

TRANSURETHRAL RESECTION OF THE PROSTATE

A discussion of the operation and the pre and post operative care

You and your doctor have considered the possibility that you have a transurethral resection of the prostate (TURP). Why? What is it? Where? What can I expect afterwards? The following literature will hopefully give you some of the answers and understanding of prostate surgery. Perhaps not every question will be answered, so feel free to call us if more information is needed.

The Problem

The prostate gland sits between the bladder (the muscular reservoir for urine coming from the kidneys) and the urethra (the channel in the penis, through which the urine flows). The prostate's function is to make seminal fluid or semen, which is added to the sperm coming from the testicles and then ejaculated during sexual intercourse. However, the urine from the bladder must pass through the prostate to get into the urethra.

As men grow older, the prostate grows in size. This enlargement is also referred to as 'BPH', which stands for Benign Prostatic Hyperplasia. Benign means that this growth is NOT cancerous, hyperplasia is doctor talk for something that grows. The prostate's position between the bladder and urethra causes an obstruction to the flow of urine. This obstruction can present in many ways. Slowing of the stream, difficulty starting, getting up at night to urinate, urgency or a very strong desire to urinate, urinary infections, bleeding, and total inability to urinate.

The most common way of treating prostate enlargement or BPH is to do a transurethral resection of the prostate, or TURP. Using a special telescopic electric knife which allows an excellent view of the prostate channel, the Urologist is able to remove the part of the prostate which is blocking the channel. The entire prostate is NOT removed in this operation, but only that portion which is obstructing the channel.

Other types of prostate operations do exist and you may have heard of some of them. These include the 'open prostatectomy', 'suprapubic prostatectomy' or 'retropubic prostatectomy' which is also performed for BPH except that it is done through an incision in the lower abdomen. Its use is limited to prostates that are too big to be removed by the TURP route and accomplishes to same end result, that is to remove only the blocking part of the prostate. The other type of operation is called the 'radical prostatectomy' in which the entire prostate is removed. This operation is done only for cancer of the prostate and is a much more difficult procedure.

Preparation for the Operation

Any surgical procedure of this magnitude is done in a hospital. Unless there are some extraordinary circumstances, you will probably be admitted on the day of surgery. You may need blood tests, an electrocardiogram (EKG), and other tests done prior to your surgical date, or on the morning of admission, but it is unusual that men need to be brought in the night before a transurethral resection of the prostate. It is very important that you refrain from eating or drinking anything for at least eight hours prior to your scheduled operation time. In most circumstances this means nothing should pass your lips after midnight before your surgical procedure.

After coming through the admitting area and, perhaps, the blood drawing area, you will arrive at the nursing station on one of the floors and be given a bed and hospital gown. You may or may not be given an enema and have an intravenous line started to replenish your body's fluids. You will be brought down to a surgical holding area where an anesthesiologist will talk to you about the various choices of anesthesia, usually general anesthesia or spinal anesthesia. General anesthesia means that you are completely asleep and is usually induced by a fast-acting barbiturate. You will be kept asleep by breathing an anesthetic agent, of which there are many kinds. The other and more popular option is spinal anesthesia in which you are awake but sedated, and the lower half of your body is temporarily anesthetized with an injection of a local anesthetic into your back. For the most part, spinal anesthesia is preferred by urologists because of the long-term comfort it affords and somewhat less bleeding during the procedure.

The Operation and Recovery Room

You will be transported into the operating room and the anesthetic will be given. If you select a spinal anesthetic, you will note that your legs will be raised in special stirrups to perform the operation. The surgery is done usually within the hour, and you will be taken to a recovery room where nurses will watch you very carefully until your anesthetic has worn off. You will note that the nurses are constantly watching the rubber tube that leads from your penis to a drainage bag on the side of the bed. You will also note a bag of water hanging at the foot of the bed that connects to the tube. This tube or 'catheter' has been placed through your penis, through the prostate channel and into your bladder. It is held in position by a small balloon at the end of the tube which is inflated after it is placed. The nurses will be watching the tube drainage carefully. It will contain urine from the bladder, irrigation from the bag at the foot of the bed and any bloody drainage from the operative site in the prostate. This tube or 'catheter' that is in the bladder is very important for your early post-operative recovery. It essentially puts the bladder and prostate at rest, and if there is any bleeding it allows the blood to come out immediately rather than staying in the bladder and prostate to form clots. Occasionally clots will form and the tube will stop draining. The nurses will then use a special syringe with water to hand irrigate the catheter to free it of clots. Hand irrigation might be somewhat uncomfortable, but necessary to clear any plugging of the channel and allow the urine to flow. Once your anesthetic has worn off and the urine is draining satisfactorily, you will be transported to a hospital room.

