



JAMES BUCHANAN BRADY UROLOGICAL INSTITUTE

ROBOTIC-ASSISTED LAPAROSCOPIC RADICAL PROSTATECTOMY

OUR SURGEONS

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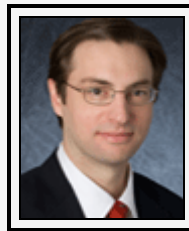
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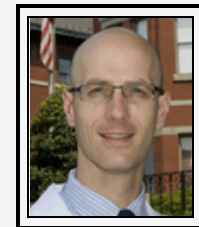
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APPOINTMENTS

Johns Hopkins Hospital Patients and **Johns Hopkins Bayview Medical Center Patients** please use the phone numbers listed above.

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** (for Johns Hopkins Hospital Patients) or **410-550-0100** (for Johns Hopkins Bayview Medical Center Patients) and ask to speak to the urologist on call.

NOTE: Patients must remember to bring all pathology reports, PSA values, and **glass pathology slides** to their consultation appointment. The pathology slides will be submitted for review at Johns Hopkins.

For **directions to Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center** please [click here](#)

PRIOR TO THE SURGERY

What to expect during you preoperative consultation

During your preoperative consultation your surgeon will review your history, medical records, PSA values, and any available radiology films or reports.

You will then undergo a full physical examination followed by a discussion of treatment options for your stage of prostate cancer.

Your glass pathology slides will be submitted for review by the Johns Hopkins Pathology Department. Results of this review require 1-2 weeks after which the slides will automatically be sent back to the original facility from which they came.

If your surgeon decides that you are a candidate for robotic assisted radical prostatectomy, you will then meet with a Patient Service Surgery Coordinator, to schedule a date for your operation. Any scheduling changes can be made directly through her at **410-955-4048**.

Note: It is the responsibility of the patient to inform the Patient Service Surgery Coordinator of any scheduling changes/cancellations at least 4 weeks in advance of the surgery date out of courtesy to your surgeon, the operative staff, as well as other patients.

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 family doctor or primary care physician's office within 1 month prior to the date of surgery.

For Johns Hopkins Hospital Patients: These results need to be faxed by your doctor's office to the Pre-operative Evaluation Center at **443-287-9358** 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.

For Johns Hopkins Bayview Medical Center Patients : These results need to be faxed by your doctor's office to the Pre-operative Evaluation Center at **410-550-1391** one week prior to your surgery. Please call The Documentation Center at **410-550-2495** before your surgery date to confirm that this information was received.

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 preoperative testing done prior to your surgery.

- Physical exam
- EKG (electrocardiogram)
- CBC (complete blood count)
- PT / PTT (blood coagulation profile)
- Comprehensive Metabolic Panel (blood chemistry profile)
- Urinalysis

Preparation for surgery

Medications to Avoid Prior to 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).

Bowel Preparation and Clear Liquid Diet

Do not eat or drink anything after midnight the night before the surgery and drink one bottle of Magnesium Citrate (can be purchased at your local pharmacy) the evening before your surgery. Also patients are advised to self-administer one Fleets enema the morning of surgery to evacuate the colon.

Drink only clear fluids for a 24-hour period prior to the date of your surgery. Clear liquids are liquids that you are able to see through. Please follow the diet below.

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
 - Grape 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)

The Operation

Nerve-sparing robotic assisted radical prostatectomy is a well-established procedure at Johns Hopkins and is performed with the assistance of an experienced and dedicated laparoscopic surgical team including nurses, anesthesiologists, operating room technicians, many of whom you will meet the day of surgery.

Robotic prostatectomy is accomplished with the assistance of a experience and dedicated laparoscopic and robotic operating room staff including nurses, anesthesiologist, and technicians many of whom you will meet the day of surgery



Robotic assisted radical prostatectomy is accomplished using the daVinci Surgical System, a sophisticated robotic device that uses a high quality three dimensional camera image to provide a superior view of the prostate gland and surrounding anatomy (Figure 1).



Figure 1. daVinci® Surgical System operating room setup

Miniaturized robotic instruments are passed through 5 - 6 small 1-cm keyhole incisions across the mid abdomen (Figure 2) to allow the surgeon to dissect the prostate and sew the bladder to the urethra with great precision.

