



PERINEAL PROSTATECTOMY

Johns Hopkins Bayview Medical Center

- What to expect prior to the surgery
- Preparation for surgery
- The operation
- Potential risks and complications
- What to expect after the surgery
- What to expect after discharge from the hospital
- Contact Information

http://urology.jhu.edu/MIS/lap_perineal.php

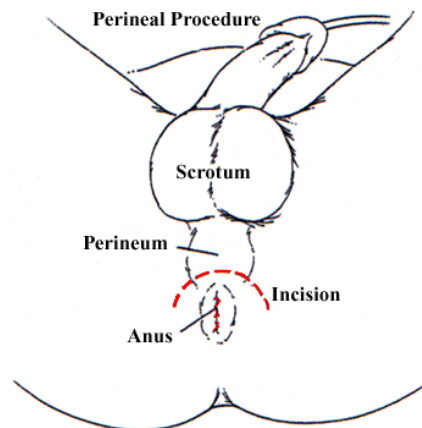
If you are a patient at Johns Hopkins Hospital, for your convenience it is recommended that you schedule the surgery while you are in the Johns Hopkins Outpatient Center. Laura Roberts, Patient Service Coordinator, is available to schedule the date and time of your surgery as well as review important information with you. If you wish to schedule the surgery at a later date, please call Laura Roberts at The Johns Hopkins Outpatient Center at 410-955-4048.

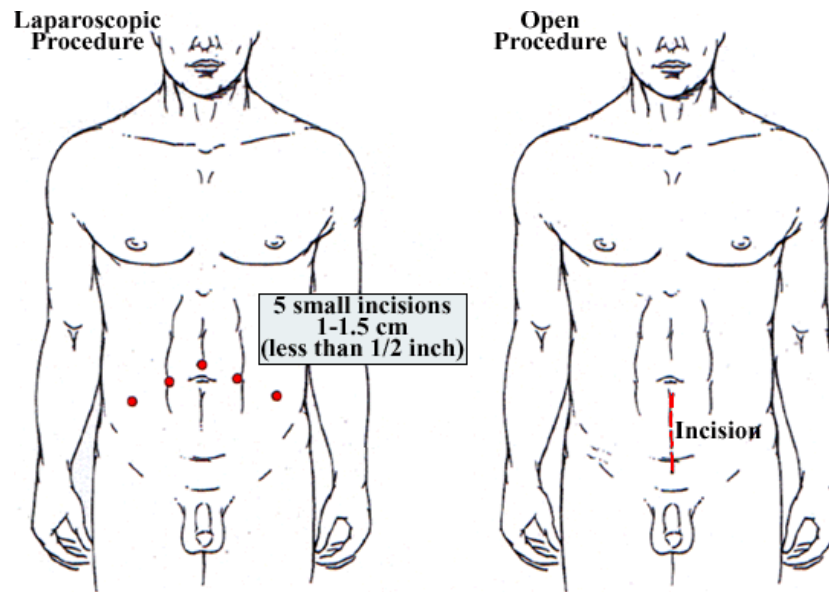
Purpose

The purpose of this section of our site is to provide an information guide for patients considering laparoscopic Radical Perineal Prostatectomy (RPP), a minimally invasive surgical technique that provides a safe and alternative way to remove the prostate gland in patients diagnosed with prostate cancer.

General Information

As compared to open radical prostatectomy where a lower midline abdominal incision is required for dissection and removal of the prostate gland, perineal prostatectomy is performed by making a small (2 inch) incision between the rectum and the scrotum. (see Figure 1). Results from multiple centers specializing in perineal prostatectomy have acceptable blood loss and similar potency and oncologic results as compared to traditional open surgery. Potency can be reserved but may be in lower percentage than the open surgery.





What to expect prior to the surgery

Since insurance companies will not permit patients to be admitted to the hospital the day before surgery to have tests completed, you must make an appointment to have pre-operative testing done at your primary care physician's office within 1 month prior to the date of surgery. Once your surgical date is secured, you will receive a form along with a letter of explanation to take to your primary care physician or family doctor in order to have the following pre-operative testing done prior to your surgery.

Once your surgical date is secured, you will receive a form along with a letter of explanation to take to your primary care physician or family doctor in order to have the following pre-operative testing done prior to your surgery.

- Physical examination
- EKG (electrocardiogram)
- CBC (complete blood count)
- PT / PTT (blood work)
- Comprehensive Metabolic Panel (blood work)
- Urinalysis

These results need to be faxed by your doctor's office to the Pre-operative Evaluation Center at 410-614-0102 or 410-614-3230 two weeks prior to your surgery. Please call The Documentation Center at 410-955-9453 two weeks before your surgery date to confirm that this information was received.

Preparation for surgery

- Drink only clear fluids for a 24-hour period prior to the date of your surgery

Clear Liquid Diet

Remember **not** to eat or drink anything after midnight the evening before your surgery. Clear liquids are liquids that you are able to see through. Please follow the diet below.

Water

Clear Broths (no cream soups, meat, noodles etc.)

