

Side-effects

- Retrograde ejaculation in more than 90% of patients. Therefore if you have not completed your family, this procedure is not for you unless absolutely necessary.
- Infertility as a result of the retrograde ejaculation.
- Stress incontinence especially in the elderly and the diabetic patients
- Patients with Multiple Sclerosis, Strokes and Parkinsons have a higher risk of incontinence and risks should be discussed and accepted prior to surgery.
- Urethral structuring in 2-3% of patients, requiring intermittent self dilatation.
- Regrowth of prostate lobes within 3-5 years requiring a second procedure.
- NB! Each person is unique and for this reason symptoms vary!

Remember

You still have a peripheral zone of your prostate and regular PSA reviews are required up to the age of 75.

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PATIENT INFORMATION BROCHURE

***SALINE/ GYRUS
TRANS URETHRAL
PROSTATE
RESECTION
(TURP)***

Patient well-being is my first priority!

Saline/ GYRUS Trans Urethral Prostate Resection (TURP)

This is the procedure used to resect the inside (enlarged, obstructive part) of the prostate.

Known generally as the “Re-Bore”.

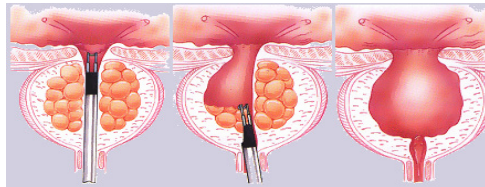
Salt water is used as irrigant.

Why is it done?

- This procedure is performed when the prostate gland is enlarged to such an extent that medication cannot relieve the urinary symptoms.
- Symptoms include: a weak stream, nightly urination, frequent urination, inability to urinate, **(LUTS)** kidney failure due to the weak urination (obstruction), bladder stones, recurrent bladder infections.
- Medication such as Flomaxtra, Xatral Minipress etc. should always be given as a first resort.
- Step-up therapy should have been used for prostates larger than 35-50cc with either Duodart, Avodart or Proscar
- Prostate cancer first needs to be ruled out by doing a PSA, and when indicated, with a 3T MRI scan of the prostate with an abnormal PSA with a possible prostate biopsy of any suspicious lesions.
- A TURP can also be performed to dis-obstruct a severe prostate cancer, to allow a normal urination process.

How is it done?

- patients will receive a general anaesthesia, unless contra-indicated.
- A cystoscopy is performed by placing a camera in the urethra with the help of a lubricant jelly and an irrigant (fluid).
- The inside of the bladder is viewed for pathology. If any suspicious lesions are seen, a biopsy will be taken.
- A resection of the prostate is then started and should take 60-90 minutes.
- Prophylactic antibiotics will be given to prevent any infections.



What can go wrong?

- Any anaesthesia has its risks and the anaesthetist will explain this to you.
- You may in extreme cases experience blood loss, which may require a blood transfusion. (<1%)
- Please inform the practice and the hospital if you are a Jehova's witness, and cannot use blood products.
- In rare circumstances you may develop a dilutional hyponatremia, **(TURP Syndrome)** requiring a High Care Facility admission.
- You will wake up with a catheter in your urethra and bladder. This will remain in the bladder for 3 days.
- You will have a continuous bladder irrigant running in and out of your bladder to prevent clot formation.
- Lower abdominal discomfort for a few days
- NB! Each person is unique and for this reason symptoms vary!

What next?

- You will spend 3-5 days in hospital.
- You will have a trial without catheter as soon as your urine is clear (day 3).
- You will be discharged as soon as you can completely empty your bladder.
- You may initially suffer from urge incontinence and will improve within the next 6 weeks.
- Allow for 6 weeks for stabilization of symptoms.
- There may be some blood in your urine. You can remedy this by drinking plenty of fluids until it clears.
- A ward prescription will be issued on your discharge, for your own collection at any pharmacy
- A follow-up appointment will be scheduled for 6 weeks. Should your pathology be worrisome, you will be contacted for an earlier appointment.
- Don't hesitate to ask Jo if you have any queries
- **DON'T SUFFER IN SILENCE, OR YOU WILL SUFFER ALONE!**