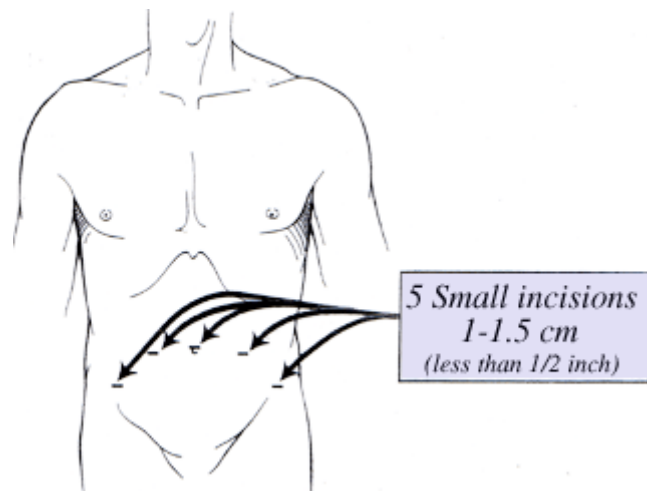


Figure2

This is in contrast to the conventional open radical retropubic prostatectomy where a lower midline abdominal incision is required for dissection and removal of the prostate gland.

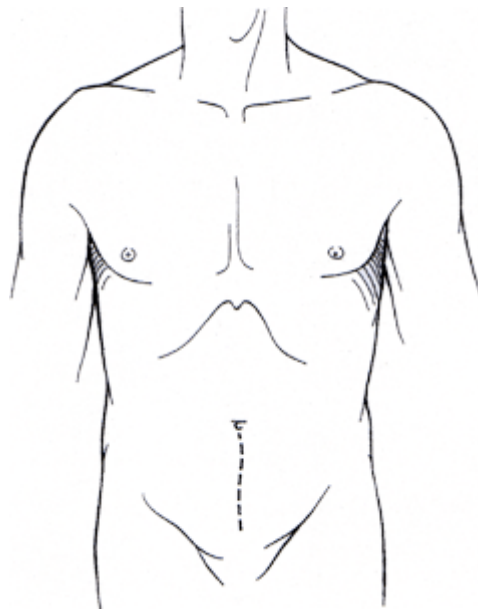


Figure3

During robotic assisted radical prostatectomy, a telescopic lens is inserted into one of the keyhole incisions, providing a three dimensional and magnified view of delicate structures surrounding the prostate gland (e.g. nerves, blood vessels, muscles) thus allowing optimal preservation of these vital structures. The cancerous prostate gland is dissected free from the bladder and urethra, and the bladder and urethra are sewn together without the surgeon's hands ever entering into the patient's body. The prostate is eventually removed intact through one of the keyhole incisions located at the belly button by extending the incision to accommodate the prostate depending on its size (usually 3-5 cm). Results from multiple

centers specializing in robotic surgery have indicated that patients undergoing robotic assisted radical prostatectomy have less blood loss than traditional open surgery. Early results for cancer cure, urinary continence, and potency also appear similar to open surgery. The surgeon is seated at a computer console (Figure 4) and manipulates the robotic wristed instruments with joystick hand controls (Figure 5). The surgery is performed adhering to the same anatomic principals of open surgery, but without the surgeon's hands entering into the patient's body cavity.



Figure4. daVinci® Surgical System surgeon console



Figure5. Joystick hand controls

All surgical steps of nerve-sparing robotic assisted radical prostatectomy can be viewed in the [Video Resources](#) section of this site. Once the prostate gland is dissected free from the bladder, rectum, and urethra, it is placed in a small plastic bag and eventually removed by extending the incision at your belly button to accommodate the prostate. The bladder is sewn back to the urethra to restore continuity of the urinary tract using laparoscopic suturing techniques inside the body. A Foley catheter is placed through the penis to drain the bladder and allow healing of the bladder-urethra connection. In addition, a small drain is placed around the surgical site, exiting one of the keyhole incisions.

The length of operative time for robotic assisted radical prostatectomy can vary greatly (3-5 hours) from patient to patient depending on the size of the prostate gland, shape of the pelvis, weight of the patient, and presence of scarring or inflammation within the pelvis due to infection or prior abdominal/pelvic surgery. Blood loss during robotic assisted radical prostatectomy is routinely less than 300 cc. Transfusions are rarely required. Donation of blood prior to surgery for autologous blood transfusion can be arranged if the patient desires.

