

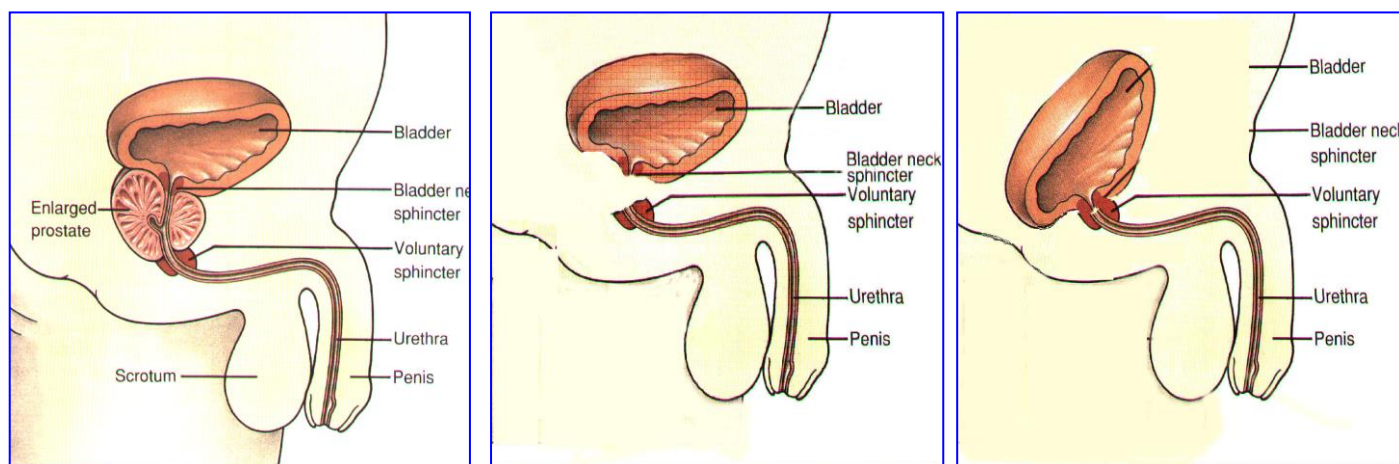
Robot Assisted Laparoscopic Radical Prostatectomy

This leaflet gives you information about having robot assisted laparoscopic surgery to treat your prostate cancer – also referred to as **robotic radical prostatectomy**. It explains why this operation may be suitable for you and what you can expect. It also outlines the advantages, possible risks and alternatives to this procedure and the most common questions raised by patients. More detailed information is available from your consultant or specialist nurse if you wish.

What is a radical prostatectomy?

'Radical' means that the whole of your prostate is removed, rather than just a part of it, with the intention to cure you of prostate cancer.

A prostatectomy is an operation to treat localised prostate cancer (cancer that has not spread outside the prostate gland). It is performed under a combined general and spinal anaesthetic and involves removing your entire prostate gland, seminal vesicles (glands that produce semen) and possibly blood vessels, nerves and fat around the prostate. These are taken out to increase the likelihood of removing all the cancer cells. Once they have been removed, the urethra (tube that carries urine through the penis and out of the body) is then re-attached to the bladder. In some cases, the pelvic lymph nodes (small bean-like structures in the lymphatic system where the cancer may spread to in high risk disease) are also removed. Your consultant will discuss this with you, if necessary, at your outpatient appointment



Anatomy of the prostate

Prostate removed

Bladder joined to the urethra

A radical prostatectomy has been traditionally performed by open surgery - where a single incision or cut of about 10-15cm is made in the abdomen, but over recent years has commonly been performed using a laparoscopic approach.

What is Laparoscopic surgery?

Laparoscopic surgery is also often called keyhole surgery. A laparoscopic prostatectomy is the same as an open prostatectomy, except that the operation is carried out using five or six small incisions (also called keyholes or port holes) rather than one large incision.

