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Dr. Gorbatiy's Patient Guide to the Robotic-Assisted Laparoscopic Radical Prostatectomy

What is the Prostate?

The prostate gland is part of a man's reproductive system. It is located in front of the rectum and under the bladder. It surrounds the urethra, the tube through which urine flows. The prostate, along with the seminal vesicles, produce most of the fluid that comes out when ejaculation occurs. During ejaculation, seminal fluid helps carry sperm out of the man's body as part of semen. Substances produced by the prostate and seminal vesicles are important for reproduction.

Men who develop prostate cancer may choose to have a specialized surgery to remove the prostate. It's called robotic-assisted laparoscopic radical prostatectomy (RALP). Laparoscopy is at type of surgery that is done by filling the belly with carbon dioxide gas so that a working space can be created. Small incisions are created through which instruments are passed. During the surgery, six - 1/4 inch to 3/4 inch punctures are made in the abdomen. A thin tube with a camera on the end is placed into one of the punctures to help the surgeon see inside the body. Long thin instruments are placed in the other punctures to help your surgeon manipulate organs and perform surgery.

The robotic-assisted laparoscopic radical prostatectomy was first reported in 2001. Since then, the robotic prostatectomy has become one of the preferred methods for radical (aka total) removal of the cancerous prostate. Dr. Gorbatiy is one of the few Fellowship-trained urologists in Broward County to do extra 2 years of training in robotic surgery. He has been trained to operate on the prostate, bladder, ureters, kidney and bowel with the use of the robotic surgical approach. The robotic machine has 4 arms, one for holding the camera and 3 which have instruments attached. The surgeon controls all of these arms. The robotic arms are placed through four punctures, and an assistant surgeon will work through the remaining two punctures.

What is accomplished with the operation?

The surgeon will separate the prostate from the bladder, remove the seminal vesicles and a portion of the sperm ducts, separate the prostate from the rectum, perform nerve-sparing in some men and divide the urine channel again at the tip, or apex, of the prostate.

After the prostate and seminal vesicles are disconnected, your surgeon will place the prostate inside a small plastic bag while it is still inside your body. The bag will be removed by enlarging one of the punctures. The bladder will be reconnected to the urine channel by suturing the two together. A catheter (small rubber tube that allows urine to drain) - will be left in place to help this area heal. The specimen will be sent to a pathologist who will carefully examine it under a microscope. Your surgeon may decide to remove lymph nodes at the time of your surgery. If so, these will also be placed in the specimen bag for examination by the pathologist as well.

A small plastic tube, called a drain, will be placed outside the bladder to collect fluid that can accumulate after surgery. This drain is usually removed before you are discharged from the hospital, but in some cases it may need to stay in longer. If so, the nursing team will show you how to manage the drain, and your surgical team will give you follow up instructions for an appointment to remove the drain.

The following section will explain how several important structures near the prostate may be affected during surgery.

Urinary Control

The urethra, or urine channel, exits the bladder and runs directly through the prostate. After the urethra exits the prostate it goes through the pelvic diaphragm, which is the muscle that will help with urinary control after surgery. The urethra then enters the penis. After your surgeon has removed the prostate, the bladder is sutured to the urethra to restore the flow of urine. A catheter, or a small plastic tube, will be placed through the penis and into the bladder to allow urine to drain freely into a bag.

During the healing process you will wear the catheter to allow this area to heal. Your nursing team will teach you how to care for the catheter while you are in the hospital. The catheter is usually removed within one week.

After the catheter is removed you will be taught to do a special exercise, called a Kegel exercise, which may help speed the recovery of urinary control. All men will have some loss of urinary control in the beginning. For most men, this improves quickly, within a few weeks. But, for others, improvement takes longer - a few months. By the end of the first year, >90% of men will have full control.

Erectile Function

The nerves that control erections may also be affected during surgeries such as RALP. These nerves control only the ability to obtain an erection of the penis, and do not affect sexual desire, frequency of intercourse, sensation in the penis, ability to experience climax or bladder control. Their sole function is creating a stiff erection.

In order to preserve the ability to have erections after surgery, some men may be candidates for a "nerve-sparing operation". Along with large blood vessels, the microscopic nerves travel on both sides of the prostate and are located in structures called "neurovascular bundles". The nerve sparing operation is a very delicate surgery that gently 'peels' the neurovascular bundle away from the surface of the prostate (like peeling the yellow cover off an onion), allowing the prostate to be removed while minimizing the effect on erections. The decision on whether to spare the nerves depends on the proximity of cancer to the neuromuscular bundles. In some men, by sparing the nerves, we run the risk of leaving some microscopic cancer behind.