Potential Risks and Complications

Although this procedure has proven to be very safe, as in any surgical procedure there are risks and potential complications. The safety and complication rates are similar when compared to the open surgery. Potential risks include:

Bleeding: Although blood loss during this procedure is relatively low compared to open surgery, a transfusion may still be required (in <1% of patients) if deemed necessary by your surgeon either during the operation or

afterwards during the postoperative period. If you are interested in autologous blood transfusion (donating your own blood) prior to surgery, you must make your surgeon aware. An authorization form can be faxed to the Red Cross in your area.

Infection: All patients are treated with intravenous antibiotics, prior to the start of surgery to decrease the chance of infection from occurring within the urinary tract or at the incision sites.

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 since all keyhole incisions are closed under direct laparoscopic view.

Conversion to Open Surgery: The surgical procedure may require conversion to a pure laparoscopic procedure (performed without the robotic system) or even to the standard open operation if extreme difficulty is encountered during the robotic procedure (e.g. excess scarring or bleeding). This could result in a standard open incision and possibly a longer recuperation period.

Urinary Incontinence: As in open surgery, urinary incontinence can occur following robotic prostatectomy, but often improves over time with the use of Kegel exercises, which help strengthen the urinary sphincter muscle.

Erectile Dysfunction: Similar to open surgery, a nerve-sparing technique is attempted during robotic 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 urinary leakage can occur at the connection between the bladder and urethra following both open and robotic prostatectomy and often resolves without further intervention within a few days to up to a week. The urinary catheter will remain in place until the leakage has stopped.

WHAT TO EXPECT AFTER SURGERY

During your hospitalization

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.

Hospital Stay: Length of hospital stay for most patients is 1 - 2 days.

Diet: You can expect to have an intravenous catheter (IV) in for 1-2 days. (An IV is a small tube placed into your vein so that you can receive necessary fluids and stay well hydrated; in addition it provides a route to receive medication.) Most patients are able to tolerate clear liquids the first day after surgery, and a regular diet the following day. Once on a regular diet, pain medication will be administered by mouth instead of by IV or shot.

Post Operative Pain: Pain medication can be controlled and delivered by the patient via an intravenous patient-controlled analgesia (PCA) pump or by injection (pain shot) administered by the nursing staff. You may experience minor transient shoulder pain (1-2 days) related to the carbon dioxide gas used to inflate your abdomen during the laparoscopic surgery.

Bladder Spasms: Bladder Spasms are commonly experienced as a moderate cramping sensation in the lower

abdomen or bladder and are quite common after prostatectomy. These spasms are usually transient and often decrease over time. If severe, medications can be prescribed by your doctor to decrease the episodes of these spasms.

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 1-2 weeks after the surgery. It is not uncommon to have blood-tinged urine for a few days to a week after your surgery.

Pelvic Drain: The pelvic drain is placed in the operating room and drains the pelvic space around the bladder-urethra anastomosis. This drain is usually removed in 2-3 days when the drainage is minimal.

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.

Constipation/Gas Cramps: You may experience sluggish bowels for several days following surgery as a result of the anesthesia. Suppositories and stool softeners are usually given to help with this problem. Taking a teaspoon of mineral oil daily at home will also help to prevent constipation. Narcotic pain medication can also cause constipation and therefore patients are encouraged to discontinue any narcotic pain medication as soon after surgery as tolerated.

What to expect after discharge from the hospital

Pain Control: You can expect to have some incisional discomfort that may require pain medication for a few days after discharge, and thereafter Tylenol should be sufficient upon returning home to control your pain.

Showering: You may shower at home. Your wound sites can get wet, but must be padded dry. Tub baths can soak your incisions and therefore are not recommended in the first 2 weeks after surgery. You will have adhesive strips across your incisions. They will either fall off on their own or can be removed in approximately 5-7 days.

Incisions and suture: Your incisions will be closed with sutures beneath the skin, which will dissolve within 4 – 6 weeks. (Figure 6).



Figure 6. Postoperative Incisions

Activity: Taking daily walks is strongly 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 developing pneumonia. Climbing stairs is possible but should be limited. Driving should be avoided for at least 2 weeks after surgery. Absolutely no heavy lifting (greater than 20 pounds) or exercising (jogging, swimming, treadmill, biking) for six weeks or until instructed by your doctor. Most patients return to full activity an average of 3-4 weeks after surgery.

Medications: You can resume your usual medications after surgery with the exception of aspirin or other blood thinners, which can increase the risk of bleeding.

