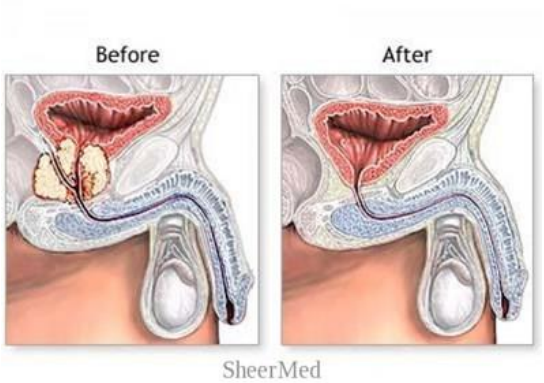
3 THE PROCEDURE

ANAESTHESIA

Robotic-assisted radical prostatectomy is performed under general anaesthesia. Small abdominal ports allow the surgeon to control the robotic instruments from a console with magnified 3-D vision.

SURGERY

The prostate and seminal vesicles are removed. The bladder neck is joined to the urethra over a urinary catheter. Pelvic lymph nodes may also be removed when indicated by the estimated risk of nodal involvement.



NERVE-SPARING OPTIONS

- Bilateral nerve sparing: both neurovascular bundles preserved when oncologically safe
- Unilateral nerve sparing: one side preserved
- Non-nerve-sparing: one or both bundles removed when required for cancer clearance

Hospital stay is commonly 1-2 nights, depending on recovery and individual medical circumstances.

CONTACT & FOLLOW-UP

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PSA & FOLLOW-UP

The catheter is removed when the bladder-to-urethra join has healed sufficiently. PSA is checked 6 weeks after surgery and then at intervals according to final pathology and cancer risk.

This brochure provides general information only and does not replace personalised medical advice. Follow the specific instructions given by your surgeon and anaesthetist.

OUTSIDE • BI-FOLD/TRI-PANEL PUBLISHER-STYLE LAYOUT

Urologist

Dr Jo Schoeman
UROLOGIST

PATIENT INFORMATION BROCHURE

ROBOTIC-ASSISTED RADICAL PROSTATECTOMY

Scan website
drjoschoeman.com.au

Nerve-sparing and non-nerve-sparing prostate cancer surgery.

Please visit **drjoschoeman.com.au** for more information

1 WHY IS RADICAL PROSTATECTOMY DONE?

Radical prostatectomy removes the prostate and seminal vesicles with the aim of curing prostate cancer. It is considered for appropriately selected men with localised or selected locally advanced prostate cancer after discussion of alternatives.

INDICATIONS & IMPORTANT CONSIDERATIONS

- Localised prostate cancer where surgery offers meaningful oncological benefit
- Selected locally advanced disease as part of multimodal treatment
- Low-risk disease may be better suited to active surveillance
- Choice depends on PSA, biopsy grade, MRI/staging, age, health and patient preference
- Surgery causes permanent loss of ejaculation and natural fertility

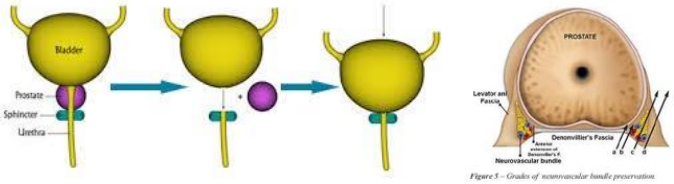

Figure 5 – Grades of neurovascular bundle preservation

2 BEFORE YOUR PROCEDURE

- Review PSA, biopsy grade group, MRI and staging investigations
- Anaesthetic assessment and optimisation of medical conditions
- Tell the team about medicines, allergies and blood thinners
- Do not stop anticoagulants/antiplatelets unless specifically instructed
- Follow hospital fasting and medication instructions
- Pelvic-floor physiotherapy before surgery is encouraged
- Discuss continence, erections, fertility and likelihood of nerve sparing

Cancer control takes priority over nerve preservation. The final nerve-sparing plan may change according to MRI, biopsy and operative findings.

4 AFTER YOUR PROCEDURE

CATHETER & WOUNDS

A urinary catheter remains temporarily while the new bladder-to-urethra join heals. Small abdominal wounds usually heal over the following weeks.

URINARY CONTROL

Urinary leakage is common after catheter removal and generally improves over weeks to months. Pelvic-floor exercises are important.

ERECTILE FUNCTION

Erectile dysfunction is common. Recovery may take many months and is more likely when erections were good before surgery and nerve sparing is possible.

SEXUAL CHANGES

There is no ejaculation after prostate removal and natural fertility is lost. Orgasm can still occur but is dry. Penile rehabilitation may be offered.

ACTIVITY

Regular walking is encouraged. Avoid heavy lifting and strenuous exercise until cleared by your surgical team.

PSA SURVEILLANCE

PSA should fall to an undetectable or very low level after surgery. A persistent or later rising PSA requires assessment and may lead to salvage treatment.

Your follow-up schedule is individualised according to the final pathology, surgical margins, lymph nodes and postoperative PSA.

5 POSSIBLE COMPLICATIONS

Most patients recover without major complications. Possible complications include:

- Bleeding or transfusion
- Wound or urinary infection
- Urine leak from the bladder-urethra join
- Lymphocele after lymph-node dissection
- Blood clots or pulmonary embolus
- Anastomotic/bladder-neck narrowing
- Persistent urinary incontinence
- Erectile dysfunction
- Rare bowel, rectal or ureteric injury
- Need for additional cancer treatment

SEEK URGENT MEDICAL HELP FOR

Chest pain or breathlessness
Marked leg swelling
High fever or shaking chills
Severe or worsening abdominal pain
Heavy bleeding or catheter blockage

6 PSA & FOLLOW-UP

PSA is checked after surgery and subsequently according to EAU/USANZ-aligned risk-based follow-up. Final pathology guides whether additional treatment or closer surveillance is required.

Pelvic-floor rehabilitation and erectile-function rehabilitation may continue for months. Recovery varies between patients and is influenced by age, baseline function, tumour factors and the extent of nerve sparing.