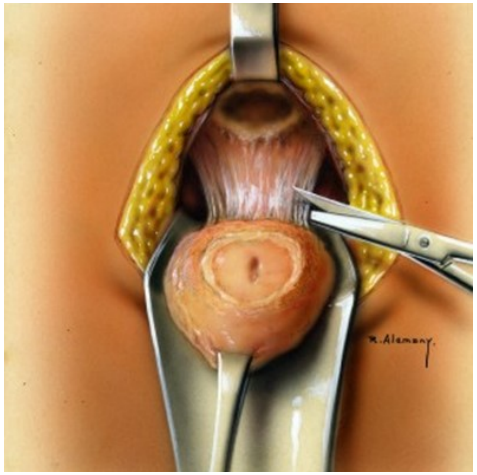
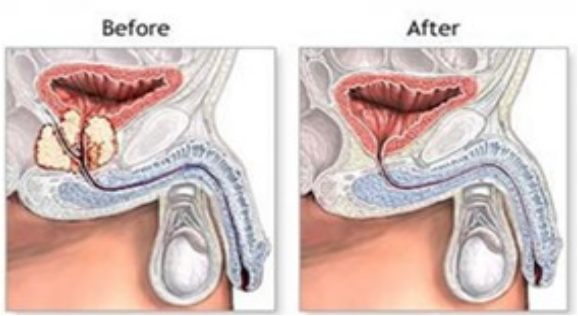
Post-operative review:

- 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



Pelvic Floor Rehabilitation

- You will be referred to a local Physiotherapy Practice which deals with Pelvic Floor Muscle Retraining to assist in regaining your continence
- **MAKE SURE YOU DO YOUR EXERCISES**

Penile Rehabilitation

- You will be referred to a local Mens Health Physician to assist in reganig your Erectile Function should this be required

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Urologist

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Specialist Urologist

PATIENT INFORMATION BROCHURE

RADICAL PERINEAL PROSTATECTOMY

See this live on:
vidscrip.com/urojo

Patient well-being is my first priority!

Radical Perineal Prostatectomy

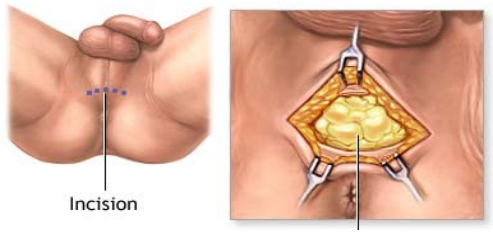
Why is it done?

This is the alternate surgical management option for a localized prostate cancer.

Criteria include:

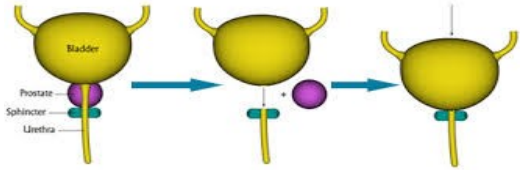
- PSA less than 10
- Gleason 3,4 adenocarcinoma prostate
- Higher grades may have extra-prostatic extension requiring wider pelvic surgery and node removal,
- Staging negative, (bone scan negative, CT negative)
- 70 years and younger

It is the complete removal of the prostate, seminal vesicles and bladder neck.
A nerve sparing procedure is attempted for those guys who have good erections and wish to maintain this.
A Cardiologist/ Physician work-up is required prior to surgery to asses your operative risk factors.
Anaethiatist review preoperatively where indicated.
A 24h post-operative High Care nursing may be required required based on pre-operative risk factors and intra-operative response.
The procedure takes 2-3hours excluding the anaesthetic time.
A cell-saver will be used to catch 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 40mg 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.
This is an alternative to a Radical Retropubic Prostatectomy for low-intermediate risk prostate cancer. Prostates are generally smaller than 50cc.
Could be ideal for those patients with excessive BMI and fitting the cancer specific criteria



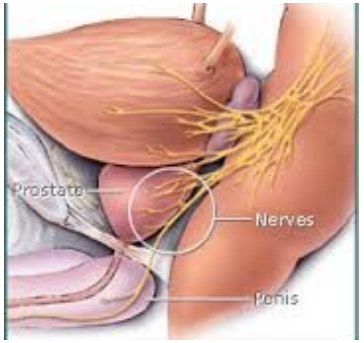
How is it done?

- General anaesthetic
- You will be placed in Hyper-lithotomy
- 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 horse shoe incision is made around the anus.
- The space in the front part of the rectum is entered and passed under the sphincteric muscle
- Dennon Villiers Fascia is cleared and opened in the midline, this brushing the erectile nerves laterally
- The urethra is encircled and cut just distal to the prostate sparing the sphincter
- The prostate is loosened anteriorly from the dorsal venous complex, thus sparing the complex and avoiding major blood loss
- The anterior bladder neck is opened
- The UO identified
- The posterior bladder neck cut
- The lateral pedicles are tied
- The Seminal Vesicles and ampullae of the Vas Deferens, the SV are removed and the Vas clipped
- The prostate is loosened and removed
- The bladder mucosa is everted
- The bladder neck reconstructed
- The anastomosis with the urethra completed over an Indwelling Catheter
- A drain is left



Complications

- Blood loss 200-400cc
- Wound infections
- Stress incontinence which 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. It may take 12-18 months to recover
- Anejaculation/ Infertilty
- Testicular pain similar to vasectomy for 2-3 days



Post operative care:

- Sutures are dissolvable and will not be required to be removed
- Normal diet
- A salt water or Betadine Douche is required after every stool for the fist week
- Apical wound dehissences can occur in 7% which requires extra care in the form of prolonged Salt water or Betadine Douches.
- Wounds generally heal in 7-10 days

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