Follow up cystogram appointment: The first postoperative appointment will be to remove the catheter, usually done at 1-2 weeks after surgery. Your surgeon will decide on the timing of this and this appointment will be arranged through the urology clinic ([410-955-6707](tel:410-955-6707)). At this appointment you may undergo a cystogram (if determined necessary by your surgeon) in the radiology department. The cystogram is an X-ray study of the bladder that determines whether the bladder has healed completely to the urethra. At that same visit, your urologist will decide on whether the catheter can be safely removed after reviewing your cystogram X-ray films or whether it will need to remain for a longer period of time to allow for healing. Most people will have some difficulty initially with urinary control at the time the catheter is removed. Therefore, come to the office with a small supply of adult diapers or insert pads (ATTENDS or DEPENDS) that can be purchased at any drug store.

Pathology Results: Pathology results are usually available approximately 7 days following surgery. These results will be reviewed with you in the office. Alternatively, you can contact your surgeon by phone or email at one week.

Long-term Follow-up: A prostate-specific antigen (PSA) test is drawn at 3 months following surgery. Patients are evaluated every 3-6 months. This can be easily accomplished over the telephone for patients who do not live close to the Baltimore area.

Discharge Instructions

CATHETER CARE:

Your catheter is very important to allow healing of the bladder to the urethra. The catheter should drain your bladder continuously. It should not be put on tension at any time. If you feel pulling or tugging, this means that your catheter needs to be fastened higher up on your leg to allow for some slack on the catheter as you move and walk. Your surgeon should be notified immediately if the catheter stops draining completely or if it falls out.

The urine collection bag must be positioned at all times below the bladder for proper draining by gravity. Drain the bag before it gets too full as this will result in a backup of urine in the bladder. Although use of the larger collection bag is advised, a smaller leg bag is available and can be worn under clothing. The larger bag is required at night as the smaller bags are likely to fill up too quickly.

The tip of the penis may get sore from catheter irritation. Use plain soap and warm water to wash this area daily. You may use Vasoline to prevent dryness and discomfort at the tip of the penis. A small amount of blood-tinged urethral secretions or even urine may leak around the catheter at the tip of the penis especially during bowel movements. This occurs due to mild straining and is completely normal.

It is common for your urine to turn pink or red-tinged as you become more active simply from the catheter rubbing against your bladder lining. If this occurs, reduce your walking and increase your fluid intake. It is permissible to bring the urine collection bag in the shower.

DIET:

You may return to your normal diet immediately upon discharge from surgery. However, adhering to foods such as rice, soups, noodles and avoiding high fiber meals (e.g. vegetables such as celery) is advised as your intestines may take up to a week to recover from the surgery and anesthesia. Because of the raw surface in your bladder and urethra, alcohol, spicy foods and drinks with caffeine may cause some irritation or sense of the need to void despite the fact that the catheter is emptying the bladder. If these foods don't bother you however there is no reason to avoid them in moderation. More importantly is to keep your urine flowing freely, drink plenty of fluids during the day (8-10 glasses). The type of fluids (except alcohol) is not as important as the amount. Water is best but juices, coffee, tea, soda are all acceptable.

ACTIVITY:

Your physical activity is to be restricted, especially during the first two weeks home. During this time use the following guidelines:

- a. Walking 6-8 separate short walks a day is advised to prevent blood clots from forming in the legs or pneumonia in the lungs.
- b. Climbing stairs is permitted if necessary but should be taken slowly. Climbing stairs is otherwise not a necessary activity in terms of exercise.
- c. No lifting heavy objects (anything greater than 10 lbs)
- d. No driving a car and limit long car rides.
- e. No strenuous exercise for 4-6 weeks. Following this, patients can return to their normal activities of daily living.

BOWELS:

Your bowels should return to normal after the surgery (over the course of 2-4 weeks) though pain medications can cause constipation and therefore should be discontinued as soon as tolerated. The rectum and the prostate are next

to each other and any very large and hard stools that require straining to pass can cause bleeding in the urine. Use a mild laxative (e.g. milk of magnesium) or stool softener (e.g. colace) if needed and call if you are having problems.

MEDICATION:

You should resume your pre surgery medication unless told not to. We recommend staying off aspirin or aspirin-containing products until after the catheter comes out and for at least 4 weeks following surgery. You will be given a prescription for pain pills (e.g. Tylox) for incisional discomfort. Most men following robotic prostatectomy rely only on extra strength Tylenol at home and do not require narcotic pain medication. You will also be given a prescription for an antibiotic (e.g. Ciprofloxacin) to take around the time the catheter comes out. Typically it will be a three-day course of antibiotics, which we ask you to start the day prior to your scheduled cystogram appointment.