Six incisions are made in total and a special telescope is inserted into one of these. It transmits the inside view of your body to monitor screens in the operating room, which magnifies the view of your pelvis, so your surgeon has a detailed view. The remaining keyholes allow access for the surgical instruments used during the procedure.

What is Robot-assisted laparoscopic surgery?

Robot assisted laparoscopic surgery is a technique that uses a robotic console (a control unit, the da Vinci® system) to help your surgeon during the operation.

A high magnification (x10) 3D camera allows your surgeon to see inside your abdomen. This is attached to one of the four arms on the robotic console and inserted into your abdomen through one of the keyholes. The other robotic arms can hold various instruments, which your surgeon will use to carry out the operation. The instruments are smaller (about 8mm) than those used for open surgery. Because of the robotic console and 3D camera, your surgeon can carry out a precise operation in a smaller space, so a large incision is not needed.

Your surgeon is in the same room, but away from you and he or she controls the robotic arms to perform the operation. **It is important to understand that the robot is not performing the surgery.** The surgeon still carries out the procedure, but the robotic console allows more controlled and precise movements during the operation. The da Vinci® system has been used extensively throughout the United States and Europe and is used for many different types of operations, for example heart surgery.

What are the advantages of robot-assisted laparoscopic surgery?

Robot-assisted laparoscopic surgery may result in:

- **less blood loss** than in open surgery. Blood loss is typically minimal and so the risk of needing a blood transfusion is less.
- **less pain after the operation**, because the wound sites are smaller patients rarely need strong painkillers and will return to normal activities and work sooner than after open surgery.
- **a shorter stay in hospital**. Most patients go home one or two nights after laparoscopic surgery.
- **smaller scars**. It avoids the scar from open surgery, although the smaller scars from the keyholes will be visible.
- **A greater likelihood of sparing the nerves and blood vessels attached to the prostate gland**. These nerves and blood vessels control erections and urinary continence (ability to control when you pass urine).

What are the disadvantages of robot-assisted laparoscopic surgery?

This operation needs specialised training, as the surgeon is unable to “feel” your tissues or organs unlike open surgery. Although very rare, it may be necessary to convert to open surgery.

Who will perform the procedure?

This procedure is currently performed by Mr Rimington and Mr Garnett, who have undergone specialist training in this procedure.

What are the alternatives?

Robot-assisted laparoscopic prostatectomy is just one of the available treatment options. Your doctor will discuss with you the alternatives listed below if they are appropriate for your grade and stage of cancer:

- **Open radical retropubic prostatectomy**, traditional surgery to remove the prostate.
- **Brachytherapy**, where radiotherapy 'seeds' are implanted into the prostate to destroy the cancer cells.
- **External beam radiotherapy**, where beams of radiation are used to destroy the cancer cells.
- **Active surveillance/monitoring**. In some cases it may be an option not to treat your cancer. This is referred to as active surveillance or monitoring. Some cancers need to be treated more urgently than others, depending on how aggressive they are. If an aggressive cancer is not treated, it may spread to other parts of the body. Your doctor or specialist nurse will tell you if active surveillance is an option for you but please do not make any decisions before speaking to your doctor or specialist nurse.

Please ask for our other leaflets for information on these specific treatments.

What are the possible risks or side effects?

Your consultant will discuss the risks for this procedure with you in more detail, but please ask questions if you are uncertain. Most procedures have possible side effects. But, although complications listed below are well-recognised, most patients do not suffer any problems.

Common (greater than 1 in 10)

- Temporary difficulties with urinary control
- Impairment of erections even if the nerves can be preserved (20 to 50% of men with good pre-operative sexual function)
- Inability to ejaculate or father children because the structures which produce seminal fluid have been removed (occurs in all patients).
- Discovery that cancer cells have already spread outside the prostate, needing further treatment.
- Positive surgical margins - cancer cells seen (under a microscope) at the edge of the removed prostate tissue, meaning that it cannot be confirmed that all the cancer cells have been removed.