- *Chicken broth*
- *Beef broth*

Juices (no orange juice or tomato juice)

- *Apple juice or apple cider*
- *Prune juice*
- *Grape juice*
- *Grapefruit juice*
- *Cranberry juice*
- *Tang*
- *Hawaiian punch*
- *Lemonade*
- *Kool Aid*
- *Gator Aid*

Tea (you may add sweetener, but **no** cream or milk)

Coffee (you may add sweetener, but **no** cream or milk)

Clear Jello (**without** fruit)

Popsicles (without fruit or cream)

Italian ices or snowball (no marshmallow)

- A bowel preparation called a Fleet Prep Kit #1 must be purchased at your local pharmacy (this is an over the counter item). You must start the preparation the day before surgery and follow the instructions included in the kit.
- Do not eat or drink anything after midnight the night before the surgery. Aspirin, Motrin, Ibuprofen, Advil, Alka Seltzer, Vitamin E, Ticlid, Coumadin, Lovenox, Celebrex, Voltaren, Vioxx, Plavix and some other arthritis medications can cause bleeding and should be avoided 1 week prior to the date of surgery (Please contact your surgeon's office if you are unsure about which medications to stop prior to surgery. Do not stop any medication without contacting the prescribing doctor to get their approval).
- If you wish you may donate blood to minimize the need for a transfusion from another individual.

The Operation

The perineal prostatectomy is performed by making an incision between the scrotum and the rectum. Instrumentation is inserted to dissect the prostate gland and seminal vesicles from the urethra and bladder. With the use of a high-powered telescopic lens attached to a camera device, excellent visualization of the prostate gland and the surrounding neurovascular structures is achieved. Once the prostate gland is dissected free from the bladder, rectum, and urethra it is removed and sent for pathological evaluation. The bladder is sewn back to the urethra to create an anastomosis. A Foley catheter is placed to drain the bladder prior to closure of the anastomosis. In addition, a small drain is placed around the surgical site, exiting the incision. It is usually removed the first post operative day. Typically, the length of the operation is 4 hours.

Potential risks and complications

Although laparoscopic prostatectomy has proven to be very safe, as in any surgical procedure there are risks and potential complications. Potential risks include:

- **Bleeding:** Although blood loss during this procedure is low compared to the retropubic approach, a transfusion may still be required if deemed necessary by your surgeon either during the operation or afterwards during the Postoperative period. It is advised to donate 2 units of autologous blood (donating your own blood) prior to surgery. If you are interested in autologous blood transfusion you must make your surgeon aware. When the packet of information is mailed to you regarding your surgery, you will receive an authorization form for you to take to the Red Cross in your area. The Red Cross will draw your blood and have it sent to Johns Hopkins Hospital for your surgery.
- **Infection:** All patients are treated with intravenous antibiotics prior to starting surgery to decrease the chance of infection from occurring in the urine or in the incision after surgery. If you develop any signs or symptoms of infection after the surgery (fever, drainage from incision, urinary frequency/discomfort, pain or anything that you may be concerned about) please contact us at once. Rarely will a bowel injury occur that may require creation of a colostomy to allow the rectal injury to heal.
- **Adjacent Tissue / Organ Injury:** Although uncommon, possible injury to surrounding tissue and organs including bowel, vascular structures, pelvic musculature, and nerves could require further procedures. Transient injury to nerves or muscles can also occur related to patient positioning during the operation.
- **Hernia:** Hernias at incision sites rarely occur.
- **Urinary Incontinence:** As in any prostatic surgery, urinary incontinence can occur following prostatectomy but often improves over time. About 75% of men will gain control by 3 months and most by 1 year. About 3 % of men will have permanent incontinence requiring additional surgery for cure.
- **Erectile Dysfunction:** A nerve-sparing technique is used during perineal dissection of the prostate gland unless there is obvious involvement of the nerve tissue by tumor. The return of erectile function following prostatectomy is a function of the age of the patient, degree of preoperative sexual function, technical precision of the nerve-sparing technique, and time.
- **Urethrovesical Anastomotic Leakage:** Transient small anastomotic leaks can occur following prostatectomy and often resolve without further intervention within a few days to a week. If this occurs,, the pelvic drain and urinary catheter is left until the leak is sealed to prevent a buildup of urine (called a urinoma) from occurring within the pelvis.
- **Rectal Incontinence:** Rectal incontinence is rare but urgency of bowel movements and seepage may occur shortly after the surgery. This should resolve over time.

What to expect after the surgery

Immediately after the surgery you will be taken to the recovery room, then transferred to your hospital room once you are fully awake and your vital signs are stable.

- **Postoperative Pain:** Pain medication can be controlled and delivered by the patient via an intravenous catheter or by injection (pain shot) administered by the nursing staff. You may experience some minor transient shoulder pain (1 -2 days) related to the carbon dioxide gas used to inflate your abdomen during the laparoscopic surgery. Occasionally patients will have incisional pain which can last several months.