HYGIENE:

You may shower or bathe as soon as you get home. Dab your incision sites dry following a shower and avoid heavy creams or ointments on your incisions. Keeping them dry and open to air is adequate.

PROBLEMS YOU SHOULD REPORT TO US: If this is an emergency the Urologist On-Call can be contacted at **410-955-6070**.

- a. Fevers over 101 degrees Fahrenheit as this may be a sign of infection.
- b. Heavy bleeding or clots in the urine.
- c. Calf or thigh pain or swelling as this may be a sign of a blood clot.
- d. Difficulty breathing or chest pain as this may be a sign of a pulmonary embolus or heart attack.
- e. Skin rash or hives as these may be signs of potential medication reactions.
- f. Nausea, vomiting, diarrhea which may be a sign of infectious diarrhea (e.g. Clostridium difficile)
- g. Call immediately if your catheter stops draining completely or falls out.

FOLLOW-UP:

The first postoperative appointment will be to remove the catheter, usually done at 1-2 weeks after surgery. Your surgeon will decide on the timing of this and this appointment will be arranged through the urology clinic (**410-955-6707**). At this appointment you may undergo a cystogram (if determined necessary by your surgeon) in the radiology department. The cystogram is an X-ray study of the bladder that determines whether the bladder has healed completely to the urethra. At that same visit, your urologist will decide on whether the catheter can be safely removed after reviewing your cystogram X-ray films or whether it will need to remain for a longer period of time to allow for healing. Most people will have some difficulty initially with urinary control at the time the catheter is removed. Therefore, come to the office with a small supply of adult diapers or insert pads (ATTENDS or DEPENDS) that can be purchased at any drug store.

Once your catheter is removed it is recommended that you avoid caffeine, alcohol, and excessive fluid intake for 1-2 months as this can aggravate incontinence.

PATHOLOGY RESULTS:

Pathology results are usually available approximately 7 days following surgery. These results will be reviewed with you in the office. Alternatively, you can contact your surgeon by phone or email at one week.

IMPORTANT CONTACT INFORMATION:

(410) 502-7707 (Myrna Sroka, RN)
(410) 955-6070 (Emergency number for urologist on call)

KEGEL EXERCISES

PELVIC MUSCLE EXERCISES TO IMPROVE BLADDER CONTROL (MALE)

Pelvic muscle exercises strengthen the group of muscles called the pelvic floor muscles. These muscles relax and contract under your command to control the opening and closing of your bladder. When these muscles are weak, urine leakage may result. However, you can exercise them and in many cases, regain your bladder control.

To achieve the best results when performing these exercises, imagine yourself an athlete in training. You need to build the strength and the endurance of your muscles. **THIS REQUIRES REGULAR EXERCISE.**

It is recommended that you start doing Kegel exercises six-eight weeks prior to surgery.

Begin by locating the muscles to be exercised:

1. As you begin urinating, try to stop or slow the urine **WITHOUT** tensing the muscles of your legs, buttocks, or abdomen. This is very important. Using other muscles will defeat the purpose of the exercise.
2. When you are able to stop or slow the stream of urine, you know that you have located the correct muscles. Feel the sensation of the muscles pulling inward and upward.
3. You may squeeze the area of the rectum to tighten the anus as if trying not to pass gas and that will be using the correct muscles.
4. Remember **NOT** to tense the abdominal, buttock, or thigh muscles.

Now you are ready to exercise regularly:

1. After you have located the correct muscles, set aside time each day for three to four exercise sessions (morning, midday, and evening)
2. Squeeze your muscles to the slow count of five. Then, relax the muscle completely to the slow count of five. The five second contraction and the five second relaxation make one "set."

TIPS

- When your pelvic floor muscles are very weak, you should begin by contracting the muscles for only three to five seconds. Begin doing what you can and continue faithfully. In a few weeks, you should be able to increase the amount of time you are able to hold the contraction and the number of exercise sets you are able to do. Your goal is to hold each contraction for ten seconds, to relax for ten seconds, and to complete 25 to 30 sets each of the three to four exercise sessions per day.
- In the beginning, check yourself frequently by looking in the mirror or placing a hand on your abdomen and buttocks to ensure that you do not feel your belly, thigh, or buttock muscles move. If there's movement, continue to experiment until you have isolated just the muscles of the pelvic floor.
- If you are unsure that you are contracting the correct muscles, at your next exam, ask your urologist to help you identify the proper muscle contraction.
- It is important to know that full control of urination may take even up to one year to return completely

following surgery. Most men experience improvement within 3-6 months. By 6 months, 70% of patients are pad-free and 90% at one year.