Occasional (between 1 in 10 and 1 in 50)

- Scarring at the bladder exit (bladder neck contracture) resulting in weakening of the urinary stream and needing further surgery (2 to 5%).
- Severe urinary incontinence (temporary or permanent) needing pads or further surgery (2 to 5%)
- Blood loss needing transfusion or repeat surgery.
- Further treatment at a later date, including radiotherapy or hormone treatment.
- Lymph fluid collection in the pelvis if lymph node sampling is performed.
- Some degree of mild constipation can occur; we will give you medication to relieve this but, if you have a history of haemorrhoids (piles), you will need to be especially careful to avoid constipation.

- Apparent shortening of the penis.
- Development of a hernia related to the site of the port insertion.
- Development of a hernia in the groin area at least 6 months after the operation.

Rare (less than 1 in 50)

- Anaesthetic or cardiovascular problems possibly requiring intensive care admission (including chest infection, pulmonary embolus, stroke, deep vein thrombosis, heart attack and death)
- Pain, infection or hernia at incision sites.
- Rectal injury needing a temporary colostomy (stool is diverted into a bag on your abdomen by bringing a loop of large intestine to the skin surface).
- Damage to structures inside the abdomen when the laparoscopic instruments are inserted. This is minimised by inserting the telescopic instrument first. This is then used to help insert the other instruments, so their placement is more controlled.

Very rare (less than 1 in 100)

- Death. Between 0.03% and 0.08% of patients die from complications of the operation.

Hospital acquired infection

- Colonisation with MRSA (0.9% - 1 in 10)
- MRSA bloodstream infection (0.02% - 1 in 5000)
- Clostridium difficile bowel infection (0.01% - 1 in 10,000)

The rates for hospital acquired infection may be greater in high risk patients for example those patients

- with long-term drainage tubes;
- who have had a long stay in hospital; or
- who have been admitted to hospital many times.

Additional treatment

It is important to note that you may need additional treatment later, such as radiotherapy or hormonal therapy if we find that the cancer has spread outside your prostate. These findings are based on the final report from our pathologist (doctor who specialises in examining tissues under a microscope).

What else should I consider before surgery?

Erectile dysfunction

If you decide to have surgery, the surgeon will discuss with you whether or not to try and preserve the nerves and blood vessels ("neurovascular bundles") attached to the side of the prostate. These contribute to normal erections. Although some period of erectile dysfunction is inevitable following a prostatectomy, preserving them makes normal erections following surgery more likely. Most men find that their erectile function gradually improves with time, but it can take up to two years.

Preservation of the neurovascular bundles running alongside the prostate can only be done if there is no clear sign of cancer at the edge of the prostate. Preserving the neurovascular bundles may increase the chance of a positive surgical margin (leaving some cancer behind). You should also be aware that if you are able to achieve orgasm, you will not ejaculate any semen, so you will be infertile. This is because you will no longer have a prostate gland, which produces the milky fluid that combines with your sperm to form semen. Some men also find that they leak urine when they ejaculate.

The risk of problems with erections varies:

- **Very high** (more than 80%; eight out of 10 men), if the erections were not good beforehand and it was not possible to preserve the nerves without jeopardising removal of the cancer
- **Moderately high** (50% to 60%; Five to six out of 10) if only one nerve bundle could be saved.
- **Moderate** (30 to 40%; three to four out of 10) if both nerve bundles were saved

Erection problems following surgery can be helped by treatments ranging from tablets to injections. It is highly unlikely that you will lose your sex drive (libido) as a result of the operation.

Urinary incontinence (inability to control when you pass urine).