Sparing the nerves does not guarantee the preservation of erections but does give most men a chance to recovery. Men under 60 years of age who had good erections before surgery and in whom both sides of the neurovascular bundles are spared have the best chances for recuperating erections after surgery. Older men and those who do not have rigid erections before surgery, or who are unable to sustain an erection during intercourse, may not have satisfactory return of erections even when both neurovascular bundles are spared. Some men who have just one side spared and the other side removed may also recuperate erections, but usually to a lesser degree. Erectile dysfunction - the inability to have a spontaneous erection - will occur if both nerves are removed. However, nerve removal does not necessarily eliminate all chances of getting erections. Treatments such as penile injection therapy, vacuum erection device therapy and penile implant surgery do not depend on the nerves and are available for men with erectile dysfunction.

The Gleason score, location of cancer on biopsy, PSA and digital rectal exam may help us. Here is the general breakdown of organ confined disease by Gleason score, assuming a PSA <10:

- Gleason 3+3, organ confined close to 95%
- Gleason 3+4, organ confined 90%
- Gleason 4+3, organ confined 60%
- Gleason 4+4 or higher, organ confined 30%

Thus, most all patients with 3+3 and 3+4 may be good candidates for bilateral nerve sparing. For Gleason 4+3 or higher, select patients can have nerve sparing, and most can at least have 1 nerve bundle spared, depending on location of their disease.

It is important for you to remember that the full recuperation of erections can take up to 2 years. During this time your urologist can offer you a variety of treatments for penile rehabilitation (pills, injections and vacuum device), which may both improve

the recovery of your erections and allow you to become sexually active during this active period of healing. While a nerve-sparing operation may be planned for both sides, it is important to remember that at the time of surgery your surgeon may encounter situations that will make nerve-sparing difficult on one or both sides or find that nerve-sparing may compromise the cancer treatment aspect of the operation. In order to provide the best cancer treatment, Dr. Gorbatiy may need to remove one or both neurovascular bundles.

Injury to the Rectum

The rectum is another important structure located very close to the prostate.
Injury to the rectum is unusual, occurring in <1% of patients.

Certain conditions such as prior surgery, hormone therapy, radiation treatment, infections and other causes of scarring to the area can increase this risk.

If an injury does occur and the rectum has been properly cleaned before surgery, it can usually be repaired at the time of surgery without significantly changing your recovery. However, if the rectum has not been properly cleaned, and the area of injury becomes soiled by stool, then a temporary colostomy may have to be performed. This is why it is very important to follow instructions for cleansing your rectum before surgery with an enema.

Lymph Node Removal

Dr. Gorbatiy may remove pelvic lymph nodes during your surgery. These small glands are located near the prostate and can be the first place prostate cancer spreads. This procedure adds an additional 20 to 30 minutes to your operation, with minimal added risk. Risks include damage to blood vessels to the leg and damage to a nerve that controls one of the groin muscles. Injury to either is very rare.

Positive Margins

We often get asked: “When you remove the prostate, can you tell if you got it all?” For the most part, the prostate cancer is invisible, and blends in with the normal gland. Thus, our goal is to remove the prostate and to avoid the surrounding structures. The final pathology is what matters the most.
Some patients may have microscopic spread of the cancer outside the gland that was not detected before or during surgery. This may result in a 'positive margin', which is identified after your surgery when the pathologist reviews the specimen. The risk of positive margins increases with presence of advanced and aggressive prostate cancer. Unfortunately, our current imaging or blood tests don’t provide the best prediction of microscopic extension of prostate cancer outside the prostate capsule.

After the prostate gland has been removed, the pathologist covers the outer aspect of the specimen with different colors of ink. Under the microscope, if there are any cancer cells touching the ink, than this is described as a 'positive surgical margin'. Having a positive surgical margin may mean that there are cancer cells left behind; this is often, but not always the case. Additional treatment after surgery may be necessary depending on the stage of disease, the aggressive nature of the cancer cells, the presence of cancer in the seminal vesicles or lymph nodes, if a positive margin is present or other findings.

If this occurs in your case, your Dr. Gorbatiy will discuss additional treatment options with you when you follow up after surgery.

Surgery Risks

Although robotic-assisted laparoscopic radical prostatectomy is a minimally-invasive procedure, it is a major operation that carries the same risks seen with any major procedure. These include:

Risks associated specifically with RALP

- Infection
  - Urinary infection
  - Wound infection
- Bladder or ureteral (tubes draining kidney) injury that may require additional procedures or surgeries to correct, <1% risk
- Internal urinary leakage from the connection between penis and bladder (<10% risk) may occur which may require leaving the drain in place longer and also wearing the catheter for a longer period of time. For most cases involving internal urinary leakage, no additional procedures are necessary, as the body will heal itself when proper drainage with the drain and catheter is provided.
- Scarring in the urethra at the connection between penis and bladder, sometimes requiring surgical cutting of the scar tissue (<5% risk)
- Permanent incontinence - the inability to control urine. This complication is rare, occurring in less than 2% of all patients (see discussion above)
- Erectile dysfunction (see discussion above)
- Rectal injury, rarely requiring a temporary colostomy, <1% risk
- Conversion to open surgery, <2% reported risk
- Robotic system failure, <5% risk
- Inguinal Hernia (bulge in the groin that may require surgical correction in the future)
- Temporary bruising of the scrotum and foreskin
- Temporary swelling of the face and eyes from positioning. This is a result of the typical position during surgery to access the pelvic region and have the bowel "fall away" from the pelvic region, you are lay on the operative table with the table tilted in a way so that your legs up and upper torso down.

