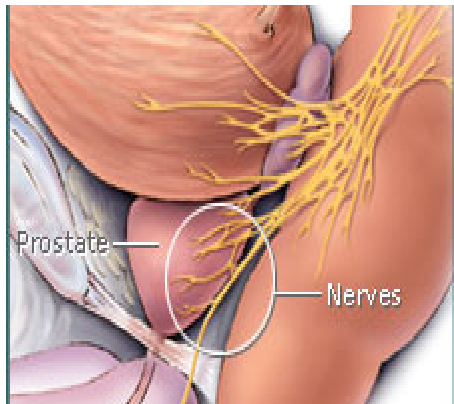
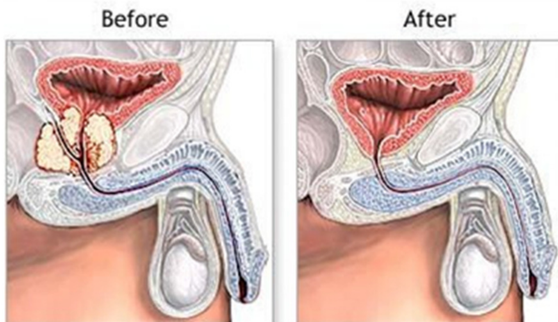
Post-operative review:

- Cystogram at 10 days post-operatively to asses complete healing of urethra bladder neck anastomosis to exclude any leakages
- Should there be any leakages, the catheter may remain another 7 days.
- Review PSA roughly 6 weeks after the surgery to asses post-operative Nadir
- Review in rooms a week later.
- 3-6 monthly review depending on risk factors.
- If stable with good PSA outcomes, refer back to GP for 6 monthly PSA review



PSA failure:

- PSA never dropping to undetectable with positive margins in histology
- 3 consequetive PSA rises following RRP



Jo Schoeman
FRACS, FCS (Urol) SA, MBChB

Pelvic Medicine Centre
St Andrews War Memorial Hospital
Wickham Terrace
Springhill, Brisbane QLD 4000

Ph: 07) 3831-9049
Fax: 07) 3834-4471
E-mail: admin@brisbane-urology.com.au
Emerg: 0403 044 072

Urologist

Dr Jo Schoeman
Specialist Urologist

PATIENT INFORMATION BROCHURE

RADICAL RETROPUBIC PROSTATECTOMY WITH OR WITHOUT PELVIC LYMPHADENECTOMY

Patient well-being is my first priority!

Radical retropubic prostatectomy with or without pelvic lymphadenectomy

Why is it done?

This is the surgical management option for a prostate cancer which fits all the criteria set out by the Urology Society of Australia for Surgery.

Criteria include:

- PSA less than 20
- Gleason 3,4 to low volume Gleason ,4,5 contained adenocarcinoma prostate,
- Higher grades may be considered with patients fully informed of the positive margins and need for adjuvant radiation therapy
  See D'Amico criteria in terminology
- Staging negative, (bone scan negative, CT negative)
- 70 years and younger

It is the complete removal of the prostate, seminal vesicles and bladder neck. It may include a bilateral pelvic lymphadenectomy. (Gleason 4,3 and higher)

A **nerve sparing procedure** is attempted for those guys who have good erections with no tumour infiltrating the erectile nerves.

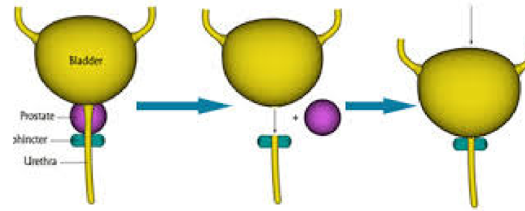
A Cardiologist/ Physician work-up is required prior to surgery to asses for those patients with risk factors and to minimize your operative risk factors.

A 24h post-operative High Care nursing may be required for patients with multiple risk factors.

The procedure takes 2-3hours excluding the anaesthetic time.

A cell-saver will be used to suck up all the blood loss, filter this flood and re-administer your own blood during the procedure. Thus preventing a blood transfusion with its possible complications.

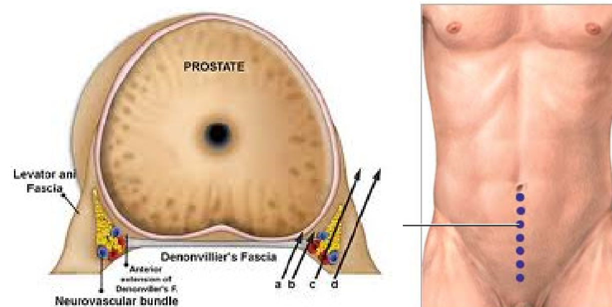
You will be given Deep-Vein-Thrombosis prophylaxis in the form of compression stockings, pneumatic compressions and Clexane 40-80mg subcutaneously daily. You will continue with the Clexane for 28 days. You are at risk for deep vein thrombosis due to the dynamics of any cancer in the body, which may lead to a pulmonary embolism with immediate death as result.



How is it done?

- General anaesthetic
- The surgical filed is prepared
- A Flexible cystoscopy is done to exclude any urethral strictures, bladder cancers and any other pathology
- An IDC is then placed
- A midline lower abdominal incision is made
- The retropubic space of Retzuis is entered.
- Endopelvic fascia is cleared and opened exposing the lateral sides of the prostate
- The urethra is encircled and cut just distal to the prostate sparing the sphincter
- The Veil of Aphrodites is loosened from the prostate sparing the neuro-vascular bundle
- The prostate is lifted off the rectal bed
- The lateral pedicles are tied
- Dennon Villiers fascia is opened to expose the Seminal Vesicles and ampullae of the Vas Deferens, the SV are removed and the Vas clipped
- The prostate is loosened from the bladder neck
- Prostate is removed
- The bladder mucosa is everted
- The bladder neck reconstructed
- The anastomosis with the urethra completed over an Indwelling Catheter

Obturator nodes may be removed depending on the D'Amico Risk category



Complications

- Blood loss 400-1200cc
- Wound infections
- The first 6 weeks are the worst with frequency and urgency as a result
- Stress incontinence may occur and will improve over the next 12 months (12%)
- Complete incontinence at 12 months (2%)
- Erectile dysfunction (40-50%) where a nerve sparing procedure has been performed yet may improve over the next 18 months
- Bladder neck stenosis 5 % requiring intermittent self dilatation
- Anejaculation/ Infertilty
- Testicular pain similar to vasectomy for up to a week

Post operative care:

- Sutures are subcutaneous and will be dissolved.
- You will have a drain in the wound for 24-48 hours until it drains less than 30ml/24 hours
- You spend your first 24 hours in a High Dependancy Unit
- Normal diet will be commenced

Catheter care

- Your catheter will remain for 10-14 days
- Only after a cystogram (radiological investigations where radio-opaque contrast is placed in the bladder) confirms no leakages from the bladder-urethra-anastomosis, will the catheter be removed
- Remember you will leak initially, with gradual improvement up to 6 weeks post-operatively
- Nursing staff will teach you catheter care
- Your catheter should always be fixed to your leg with a catheter dressing