All forms of radical prostate surgery result in some degree of urinary incontinence. Leakage of urine may occur following removal of the catheter (a tube that drains urine from the bladder into a bag). The urethra and bladder are joined by sutures (stitches) at the end of the operation. This process may cause bruising, swelling and impaired function of the sphincter (continence valve). A pad may be necessary until continence is restored. To improve urinary control, you will be given instructions on how to do pelvic floor exercises. Start the exercises before your operation and continue them regularly after your catheter has been removed. It is important to strengthen and tone the pelvic floor muscles to help with continence.

Continence rates differ amongst surgeons.

Good continence rates would be:

- 80% of patients pad free at three months after surgery
- 90% of patients pad free at six months after surgery
- 97% of patients pad free at 12 months after surgery
- There are a small number of patients using one or two pads per day 12 months after surgery and if worse than this, other measures to improve continence will be discussed, such as a surgical procedure.

Preparing for your surgery

- We will send you a date to come to the pre-assessment clinic before your surgery. You must come to this appointment, as this is when we will assess your suitability and fitness for surgery and anaesthetic. We will carry out a number of tests to make sure that your heart, lungs and kidneys are working properly. You may have a chest x-ray, electrocardiogram (ECG) which records the electrical activity of your heart and some blood tests taken. You may not see a doctor at this appointment. The medical or nursing staff will inform you if you require any further tests.
- The Urology Ward has a 'Enhancing Recovery' team approach to your care before, during and after surgery known as ERAS (Enhancing Recovery After Surgery). A Urology Nurse Practitioner will aim to see you at pre-assessment and during your admission to aid you in participating in your care and recovery.
- Your referring Consultant and Clinical Nurse Specialist (CNS) will discuss pelvic floor exercises with you before your operation and you will receive written information regarding these exercises.

- If you smoke, you will be asked to stop smoking, as this increases the risk of developing a chest infection or deep vein thrombosis (DVT). Smoking can also delay wound healing because it reduces the amount of oxygen that reaches the tissues in your body. If you would like to give up smoking, please speak to your specialist nurse or call the East Sussex Stop Smoking Service on 0800 917 8896. www.stopsmokingineastsussex.co.uk
- If you are overweight your surgeon or specialist nurse will discuss weight loss with you and decide whether you can manage this on your own or if you need assistance. It is important to be as fit as possible before surgery therefore you are advised to increase your physical activity for example by going for daily brisk walks taking into account any current physical or medical limitations.
- You will be given special advice if you take warfarin, clopidigrel, Aspirin or any other medication that might thin your blood. You should not make any changes to your usual medicines, whatever they are for, without consulting your GP or specialist first. Please remember to bring all your medicines with you to hospital.

Coming to hospital

- You will be told when to come into the hospital prior to your surgery and should expect to stay for one or two nights. Most patients are admitted to hospital on the morning of the operation.
- The anaesthetic team will visit you before your procedure and discuss with you the anaesthetic they will use. You will be able to ask the team any questions you have about your anaesthetic at this time.
- **Before your surgery you will need to sign a consent form. This consent gives the consultant permission to operate on you and confirms that you understand what the procedure involves. If you do have any questions or concerns please ask your doctor or nurse before you sign the consent form.** Although you will sign a consent form for this treatment, you may at any time after that withdraw such consent. Please discuss this with your medical team.

You will be able to eat as normal up until six hours before your surgery, and can have clear fluids up to two hours before the operation. For the two hours before the operation you will need to be Nil By Mouth (NBM), which means having nothing at all to eat or drink. This is essential as if you vomit during the operation there is the possibility of stomach contents going into your lungs and causing complications. You will be told at your pre-operative assessment when you must stop eating and drinking. **If you continue to eat or drink after this, your surgery will be cancelled.**

On the day of your surgery

On the morning of surgery you will be seen by the Urology Consultant performing the operation and the Anaesthetist. You will be asked to put on a gown and anti-thrombus stockings. These help to prevent blood clots forming in your legs (deep vein thrombosis or DVT) during surgery. You may take them off to shower during your hospital stay, but you must keep them on at all other times to help reduce the risk of blood clots. You will be able to remove them when you leave hospital.