- We secure your body to the operative table to avoid slipping. The positioning sometimes places pressure on the shoulders and thus may result in some shoulder pains or temporary numbness.

Risks associated with the Lymph Node Dissection

- Lymph nodes are located on top of and next to major blood vessels that provide blood flow to your legs. Also, they are located next to a nerve that allows you to cross your legs. Injury of the nerve or those blood vessels are very rare.
- Lymph nodes filter fluid that is not in arteries or veins of your body. When they are removed, the fluid may occasionally accumulate in areas of the operation. With open surgery, this was a very common problem, requiring drainage of this fluid until the body managed to absorb it on its own. With the robotic approach, this is rarely seen.

Risks associated with ANY surgery

- Anesthesia-related complications
- Sore throat from intubation (breathing tube)
- Bleeding that may require blood transfusions (<10% risk)
- Prolonged intubation (keeping the breathing tube longer after surgery if you can't breathe on your own too easily) Usually this risk is greater in patients who are active smokers, have a history of emphysema (COPD), other lung diseases, sleep apnea, and obesity.
- Blood clots in the veins (especially in the legs or lungs). These can be life-threatening and usually require treatment with a prolonged course of blood thinners. (<1% risk)
- Rhabdomyolysis (muscle breakdown from a prolonged surgery)
- Pressure sores
- Heart attack during or after surgery
- Air embolus - an extremely rare condition seen with laparoscopic surgery of air getting into the bloodstream and into the heart that may be life threatening
- Stroke
- Pneumonia
- Pain
- Numbness of skin around incisions or in the arms and legs. This is often temporary and may be a result of pressure on nerves from positioning.
- Incisional Hernia (a tear in the tissue where cuts were made causing a bulge underneath the skin, sometimes requiring surgical correction) This may be caused by lifting heavy objects prior to full healing of the incisions is is more common in patients with poor healing or poor nutrition. (<5% risk)
- Bowel Obstruction (partial or complete obstruction of intestines that often resolves with time, a temporary nose-stomach tube, or rarely a surgical exploration to untwist or cut any scar tissue that is causing obstruction)

- Ileus (bowel takes a long time to wake up and start passing gas) is among the most common problems seen with any abdominal surgery
- Bowel adhesions (scarring) is commonly seen in patients undergoing any abdominal surgery. Rarely these adhesions may cause bowel obstruction.
- Allergic reaction to drugs and/or equipment.
- Electrolyte (salt) imbalances may occur.

What if I am overweight?

The robotic camera and instruments can access the pelvis very well in most men, even up to 350 pounds, so this procedure may be an advantage in this circumstance. We do see, however, a greater chance of complications in patients who are obese. These complications include an increased risk of bleeding, breathing problems, urinary incontinence, blood clots, and pressure ulcers.

Rarely, a very obese patient cannot tolerate our positioning during the surgery (head down, legs up) because his own weight doesn't allow the lungs to expand fully. Thus, in this rare scenario we don't even start the surgery if we see that the patient cannot be ventilated properly at the beginning of the case.

What about prior surgery?

In most cases, laparoscopic instruments can mobilize prior scar tissue and proceed with the case. However, this often increases the length of surgery and does increase the risk of bowel and blood vessel injury and at times may increase the length of recovery.

Equipment Problems

Occasionally, mechanical difficulties occur with the robotic machine.
The system has multiple built-in safety features to prevent using the machine when a problem is present, In many of these cases, our team can troubleshoot these mechanical issues and proceed as planned. In some cases, however, the machine cannot be used until an engineer arrives to address the problem.
If mechanical difficulties are identified before you are put to sleep, your surgical team will discuss with you how to best proceed. In circumstances such as these, your procedure may need to be rescheduled, possibly resulting in additional expense and inconvenience. Sometimes mechanical difficulties are identified after the patient is asleep and surgery has started. Our goal as surgeons is to always keep the surgery as safe as possible. Mechanical failure may be outside of our control, and can greatly affect surgical efficiency and/or our ability to perform RALP. While very rare, if an irreversible mechanical difficulty is encountered after the surgery has started, we will use our best judgment as to how to proceed; in some patients it may be necessary to disconnect the robot, and make a traditional incision and complete the surgery in an open manner.

Reducing Risks

Your surgical and anesthesia teams will take measures to reduce the risk of complications by giving you antibiotics during surgery and other measures meant to reduce the risk of certain known complications.

But, as with any operation, risk cannot be totally eliminated. There is a chance that complications could result in the need for a larger incision (open surgery). Your surgeon and surgical team will try to identify and respond to any problems that occur as early as possible. There may be unforeseen and unexpected complications that require additional treatment. Fortunately, most complications are reversible, readily treatable and do not require additional major procedures.