- Exercise your pelvic muscles regularly for a lifetime to improve and maintain bladder control.
- Pelvic muscle exercises also improve orgasmic function. Whether you are doing pelvic muscle exercise to improve or maintain bladder control or improve orgasmic function, or both, they must be done faithfully. Make them part of your routine.
- Use daily activities such as eating meals, watching the news, stopping at traffic lights, and waiting in lines as clues to do a few pelvic muscle exercises.
- **Avoid caffeine, alcohol or excessive fluid intake for first 1-2 months after surgery** as this will exacerbate urinary leakage

FROM ONE PATIENT TO ANOTHER TIPS FOR EASIER RECOVERY FOLLOWING RADICAL PROSTATE SURGERY

(This paper was written by a patient, describing his views about recovery from radical prostatectomy. If you have something to add or suggest, please don't hesitate to let us know your 'Picks to Click' as they say. Some of the products may take some searching or calling)

Upon arriving home from the hospital, the patient will find it much more comfortable (if not absolutely necessary) to spend most of the time in a Lazy Boy type recliner chair since it is almost impossible to lie on the flat surface of a bed because of the catheter. The adjustability of the reclining chair permits comfortable sleeping as well as sitting.

Another item needed for comfort because of the catheter is a nightshirt. An inexpensive substitute is an XXL "one size fits all" ladies T shirt, which can be found at Wal Mart stores. Because of the catheter, replacing the conventional toilet seat with one having a split front will make use of the toilet much more comfortable and convenient.

Once the catheter is removed, a new phase begins "the return to the diaper" stage. The Depend Company makes two basic styles of diaper: (a) the "bikini" style, shaped like a "V" and supported by elastic straps which button to the diaper, and (b) the typical diaper similar to that used on babies which covers a much larger area than the bikini style and attaches by three sticky tabs on each side. When in place, this diaper resembles a boxer style brief.

For at least the first few weeks following de catheterization, the "boxer style" diaper is needed to absorb urine that at times may be difficult to control or unpredictable. The diaper will probably require changing two or three times a day. During this time, an absorbent pad should be used to cover the chair seat. Once some control of bladder function returns, fewer diaper changes will be required daily. It's a good idea to change to a fresh diaper before retiring for the night as well as to keep the drinking of liquids to a minimum after 5:00 or 6:00 pm.

As far as water drinking is concerned, two liters or more should be taken during the course of the day. (A two liter soft drink bottle used as a water jug is a good measure of the amount of water intake.) Also, keeping the color of the urine in the catheter bag clear is also an indicator of proper fluid intake. Increase water consumption if the urine becomes amber or darker.

The scrotum and groin area will become irritated from being continually wet with urine. An excellent cleansing material which will increase your comfort is Carrington Perineal Cleansing Foam for Incontinent Care. It is an

aerosol preparation that is easily applied and then wiped away, leaving the sticky, messy, irritated area clean and comfortable and will make life much more pleasant during this trying period. Nothing beats a good bath and soaking upon awakening in the morning, but Carrington's Perineal Cleansing Foam applied when necessary during the day is the next best thing. Another alternative for skin protection from moisture is Baza® Clear Skin Protectant Ointment which may be available at certain pharmacies or can be obtained on-line.

About three weeks following removal of the catheter and after reacquiring major bladder control, you may find it possible to sleep without the diaper at night and really enjoy comfortable sleep. Once you become active during the day, however, the diaper will be necessary again.

By this time, you can switch to the bikini style diaper which allows for more freedom and more comfortable movement. Buy the "extra absorbency" form of the diaper to reduce changes because, by this time, you will have become much more mobile. Once you become more mobile, more socially active, and even feel that you can return to a limited work schedule, you will find that discarding the diaper for an "Incontinent Brief" will make your life feel like it's almost back to normal. A very nice incontinent brief is the "Prefer" Incontinent Brief which has a zippered front into which can be inserted an absorbent pad. What an improvement over wearing the diaper, even the bikini type!

(The Prefer Incontinent Brief can be purchased at many health supply stores.)