You will need to be ready for surgery at least one hour beforehand. You will be taken on a trolley to the anaesthetic room, where you will be seen by the anaesthetic nurse and doctors. They will put a drip into your arm to allow them access to your veins during your operation.

Once anaesthetised, you will be taken through to the operating theatre. The combined anaesthetic and operating time can be anywhere between 3 to 4 hours.

What should I expect after my surgery?

After the surgery is finished, you will be taken to the post anaesthetic care unit (PACU) and remain there until you recover fully from the anaesthetic. You may remain in the PACU for the night after the surgery so that you can be individually monitored by specially trained staff. The next morning, after assessment, you will be taken back to your ward. The majority of patients return to the ward on the day of surgery. You should initially limit your visitors to immediate family.

You will wake up with:

- **A catheter:** this is a tube inserted into the bladder through your penis and is attached to a leg bag. This will collect your urine so you will not need to leave your bed to pass urine. We will leave this in place whilst the rejoining of the bladder and urethra heals. Please make sure you are given a date to come back to have the catheter removed **before** you leave hospital.
- **Stitches closing your wounds:** these dissolve and do not need to be removed.
- **Dressings:** these small plasters cover the keyhole sites and are generally removed 48 hours after surgery. You can wash or shower with them on.
- **A drip:** this delivers fluids into one of your arm veins to prevent you getting dehydrated. It is usually removed the day after your surgery when you are able to drink freely.

Occasionally a drainage tube is inserted at the operation site. This is a plastic tube that comes out from one of the small keyhole incisions. It prevents blood and urine collecting inside the abdomen after surgery. It is normally removed the morning after surgery.

You will be able to drink clear fluids when you have come round from the anaesthetic. You may experience some discomfort, but this can be easily controlled using the painkilling drugs you will be offered. A common side-effect of robot assisted laparoscopic surgery is 'shoulder tip pain' pain at the top of the shoulders. This is caused by pressure on the nerves of the diaphragm below the lungs when the abdomen is inflated with gas during the operation. Sitting upright and mobilising as soon as possible helps to relieve this type of pain and it will subside 2 to 3 days after surgery.

When you are fully awake and able to drink water you will be offered something to eat.

While you are in bed on the day of the operation, you will be encouraged to bend and stretch your feet up and down at the ankles to help the circulation in your legs. This will reduce the risk of blood clots forming in your legs. You will also be advised to do deep breathing exercises to reduce the risk of developing a chest infection. You will sit out of bed the following morning and be encouraged to take short walks later in the day.

Leaving hospital

You will be able to leave hospital when you:

- are fully mobile or returned to the level of mobility you had on admission
- have opened your bowels. (If you do not have your bowels open you will be given a laxative or a suppository and/ or laxatives will be given for you to take after discharge.)
- can attend to your personal needs as well as you did before you came into hospital;
- are able to care for your catheter and your leg bag (the ward nurses will teach you how to do this).
- have good pain control using the appropriate tablets taken by mouth (orally), where necessary.
- Your observations and blood tests taken are within the accepted normal range.

Your nursing staff will make sure you have:

- an appointment date to have your catheter removed.
- been referred to the District Nurse. The District Nurse will visit if you are house bound to change the dressings if your wounds are oozing. He /she will be able to give advice regarding catheter care **but is not permitted to flush or change the catheter.** Alternatively you can visit the Practice Nurse at your surgery
- A “Urinary Catheter Passport” - written information on how to look after your catheter.
- an outpatient appointment for you to see your consultant four to six weeks after your operation.
- a small supply of incontinence pads. These will be given to you when you attend to have your catheter removed. You will need to purchase your own supply of incontinence pads for future use.
- an information sheet regarding pelvic floor exercises

What can I expect when I get home?

