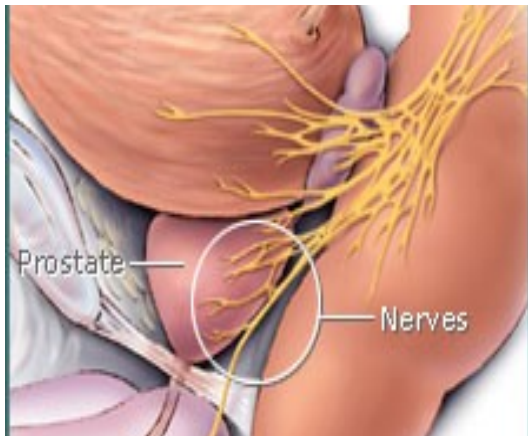


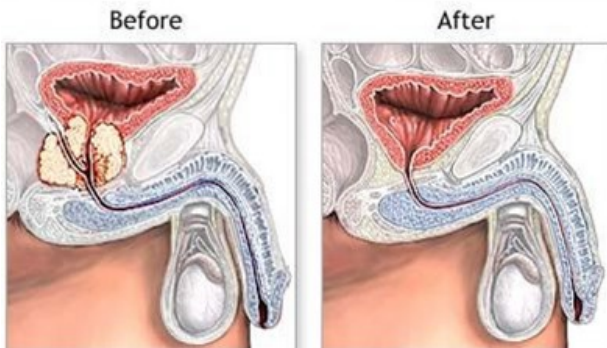
Post-operative review:

- Cystogram at 10 days post-operatively to assess 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 assess 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 consecutive 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**

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Urologist



Dr Jo Schoeman
Specialist Urologist

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RADICAL
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NERVE SPARING
+/-
PELVIC
LYMPHADENECTOMY**

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Patient well-being is my first priority!

Robotic-assisted Radical Prostatectomy, Nerve Sparing +/- 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.

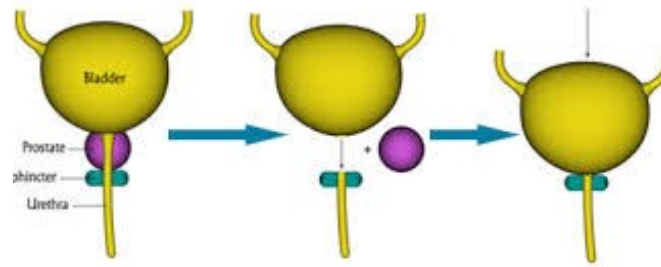
A Cardiologist/ Physician work-up is required prior to surgery to asses for those patients with risk factors and to minimize your operative risk factors.

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 field 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 bladder dropped from the abdominal wall.

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 and cut

The erectile nerves are now completely spared off the prostate

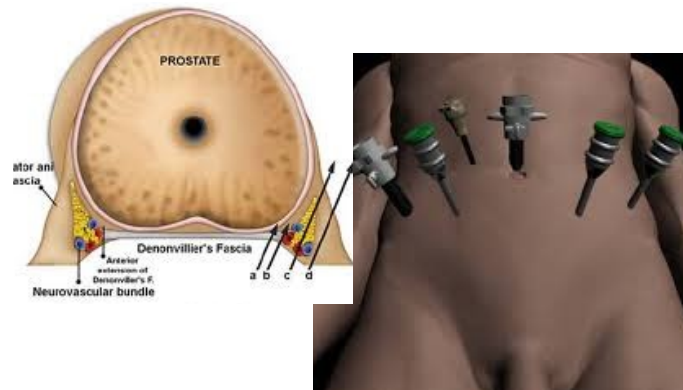
The Dorsal Venous Plexus is cut and oversewn

The urethra is cut

Prostate is removed

The anastomosis with the urethra is completed 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/ Infertility
- 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 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

Erections

You will be referred to a Mens Health Physician to assist with penile rehabilitation