WHAT TO EXPECT - BRIEF OVERVIEW

The usual course experienced by patients undergoing robotic prostatectomy is as follows. The patient arrives in the hospital the day of the procedure. The procedure is then performed and typically takes between 2 and 4 hours. The patient then spends the first night in the hospital and is given a regular diet and is encouraged to walk the night of the procedure. Discharge is planned for the next morning and instructions are given on general postoperative and catheter care.

Patients are sent home with a prescription for a narcotic oral medication. Patients should walk as much as possible immediately. Stair climbing is acceptable. Some patients do experience constipation, which can be remedied by stool softeners or milk of magnesia.

The urinary catheter is removed in the office in one week. Patients are allowed to drive after catheter removal. The patient then may return to work within 2-3 weeks and then can go back to unrestricted activity in 3-4 weeks.

Pre-Operative Instructions: Robotic Radical Prostatectomy

If you are currently awaiting a robotic prostatectomy, it is essential for your own safety and for the success of your surgery that you carefully read and observe these instructions.

Medications

- Ten (10) days before surgery please **STOP** taking any Aspirin, Motrin (Ibuprofen), Aleve, Vitamin E, Fish Oil and any other blood thinners, including Herbal medications and multi-Vitamins.
- If you are on Plavix (clopidogrel), Coumadin (warfarin) or any other prescribed blood thinner, make sure you mention this to Dr. Gorbatiy so we could have a clear permission from your primary doctor or cardiologist to stop those medications safely prior to surgery.
- Take usual doses of heart, thyroid, asthma medication on the morning of surgery with a tiny sip of water. If you are diabetic and take medication, do not take them on the morning of surgery. If you take insulin, only use half the normal dose the morning of surgery.

Preparing the Sphincter Prior to Surgery to Hasten Urinary Control

Removal of the prostate will cause a period of incontinence (urinary leakage) for most patients. Every patient is different, so do not compare notes. On average, most patients by 2-3 months are dry but there are patients that will never
leak and some that will take much longer. The leaking can be some squirts with position change (stress incontinence) to soaking pads. There can be urge incontinence (when you have to go, you really have to go) so it will be advantageous to urinate before you have a strong urge. Most patients will not leak at night but might have to wake up every hour or two to urinate. The Kegel exercise builds up the muscles around the bladder opening. For most patients, doing the Kegels is the first and only thing needed to regain control. They should be started before surgery so you get a head start and hopefully will spend less time after surgery dealing with incontinence.

Kegel Exercises
Kegels can be done standing, sitting, or lying down. The correct way is to tighten the muscle that helps you stop urine flow during urination. It should be a contraction that you ease into and sustain. It is not a vigorous clamping down and you legs, buttocks, and abdomen should not tighten. You should not strain or hold your breath. You may notice your penis move up when done but do not concentrate on making your penis go up and down. If done correctly, while

urinating, Kegeling should stop the urine flow. This can be used to check the technique but you should not be routinely Kegeling while urinating.

The Regime
The Kegels should be 10 repetitions in a row holding each contraction for a count of 10 with a few seconds of relaxing the muscle in between each contraction. Before surgery, doing 4-8 sets of 10 reps every day in the weeks preceding surgery would be helpful. The first few days after the catheter is removed three sets a day can be done. Then for the remainder of that first week you should increase to doing 10 reps every other hour. After that, you can increase to doing them every waking hour. When done correctly you should not
squirt urine while tightening or relaxing, become sore, or have your control worsening.

The Occasional Kegel
After the catheter is removed, with position change, cough, sneeze, or strain, you can notice a spritz/squirt. It is ok to Kegel through these movements that make you leak. For example, at night you probably will not leak but you might have to wake up every hour or two. You can tighten up (Kegel) and hold the urine until
you get to the bathroom. On the other hand, if you are out walking and you are getting a consistent drip, you can not sustain a Kegel for extended periods of time. It is detrimental and you are wearing a pad. Of note, the best pads are the small ones like Depends Guards for Men that fit into fitted briefs (Jockey's, tightly whiteys).

What to Bring with you to the Hospital

- A pair of loose-fitting pants, like sweat pants.
- Brief-style underwear that is 1 to 2 sizes larger than you normally wear.
- Sneakers that lace up. You may have some swelling in your feet, lace up sneakers can accommodate this swelling.
- If you have a history of sleep apnea and use a CPAP, then bring it to the hospital.
- Your cell phone with a charger cord/plug
- Your Health Care Proxy Form, if you have completed one.
- A case for your personal items, such as eyeglasses, hearing aid(s), dentures, toothbrush, shaving kit, and religious articles.
- This handout as a reference.
- Your Driver's License for ID and insurance cards.
- List of all your current medications.