When you finally get to the stage that you are almost "dry" and experience only occasional dribbles during the day, another Depend product is great. It is the "Poise Pad," which has an adhesive tape on the outer surface that sticks to the inner surface of your ordinary jockey type shorts. Get the extra absorbent long Poise Pad.

You've gotten this far in your recuperation, so you're in the home stretch. Just don't get too frisky and overdo anything: work, exercise, or anything else. Take it easy, eat properly, drink lots of fluids, get a lot of rest, follow your doctor's instructions and get well completely.

FREQUENTLY ASKED QUESTIONS

1. **What is the difference between LRP and RALP?**

Both of these techniques are minimally invasive laparoscopic procedures that require 4-5 keyhole incisions. Both require a general anesthesia and have similar early outcomes with regards to cancer control, urinary continence, and sexual function. The only difference is that in the robotic assisted technique, a sophisticated robotic system called the daVinci™ robot is used to accomplish dissection of the prostate gland and suturing of the bladder to the urethra. In the robotic assisted technique the surgeon has complete control over movement of a high definition 3-D camera as well as wristed robotic instruments that move and rotate with the facility of a human wrist.

2. **How do I know if I am a candidate for LRP or RALP?**

Most men who are considered candidates for open surgery are also good candidates for a minimally invasive approach. Patients with a history of multiple prior abdominal or pelvic surgeries, large prostate glands (e.g. over 100 grams), or morbid obesity are often more challenging, however, these conditions are not absolute contraindications for LRP or RALP.

3. How long is the operation?

The length of these operations may vary based on a patient's weight, size of the prostate, and the presence of scarring around the prostate gland. In general these cases can last anywhere between 3-5 hours.

4. Will I need a transfusion and do I need to donate blood?

Transfusions are rare with these minimally invasive techniques. This is one of the most significant advantages over open surgery as bleeding is drastically reduced as compared to open surgery with routinely only 100-200 cc of blood loss. Donation of blood is optional but not generally required nor recommended.

5. How much pain will I have after surgery?

Patients often require a small amount of intravenous and/or oral narcotic pain medication during their hospital stay but often use only extra strength Tylenol™ once discharged from the hospital.

6. How long is the hospitalization?

Hospitalization is usually 1-2 days with these minimally invasive laparoscopic techniques. Patients are able to walk the following day under their own power.

7. How long will I have to have the bladder catheter?

Removal of the catheter will be dependent on the surgeon's particular preference. In general, however, because of the excellent visualization offered by these minimally invasive laparoscopic techniques a water tight connection between the bladder and urethra can be easily achieved allowing for safe removal of the bladder catheter within 1-2 weeks following surgery. The surgeon may perform a cystogram (bladder Xray test) to confirm that the connection between the bladder and urethra are healed sufficiently.

8. When can I return to normal activities?

In general most patients can return to full activities by 3-4 weeks after surgery. However, urinary control and sexual function may take months and even up to a year or so to improve significantly, just as in open surgery.

9. What is my chance of urinary incontinence?

Most men experience at least some degree of stress urinary incontinence for example when sneezing or coughing. This generally improves with time and with vigilance in performing Kegel exercises. We have found that approximately 70% of men were dry at 6 months and 90% at 12 months following LRP.

10. What is my chance of erectile dysfunction?

The return of erectile function is perhaps the most difficult outcome measure to predict. Many factors are involved in the return to sexual function following surgery including age of the patient, having an active sexual partner, whether one or both nerve bundles were spared, and time since surgery. When we evaluated preoperatively potent men who underwent nerve-sparing LRP, we found that 48% of men who had both nerve bundles spared reported successful intercourse at 6 months and 72% at one year following surgery with or without the use of oral medications (e.g. Viagra or Cialis) (see Figure 1).