- **Nausea:** You may experience transient nausea during the first 24 hours following surgery, which can be related to the anesthesia. Medication is available to treat persistent nausea.
- **Urinary Catheter:** You can expect to have a urinary catheter (Foley) draining your bladder (which is placed in the operating room under anesthesia) for approximately 1 week after the surgery. If the urethra is not healed it may stay in longer.
- **Pelvic Drain:** The wound drain is placed in the operating room. This drain is usually removed the morning after surgery, but may be kept in as long as a week if a leak at the anastomosis occurs.
- **Diet:** You can expect to have an intravenous catheter (IV) in overnight. (An I'V is a small tube placed into your vein so that you can receive necessary fluids and stay well hydrated; in addition it provides a way to receive medication.) Most patients are able to tolerate ice chips and liquids the day of surgery and clear liquids the first day after surgery. Once on a regular diet, pain medication will be administered by mouth instead of by IV or shot.
- **Fatigue:** Fatigue is common and should start to subside in a few weeks.
- **Incentive Spirometry:** You will be expected to do some very simple breathing exercises to help prevent respiratory infections by using an incentive spirometry device (these exercises will be explained to you during your hospital stay). Coughing and deep breathing is an important part of your recuperation and helps prevent pneumonia and other pulmonary complications.
- **Ambulation:** On the day after surgery it is very important to get out of bed and begin walking with the supervision of your nurse or family member to help prevent blood clots from forming in your legs. You can expect to have SCD's (sequential compression devices) along with tight white stockings on your legs to prevent blood clots from forming in your legs while you are lying in bed.
- **Hospital Stay:** The length of hospital stay for most patients is approximately one day.
- **Constipation:** You may experience sluggish bowels for several days to a week after surgery. Suppositories and stool softeners are usually given to help with this problem. Taking one teaspoon of mineral oil and milk of magnesia at home will also help to prevent constipation.
- **Wound Care:** Some patients develop some drainage from the incision after they go home. This can either be clear fluid (seroma) or a mixture of blood and pus. You should call your doctor and report the color and amount of drainage.

What to expect after discharge from the hospital

- **Pain Control:** You can expect to have some pain that may require pain medication for a few days and occasionally last for a few weeks after discharge, and then in most cases Tylenol should be sufficient to control your pain.
- **Urinary Catheter:** You may have some bloody discharge around the catheter during a bowel movement, this is not uncommon and will subside. It is not uncommon to feel some increased pressure in your bladder during a bowel movement. If you see blood in your urine (which is not uncommon) it will help to increase your fluid intake. By increasing your intake your urine will remain diluted, preventing blood clots from forming and obstructing your catheter. Increasing your fluid intake will also help to stop the bleeding. Bloody urine is usually insignificant and resolves on its own. You may notice some leaking around the catheter when you are walking around. This can be managed through the use of pads or absorbent materials. If you notice that your catheter stops draining completely, lie flat and drink a lot of water. If your catheter is still not draining after 1 hour you may have to have your catheter irrigated. You must notify the urology office, call the urology resident on call (see contacts) or visit your local emergency room. Please have the doctor at the emergency room call prior to removing the catheter.
- **Urinary Tract Infection:** You may develop a urinary tract infection related to the urinary catheter (usually due to placement and catheter removal). It is important to check the clarity of your urine before the catheter is removed as well as drainage around the catheter. If you notice any urinary frequency or burning after the catheter is removed you may have an infection. It is important to call your doctor with any of these symptoms. Your doctor may prescribe an antibiotic to prevent such infections.
- **Showering:** You may shower at home. Your wound sites can get wet, but must be patted dry. Tub baths can soak your incisions and therefore are not recommended in the first 2 weeks after surgery. Sutures underneath the skin will

dissolve in 4-6 weeks.

- **Activity:** Taking walks is advised. Prolonged sitting or lying in bed should be avoided and can increase your risk for forming blood clots in the legs as well as pneumonia. If you notice any pain or swelling in your leg, chest pain, especially when deep breathing, shortness of breath, sudden onset of weakness or fainting, and or bloody sputum, please notify us immediately or go to your local emergency room. Climbing stairs is possible but should be limited. Driving should be avoided for at least 1 week after surgery. Absolutely no heavy lifting (greater than 20 pounds) or exercising jogging, swimming, treadmill, biking) until instructed by your doctor. Most patients return to full activity on an average of 3 weeks after surgery. It is common for patients to feel fatigue or weak for a while. The length of time it takes to recover may vary.
- **Diet:** No restrictions. Drink plenty of fluids.
- **Follow-up Appointment:** You will need to call soon after your discharge (unless arrangements were made before discharge) to schedule a follow up visit for a cystogram, voiding trial and catheter removal to be done one week after your surgery. The foley catheter will only be removed if your cystogram is negative. For this appointment please call The Johns Hopkins Out Patient Center at 410-955-6101.
- **Long-Term Follow-up:** A PSA test is drawn at 3 months following surgery and at regular intervals thereafter.

CONTACTS

Jamie Wright, M.D.: Daytime office number: 410-550-1700

Myrna Sroka, RN: Daytime office number: 410-502-7707

In the event of an emergency and you need to contact someone in the evening hours or on the week end, please call the paging operator at 410-955-6070 and ask to speak to the Urologist on call.