Bowel Prep

- Take a Fleet's enema the morning before surgery to empty the rectum. An enema may be purchased at any pharmacy like Walgreen's, CVS, Target, Publix and you may use their brand.

Diet Day Before Surgery

The day before your surgery, please eat very light meals and stay hydrated, in the evening before surgery try to stay on a clear liquid diet. This includes the following: tea, broth, popsicles, water, Gatorade, apple juice, cranberry juice, grape juice, black coffee, Jell-O, cola/7-Up.

*****DO NOT DRINK ORANGE JUICE, TOMATO JUICE OR MILK!*****
NOTHING TO EAT OR DRINK AFTER MIDNIGHT

Day of Surgery

Here is what you should expect on the day of surgery.

Arriving to Hospital

- You will be asked to arrive at least 2 hours prior to the surgery.
- Once parked, please go to the admitting/registration of the hospital, directions will be given by the security at the hospital entrances.
- After registration, you will be going to the preoperative area.

Pre-Operative Area

- In the preoperative area, you will be in a semiprivate suite with a bed and curtains around you for privacy. Your family members may stay with you in this area.
- Here you will meet with your nurse who will get you ready for surgery
- You will change to a hospital gown, robe, and nonskid socks to wear.
- Tell your nurse the dose of any medications and tell the nurse when you last took those medications
- Your nurse will place an intravenous (IV) line into a vein, usually in your arm or hand. The IV line will be used to give you fluids and anesthesia medications during your surgery.

Meeting With Your Anesthesia Team

- After meeting your nurse, the anesthesia team will start talking with you to review your medical history, your surgical history and your experience with any previous anesthesia.
- They will talk to you about your comfort and safety during your surgery.
- You will have a chance to talk about the kind of anesthesia you will receive.
- For most major surgeries, general anesthesia is given with you completely asleep and a machine breathing for you.
- The anesthesia team includes a nurse anesthetist who is a very experienced nurse trained to administer anesthesia, they work under direct supervision of the anesthesia doctor. After initial questions by the nurse anesthetist, you WILL meet the doctor and will have a chance to ask any questions you may have about your anesthesia.

Seeing Dr. Gorbatiy

- Once the nurse and the anesthesia are done getting you ready, Dr. Gorbatiy will meet with you and your family and answer any last questions you may have.
- The surgery (including anesthesia, preparation, operation, waking up in recovery) takes about 4 hours in total on average.
- PLEASE tell Dr. Gorbatiy of any changes in your health since the last time you saw him in the office. If these changes are things like a fever, severe cold or flu, respiratory or heart problems, please call our office prior to surgery as these

problems may pose risk to your surgery and the procedure may need to be delayed for safety reasons.

Time To Rock & Roll!

- Once all your questions have been answered and you are ready for surgery, the anesthesia team will give you an IV medication for relaxation and make you sleepy and forgetful. At this point you may kiss your loved ones, who will be escorted to the family waiting area.
- You will be taken in on a stretcher. to the operating room by a member of the operating room team will help you onto the operating bed. Compression devices that look like large blood pressure cuffs will be placed on your legs and will be squeezing your leg muscles to move blood out of your legs and prevent blood clots both during and after surgery.
- Once you're fully asleep under anesthesia, a breathing tube will be placed through your mouth and into your windpipe to help you breathe. You will also have a urinary catheter placed to drain urine from your bladder.
- Surgery then begins and you will then be gently woken up and safe, the anesthesia team will remove the breathing tube. You will not remember any of this. You will be moved from the operating room bed to a stretcher and transported to the PACU (post anesthesia care unit), which is the recovery area.

Post-Operative Instructions: Robotic Radical Prostatectomy

Following robotic radical prostatectomy, your attention to proper post-operative follow-up will contribute to the success of your surgery. You are being provided with written instructions and information that addresses common questions and concerns. Please review this information and feel free to ask any further questions.

Immediately after Surgery

- You will wake up in the recovery area called the "PACU".
- There you will be monitored for about one hour and until a hospital bed is available on the floor unit
- You will wake up with a tube in the penis and may have a tube coming out of one of the belly incisions.
- You will also likely have a mask on your face that will deliver oxygen.
- Once you get to your room, you may still feel sleepy but as soon as you wake up, it is necessary for you to be out of bed as quickly as possible in order to prevent blood clots and to build up stamina.
- Don't wait for the nurse to offer you to move and get out of bed. Instead, when you feel ready and feel like your pain is well controlled to move, call for the nurse to be in the room and assist you at least the first time you get up. Someone must supervise you at least the first time to make sure you're steady.
- My advice is to first sit at the edge of the bed dangling your feet. Do not be frightened if you feel lightheaded. This is not unusual. If this happens, lie down.
- Sitting up in a chair will be your first experience out of bed. Walking will be your next.

LEAVING the HOSPITAL

- Patients generally stay in the hospital approximately 24-48 hours after surgery.
- You are not permitted to drive home by yourself, so please coordinate to have someone pick you up upon leaving the hospital.
- Walking is very important after surgery. You are allowed to climb steps and walk as much as you can tolerate.