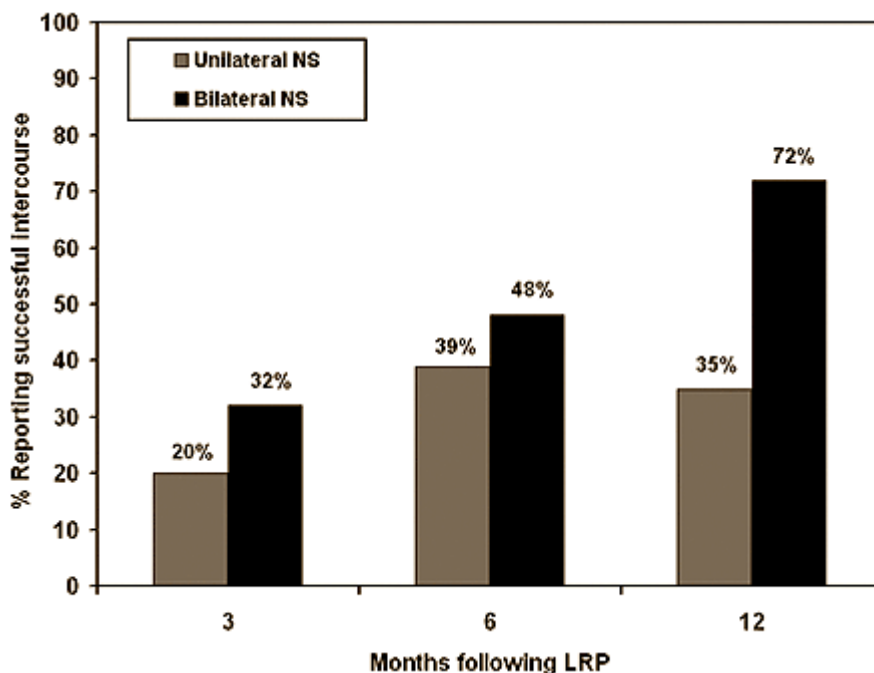


figure1

Younger men (< 58 years) appear to have a higher potency rate as compared to older patients (>58 years) at one year (i.e. 74% vs. 41%) (see Figure 2).

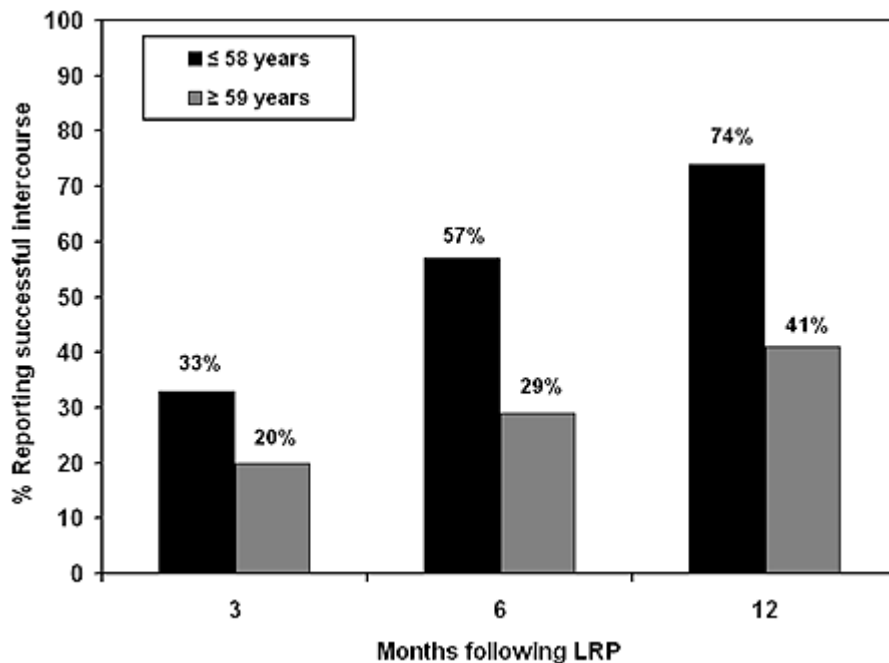


figure2

Lastly, in younger men (<58 years old) who had both nerves spared, 82% reported intercourse at one year. These results are very similar to results reported with open nerve sparing prostatectomy performed at our institution.

11. Will I need to follow up at Hopkins after my surgery?

Your first follow up appointment will be for the cystogram or bladder Xray study in 1-2 weeks following surgery. Following this, a PSA test and office visit either to your local urologist or with your Hopkins urologist is recommended at 3, 6, 12 months and then typically annually thereafter.

12. When will the pathology results be available?

Once the cancerous prostate gland is removed it is thoroughly evaluated by the Johns Hopkins pathologists. They are able to identify the Gleason grade, location, and extent of the cancer. In general these results are made available to the surgeon in 5-7 days.

13. Will I need further treatment following surgery for my prostate cancer?

Much of the decision on whether further treatment such as radiation or hormonal therapy is required will be based upon the pathologic stage of the cancer as well as the trend in PSA values following surgery. Most patients nowadays have early cancers detected by PSA screening and therefore are by and large curable with surgery. Therefore most patients do not require additional therapy following surgery. But obviously each case is individualized.