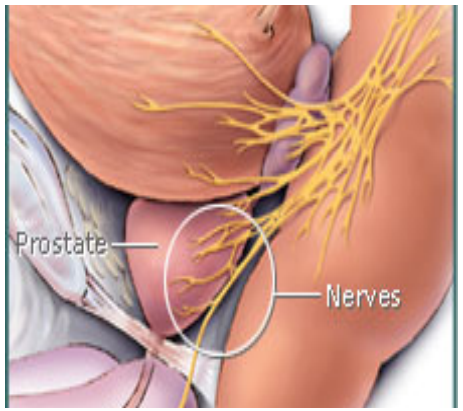
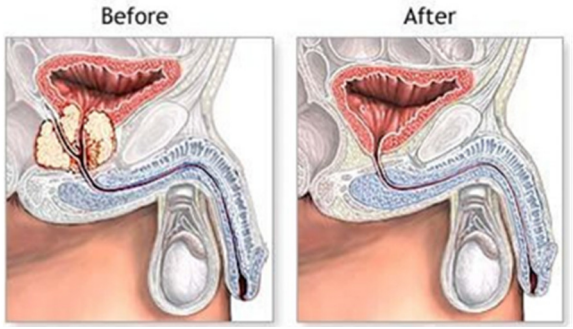
## Post-operative review:

- 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

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# Urologist

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Specialist Urologist

# PATIENT INFORMATION BROCHURE

***ROBOTIC-ASSISTED 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.

This Surgery is done minimally invasive with the help of DaVinci Robotic System

## 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.

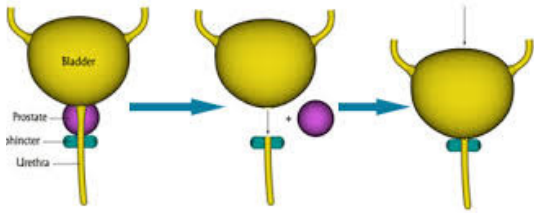
A Cardiologist/ Physician work-up is required prior to surgery to asses for those patients with risk factors and to minimize your operative risk factors.

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.

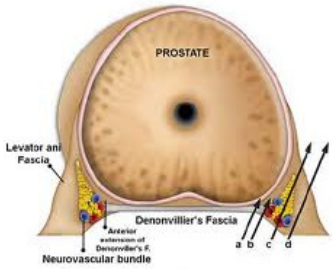
You will be given Deep-Vein-Thrombosis prophylaxis in the form of compression stockings, pneumatic compressions and Clexane 40-80mg subcutaneously daily. You will continue with the Clexane for 28 days. You are at risk for deep vein thrombosis due to the dynamics of any cancer in the body, which may lead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

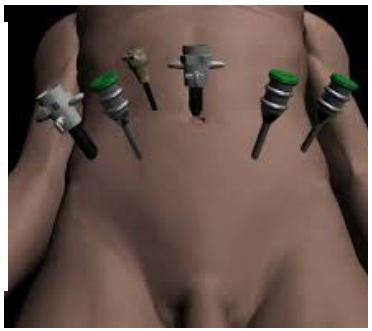



## How is it done?

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 Camera port is placed above the Umbilicus
3 Additional ports for robotic arms in a horizontal line on the abdomen with 2 assistant ports on the right side of the abdomen
The abdominal space is entered and the Retropubic space of Retzuis is entered.
Endopelvic fascia is cleared and opened exposing the lateral sides of the prostate
The Veil of Aphrodites is partially loosened from the prostate sparing the neuro-vascular bundle
The bladder neck is opened
The bladder is loosened from the prostate
Dennon Villiers fascia is opened to expose the Seminal Vesicles and ampullae of the Vas Deferens, the SV are dissected and the Vas clipped
The lateral vascular pedicles are clipped
The erectile nerves are now completed spared off the prostate
The Dorsal Venous Plexus is cut and oversewn
The urethra is cut
Prostate is removed
The anastomosis with the urethra iscompleted over an Indwelling Catheter

Obturator nodes may be removed depending on the D'Amico Risk category at the beginning of the procedure



## 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
- Possibility of bowel injury

## 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 may be discharged on the 2-3 day
- 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