Diet

- Remain on a clear liquid diet such as Jell-O, broth, apple juice, water, Gatorade and sorbet until you have passed gas rectally.
- Once you have passed gas, you can begin to consume a soft diet consisting of:
  - Cereal
  - Chicken Noodle Soup
  - Sweet Potatoes
  - Scrambled Eggs
  - Oatmeal

- Toasted Bread
- After your first solid bowel movement you can begin a regular diet except the following for one week:
  - Carbonated drinks such as soda, ginger ale and seltzer in addition to gassy foods such as broccoli, beans, cabbage and spicy foods
- I encourage patients to practice moderation as they re-introduce food into their diet. Five or six small meals throughout the day may be more advantageous than a few large meals.

Restrictions

- Avoid straining/pushing during bowel movements
- Avoid sitting in one position for more than 45 minutes
- Avoid exercising or any sports activities
- Avoid taking a bath or swimming
- Avoid heavy lifting

Wound Care

- All the sutures used on the skin dissolve on their own and do not need to be removed.
- A "skin glue" is used to cover the incision, so it is okay to get the incisions wet. You should shower daily at home.
- Application of antibiotic or other ointments to incisions is not recommended.
- A small amount of redness at the edges of the incision and bruising, as well as a small amount of clear or bloody leakage from the wound, is acceptable and common.
- Redness greater than ½ inch from the incision should be reported to Dr. Gorbatiy.
- If you had an abdominal drain removed before your left the hospital, then it is recommended that you keep a gauze secured with some tape (both of which are provided before you leave the hospital) to prevent your clothes from getting wet. It is common and normal to drain quite a bit the first few days. It will eventually stop. To shower, please remove the gauze and shower with soap and water. Don't avoid cleaning the incision. After the shower, re-cover the incision if it is still draining. If it stopped draining you make keep it open to air and no longer cover it up with gauze or band aids.

Catheter Care

- You will be released from the hospital with a penile catheter in place (also known as a "Foley"). At the end of the catheter there is a balloon which prevents the catheter from falling out of the penis. Do not try to remove the catheter on your own.
- The catheter will remain in place for approximately 7 days. It will be removed at our office.

- If you don't have any urine output for 3 hours and you are feeling discomfort in your lower abdomen, you must go to your nearest emergency room and contact our office.
- It is normal to have urine and blood leak around the catheter. This is particularly normal when you are experiencing bladder spasms.
- Blood/blood clots in the urine are also normal. If you see this occurring be sure to hydrate yourself in an effort to flush out any clots.
- Kegel exercises are not permitted while the catheter is in place. Once it has been removed, you can resume doing the exercises.
- Apply a small amount of Neosporin or Triple antibiotic to the tip of penis where catheter exits will reduce discomfort and ease the movement of the catheter.
- You will be provided with two catheter collection bags, a smaller bag to be worn (above the knee) during the day beneath trousers, and a larger bag to be used a night. These bags can be removed and exchanged as needed.
- The catheter collection bag may be removed during showering. Gently pull the clear plastic tubing of the bag from the catheter and allow urine to run into the shower. Once you are done showering, you may reconnect the tubing.
- Should your catheter fall out on its own, it is critical that you notify Dr. Gorbatiy or one of his associates immediately. Do NOT allow a non-urologist (nurse or doctor) to replace it.

Pain

- Pain is seen with every abdominal surgery, however, laparoscopic approach offers small incisions and thus less pain compared to open surgery.
- During the hospitalization, we will be giving IV pain medications at the same time as you try pills for pain control. We need you to try the pills because this is what you will be going home with. We need to know if you can tolerate the pain medications before your leave the hospital. Narcotic pain medications are best taken with some food and not on an empty stomach. Mild nausea, dizziness, sleepiness and constipation are common from the narcotic pain medications. We encourage you to try the simpler Tylenol or Advil for pain, but don't be shy to use the narcotics as well. You may alternate these pain medications as needed.
- Pain seems to be greater in patients with very developed abdominal muscles. The more you move, the more pain you may experience. However, we need you to move as much as you can because this will hasten your bowel function and eventually decrease pain from incisions as well.
- Pain will be greatest the first few days. Take enough pain medications so you may be able to move more — not just to lay comfortably.
- Mild pain behind the scrotum as well as scrotal swelling and soreness can linger for a few weeks.
- Another type of pain that is seen after surgery is related to bladder cramps (spasms). This pain is generally felt below the belly button and usually comes and goes. It is generally related to the catheter irritating the bladder.
- Medications (like Hyoscyamine) are sometimes provided for this problem.

