position is encouraged while resign in bed.

## **THE NEXT FEW DAYS**

Your observations and pain score will continue to be monitored regularly.

The physio will review you daily to encourage you to deep breath, cough and mobilise where necessary. We encourage you to mobilise at least twice a day, starting the day after the operation. Early mobilisation improves the recovery and decreases the pain.

Your nurse will assist you in the shower daily regardless of your tubes (they will be secured)

You will be gently restarted on diet with just fluids and building your way back to a normal diet as your bowel function returns to normal (i.e. when our stomach begins to rumble and you start to pass wind).

The tubing that are in place will slowly be removed over the next few days, you will find it easier to move once this has occurred. However, all patients will be discharged with the catheter in place. More details can be provided if required.

The dressing on your wound will be checked every day and should be removed after a week. The wound now remains uncovered unless there is a discharge.

Most patients will receive injections twice a day to thin your blood, this will prevent you from developing blots. Once you are discharged you have to continue with a daily injection for a month in your tummy of Clexane to prevent you from developing clots in the first month of discharge.

Most patients are sufficiently comfortable to leave hospital after 3 days

## **HOME ADVICE**

### **ACTIVITY**

Avoid straining and heavy lifting form six weeks after the operation

Walking is the best exercise. After one week, slowly increased the distance you walk each day. You will find that you tire quickly in the early weeks after surgery.

You should not drive for 1-2 weeks following the operation, but seek clarification from your doctor.

### **DRINKING**

Drink 2-3 litres of fluid/day to continue flushing your urinary system.

### **WOUND**

The wound can no stay uncover unless there is discharge. Monitor your wound over the next few weeks for sings of infection such as redness, selling, ooze, heat or increased pain. Please, seek medical attention if you are concerned about the wound.

## **URINARY CATHETER**

### **CARE OF THE CATHETER.**

The urinary catheter is protecting your bladder to have a proper healing with the urethra without leakage. The urinary catheter only can be removed by the urologist after checking the Cystogram done 10 to 14 days after the surgery looking for any leakage. The Cystogram is a test done in the Medical Imaging Department, that consists in injecting contrast through the catheter

to fill the bladder to check for any leakage in the healing of the anastomosis of the bladder with the urethra.

Don't let anyone remove your catheter without contacting with your urologist

## **DRAINS**

If you have any drain in the side of the wound, you have to empty daily the content in the collection device and written down the amount contained

## **CONTINENCE**

Although patients generally experience some difficulties with urine control following the removal of the catheter, control is improved over time. Pelvic muscle exercises increase the chances of early recovery. Most of the patients recover continence in the first 2 months after the operation. The continence can improve in the first 12 months. Some patient will need at the beginning some small incontinence pads, especially with exercise.

If you are experience problems report to your treating doctor.

## **SEXUAL FUNCTION**

You will find that sexual activity will feel different after the operation. You may not be able to achieve an erection. The recovery of the potency is related to the pre-existent function before your surgery.

Erection may improve with time, can take up to 2 years. To improve the recovery, we recommend early help with tablets and/or injection as rehabilitation of the sexual function.

Your fertility is going to be affected, and you will not discharge semen with and orgasm, it will be a dry ejaculation.

## HOSPITAL DISCHARGE

At the time of your discharge, please, ensure that you have been provided with:

- a discharge letter and follow up appointment
- all your usual and any new medication
- a medical certificate if required
- as crimp with the antibiotic, a script with clexane
- information about the care of the IDC catheter
- information and training about how to self-administrate Clexane



## IN CASE OF PROBLEMS

If you develop any of the following

- Dark blood stained urine
- Fever chills, sweats
- worsening wound discomfort
- concerns with continence of impotence

NOTIFY THE UROLOGIST OR ATTEND TO THE EMERGENCY  
DEPARTMENT



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