Postoperative Care

In most instances you will be able to eat a regular meal on the evening of surgery. You will probably stay at bedrest until the next morning, and the intravenous line will be removed if you are taking in enough fluids. The nurses on the floor will continue to observe your catheter drainage and irrigate the tubes as needed. You may be on antibiotics, pain medication and stool softeners. Your usual medications will be restarted (except aspirin-containing products).

Getting Ready for Discharge to Home

As the catheter is a foreign body and an irritant, we have found that removing the catheter as soon as it is safe to do so is the best course of action. The major reason for the catheter, as mentioned earlier, is the removal of blood within the bladder and prostate. If, by the next morning, the urine drainage is relatively clear, the catheter can be safely removed and you could be discharged that very day. If there is still some bleeding present, then the catheter may be left in a second day. Most patients will have the catheter removed on the first and second day and discharged at that point. It is not too uncommon to have continued bleeding even at two days, and in these circumstances the catheter may need to be left in a little bit longer. Your physician may decide to discharge you with a catheter in place and a special drainage bag to be worn around your leg. This will allow the bladder to heal more fully. You will probably then be brought back to his office within three or four days to have the catheter removed. We have been particularly anxious to have patients take care of themselves at home as soon as the need for intravenous feeding and monitoring is not necessary. There are many reasons for this, including the sky-rocketing costs of medical care, but also the fact that bacterial infections that are generated in the hospital because of the indwelling catheter are much more difficult to treat than the rare infection that occurs as an outpatient. You will probably be discharged with antibiotics whether or not the catheter is in place. Also, you will receive stool softeners, to keep the stool from becoming too hard and preventing you from having to strain to have a bowel movement.

Post Operative Expectations

One should not expect too much immediately from the prostate operation. The objective of the surgery is to open the channel to allow better emptying of the bladder. The patient may continue to have symptoms for a veritable amount of time, and this includes getting up at night, frequency, some hesitancy and blood in the urine. It may take as long as six to eight weeks to get a better idea of how successful the operation might be, and some of the factors that come to play here include any residual infection and how much damage was done to the bladder wall by the obstruction of the prostate before the operation.

After Discharge to Home from the Hospital

Because of the raw surface around your prostate and the irritating effects of urine, you may expect frequency of urination and/or urgency (a stronger desire to urinate) and perhaps even more getting up at night. This will usually resolve or improve slowly over the healing period. You may see some blood in your urine over the first six weeks. Do not be alarmed, even if the urine was clear for a while. Stay in bed and drink lots of fluids until clearing occurs.

DIET:

You may return to your normal diet immediately. Because of the raw surface alcohol, spicy foods and drinks with caffeine may cause some irritation or frequency and should be used in moderation. To keep your urine flowing freely and to avoid constipation, drink plenty of fluids during the day (8 - 10 glasses).

ACTIVITY:

Your physical activity is to be restricted, especially during the first two weeks. During this time use the following guidelines: a. No lifting heavy objects (anything greater than 10 lbs); b. No driving a car and limit long car rides; c. NO strenuous exercise, limit stair climbing to minimum; d. NO sexual intercourse until okayed by one of your doctors; e. No severe straining during bowel movements - take a laxative if necessary .

SEX:

If you were sexually active prior to your surgery, your physician will advise you about when you can resume normal sexual activity. Resection of the prostate usually has little effect on a man's potency, orgasm, or ability to sense orgasm. Because the prostate makes semen, and because the junction of the bladder and prostate is involved in the operation, no semen can be expected to be ejaculated with sexual intercourse. Usually you will need to wait 4 to 6 weeks before resuming sexual activity, with the approval of your doctor, and the absence of bleeding in the urine (which means that the prostate still has some healing to do).

BOWELS:

It is important to have regular bowel movements during the post-operative period. 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. You will be given stool softeners (usually) but these are not laxatives. A bowel movement every other day is reasonable. Use a mild laxative if needed and call if you are having problems. (Milk of magnesia 2-3 tablespoons, or 2 Dulcolax tablets, for example).

MEDICATION:

You should resume your pre-surgery medication unless told not to. In addition you will often be given an antibiotic to prevent infection and stool softeners. These should be taken as prescribed until the bottles are finished unless you are having an unusual reaction to one of the drugs.

PROBLEMS YOU SHOULD REPORT TO US:

- a. Fevers over 100.5 Fahrenheit
- b. Heavy bleeding, or clots (See notes above about blood in urine)
- c. Inability to urinate
- d. Drug reactions (Hives, rash, nausea, vomiting, diarrhea)
- e. Severe burning or pain with urination that is not improving.

FOLLOW-UP:

You will need a follow-up appointment to monitor your progress. Call for this appointment at the number above when you get home or from the phone in your hospital room before leaving. Usually the first appointment will be about 7 - 14 days after your surgery.