Breathing

- Deep breathing and coughing is very important after surgery. During the operation, a breathing machine does the job of moving air in and out of your lungs. However, it usually causes the lungs to deflate a bit. In order to expand your lungs and prevent pneumonia and improve oxygenation after surgery, you should be doing deep breathing and hacking up mucus.
- Your nurse will provide you with a device through which you take deep breaths — an ***incentive spirometer***. You will be able to track the volume of air your you inhale and gauge your progress. We encourage you to breathe in at least 1000-1500 mL of air on your incentive spirometer. If you don't see a spirometer next to your bed, please remind the nurse to get you that device.
- It is normal to have coughing with the use of the spirometer. We want you to cough up and prevent a lung infection.
- Hug a pillow around your belly to help you deal with pain when you cough while using the spirometer.
- If you have a history of sleep apnea and use a CPAP machine, it is VERY important for you to bring the machine with you so you may use it after surgery during sleep.

Activities

- Following discharge from the hospital, you will be fully ambulatory and are encouraged to walk at least 3 times a day.
- You are advised to refrain from driving until the catheter has been removed.
- You can return to moderately strenuous activity such golfing and slow jogging 4 weeks after surgery.
- You should refrain from vigorous activity (running, bicycling and heavy lifting) for 6 weeks after your surgery. After 6 weeks, you may resume full activities except for bicycling, motorcycling or horse-riding which you can resume 3 months following surgery.
- Perineal discomfort (pain between your rectum and scrotum) is frequently seen after surgery. This may last for several weeks but it should resolve on its own. Use a donut pillow for sitting. This is worse with the catheter in place but eventually goes away.
- When you return to work depends on your occupation and your recovery from surgery. Typically most patients return to work 2 - 4 weeks after the surgery.

Urinary Control

- Most men have difficulty with urinary control for a limited time following catheter removal. You should bring an adult diaper (Depends, etc) with you the day your catheter is removed.
- You should expect to wear pads for a while because normal urinary control may not be regained for several months from the time of your surgery.

- Keep in mind that everyone is different; some men achieve control within one week while others require 6 months to achieve normalcy. Don't be discouraged!
- Things will get better with time. You will typically leak more when standing up, moving, coughing and laughing than when sitting or lying down. Leakage is also typically worse later in the day as your sphincter muscle gets tired.
- Restricting fluid intake, particularly caffeine and alcohol can reduce the amount of leakage. Going to urinate at a scheduled time (every 3 hours) can also help.
- Having pink-cranberry tinged urine or the occasional bright red drops at the beginning or end of urination or with a bowel movement is normal for approximately six weeks after surgery even after having clear urine for weeks.
- The operation removed your prostate and affected your secondary urinary control mechanisms. Your external sphincter muscle must now take over all responsibility for control. You may be able to help this muscle by doing regular Kegel exercises (see above).

Sexual Function

- The operation will affect sexual function in several ways, but it should not prevent you from having a fulfilling sex life when you recover.
- There are three components to sexual function in men: sexual drive, sensation, erection and climax (orgasm). Although these three normally occur together, they are really separate functions.
- Erections occur due to a complex sequence of events involving stimulation of the cavernosal nerves and engorgement of the penis with blood.
- The cavernosal nerves run alongside the prostate, only millimeters away from where cancer often occurs. Even if these nerves have been successfully spared they are often bruised or damaged during the surgery.
- It often takes more than one year from the time of surgery for these nerves to completely heal. It is for this reason that it usually takes anywhere from 3 to 18 months for erections to return.
- The use of Viagra, Cialis or Levitra can hasten the healing process, as well as help to obtain an erection during sexual stimulation.
- While you are waiting for erections to return, a number of different therapies can be used to achieve satisfying erections. This include a vacuum erection device (ie VED or Erectaide), urethral suppository (MUSE) or inter-cavernosal injections (Caverject).
- Orgasm (climax) will not be affected by the surgery, but ejaculation (the release of fluid during orgasm) will no longer occur. This is because the seminal vesicles, which store fluid for ejaculation, and the vas deferens, the tubes that carry sperm to the prostate, are removed and cut during the operation. In addition to creating a dry ejaculation, this means that you will be infertile (no longer be able to father children).
- Some men experience mild penile shortening after the operation. However, the penis typically stretches to the pre-surgery length during an erection. To reduce the risk of penile shortening, we encourage patients to use the vacuum erection device to stretch the penile compartments.

Scrotal Care

- The scrotum may be swollen and or black and blue when you leave the hospital or within a few days after.
- Do not worry this should resolve in 7-14 days. To help alleviate any swelling elevate the scrotum when you are at rest.
- This can be accomplished by using a towel as a sling under the scrotum and across the top of your thighs.

Bowel Care

- Patients often experience constipation and/or bloating following the surgery.
- To help alleviate this home take stool softener, Colace, as prescribed unless you are having loose bowel movements or diarrhea.
- Passage of gas is a great sign of good bowel function and usually seen the first 24 hours after surgery.
- After surgery, it is quite normal for the bowel tract not to work for two to five days or longer.
- You do not need to have a bowel movement before discharge from the hospital. If constipation remains a problem for more than 2 days after you have left the hospital you can take Milk of Magnesia to help move things along.
- During those days you will receive all the necessary nutrients through an intravenous or by taking liquids (including soup, etc.) until you are having satisfactory bowel movements.
- DO NOT use an enema or a suppository as this could risk disrupting the connection between the bladder and the urethra.

Medications

- Most patients have minimal discomfort that can be controlled with Tylenol (acetaminophen), Motrin (Ibuprofen).
- If you still have significant pain despite Motrin or Tylenol, you may use the stronger pain-killers, but if these do not help with pain, then contact Dr. Gorbatiy or one of his associates.
- Most narcotic medications will also contain Tylenol (acetaminophen) with it as well. Do not exceed more than 4000 mg of acetaminophen per day, thus do not exceed the dose on the prescription and monitor how much tylenol you take in addition to the narcotic.
- At the time of discharge you will receive a prescription for the following medications:
  - *Pain Medications*: Typically Percocet or Vicodin is taken at one tablet every 4 hours as needed for pain (see above regarding pain control)
  - *Antibiotics*: Take the prescribed antibiotic medication <u>starting one day before</u> catheter removal for a total of 3 days.

- *Stool Softener*: Colace (docusate sodium) 100 mg orally twice a day.
- *Anti-Bladder Spasm/Cramping Medication*: Hyoscyamine 0.125 mg quick dissolving tablet placed under the tongue every 4-6 hours as needed.

Mood

- Within the first weeks after surgery, you may experience some minor depression. This is a natural feeling following a surgical event. Once whatever pain and discomfort you have subsides and you are able to resume your normal activities, your sense of well being will also improve.

Follow-up

- You will be seen in the office 6 - 8 days after surgery for catheter removal.
- The catheter will be removed by one of Dr. Gorbatiy's nurses.
- Dr. Gorbatiy will discuss with your pathology report as soon as it is available (typically within 5 - 7 days from the time of surgery).
- You will be seen by Dr. Gorbatiy again at 6 weeks and 3 months following surgery. Your first post-operative PSA will be obtained just prior to your 6-week visit.

What is NOT NORMAL and require immediate medical attention:

- Fever of 101°F, swelling, redness or large amount/smelly drainage from abdominal surgical incisions. A little yellowish/bloody drainage is acceptable.
- Nausea, vomiting, unrelieved abdominal distention and pain.
- Significantly large amount of blood with blood clots in urine
- Significant decrease in urine output and/or inability to urinate.
- Pain or swelling in one leg or calf
- Chest pain or shortness of breath

You should alert Dr. Gorbatiy or one of his associates if any of the above occur. If you have any additional concerns or questions, please do not hesitate to call our office **(954)-463-6408**

Dr. Gorbatiy's Post Operative Recovery To-Do Cheat Sheet

Day of Surgery

Activity	stand, sit in chair, walk to doorway and back, activity goal 2 hrs, ask **nurse to supervise**
Diet	Chew gum, start drinking clear liquids, avoid carbonated drinks
Pain	you will have around the clock pain medicines, but also ask for additional pain medications as needed, try pills instead of IV only

Breathing	use Incentive Spirometer every 1 hr while awake
Rest	try to stay awake during the day and sleep at night, but may take some naps when tired

Day 1 After Surgery

Activity	start walking early in the day, don't wait to be told to do so, ask **nurse to supervise** and help with the drainage tubes up in chair x 1 hr for each meal, walk three times per day at least 20 min each, activity goal 4 hrs
Diet	will advance the diet to thicker meals until regular food is served, don't have to finish every meal, eat as much as you feel like, avoid carbonated drinks
Pain	you will have around the clock pain medicines, but also ask for additional pain medications as needed, use pain medications to help you move, NOT to help you sleep, try pills instead of IV meds
Breathing	use Incentive Spirometer every 1 hr while awake
Rest	try to stay awake during the day and sleep at night, be active at least 4 hours and may rest the remaining hours

Day 2 and until full Recovery

Activity	in chair 1.5 hrs with each meal, walk three times per day 30 min each time, activity goal 6 hrs
Diet	eat your usual diet, avoid carbonated drinks, avoid heavy meals, eat as much as you like, don't force it, eat food that typically helps you have good bowel movements and doesn't constipate you
Pain	use the least amount of narcotic medications as possible, use pain medications to help you move, NOT to help you sleep
Breathing	use Incentive Spirometer every 2 hr while awake
Rest	try to stay awake during the day and sleep at night, be active at least 6 hours and may rest the remaining hours

Broward Urology Center

Robotic Prostatectomy with Bilateral Lymph Node Dissection Consent Form.

Consent

I discussed and understand the above risks, benefits, and alternatives with the doctor. I had an opportunity to have all questions answered by the doctor.

Patient or Guardian Signature_____Date_____

Name (print)_____Witness_____

The procedure stated on this form, including the possible risks, complications, alternative treatments (including non- treatment) and anticipated results, was explained by me to the patient.

Physician's Signature _____Date_____