The most common complaint after surgery is tiredness. Even though you will have small wound sites, you should not forget that you have had major surgery. You will need time to recover before returning to your normal activities.

You may also feel bloated and your clothes may feel tighter than usual. Wear loose clothing and try to walk around the house or go out for gentle walks. It can be uncomfortable if you have not passed wind or had a bowel movement for a few days and exercise such as walking will help to get your bowel moving again after surgery.

You might find after the first few days that you notice some urine bypassing around the sides of your catheter. This sometimes happens as a result of the bladder being irritated by the catheter; try passing the catheter over the top of your underwear rather than down the inside leg. If you become very uncomfortable, contact your ward or specialist nurse who will give you advice. You may also leak some blood around the catheter when you first open your bowels after the procedure. Blood in the urine is common whilst your catheter is in place and for up to three weeks after the catheter is removed.

You will need to:

- carry out twice-daily catheter care to help reduce the risk of infection. We will show you how to do this before you leave hospital.
- drink two to two and a half litres of fluid per day whilst the catheter is in place to prevent blockage.

- Call Hailsham 4 Urology Assessment Unit at Eastbourne DGH (01323 417 400 ext 4747) if you experience problems such as: increasing abdominal pain and distension not relieved by the pain killers given to you on discharge.
- If the catheter becomes blocked or you have any concerns you should contact your Specialist Nurse or call Hailsham 4 Urology Assessment Unit urgently for advice.
- **The catheter must not be flushed, removed or replaced by anyone other than a senior member of the Urology team. Patients who have been referred for surgery from the Brighton area** should call Hailsham 4 Urology Assessment Unit for advice if experiencing problems after discharge. However, in the event of an emergency they must attend their local Emergency Department, for an initial assessment.
- eat a light diet until your bowel movements are back to normal.
- avoid constipation by eating a diet high in fibre, fruit and vegetables and drinking 2 litres of fluid every day (8 glasses). Take the laxative prescribed on discharge if you have not had a bowel action for two days. Do not strain to open your bowels.
- take it easy. Do not lift anything heavy or do anything too energetic for example, shopping, vacuuming, gardening, mowing the lawn, lifting weights or running, for at least two to four weeks after your surgery. Doing these things may put too much strain on your stitches and may make your recovery take longer.
- give yourself a couple of weeks rest before returning to work. If your work involves heavy lifting or exercise, please speak to your consultant. On the day of your discharge from hospital, the ward staff can supply you with a two week sick certificate. Further sick certificates can be obtained from your GP if necessary.
- only start driving again when you are able to perform an emergency stop without feeling hesitant, usually two weeks after surgery. Do not drive whilst the catheter is still in place. **If you are still taking painkillers please check with the pharmacist whether it is safe to drive.**

Looking after your wounds

When bathing or showering use un-perfumed soap, rinse this thoroughly from your body and pat yourself dry with a clean towel . Keep the wounds clean and dry at all other times until the wounds have healed. Please do not use lotions or creams on the area while they are healing, as this may increase the possibility of infection.

Your catheter removal

Before your appointment for catheter removal, you should make sure that you have a supply of incontinence pads at home. You will need to bring some pads with you to your appointment for catheter removal. The ward will provide one small pack of pads before your discharge.

Incontinence pads can be obtained from various sources:

- **Your local pharmacy or supermarket** – they may need to be specially ordered.
- **Order by phone.** You can place an order by calling Tena Direct on 0800 393431 (this is a freephone number). You can pay by credit or debit card. Lines are open Monday to Friday 09.00 to 17.00hr (enquiries may be diverted to an answer machine if all lines are busy).
- **Order on-line** at <http://www.tenadirect.co.uk> - where you can select the products you need and complete your purchase using the secure on-line payment system.

Your catheter will be removed by the specialist nurse after your surgery. You may not see a doctor at this appointment. The specialist nurse will then monitor you for the next few hours to make sure you are able to pass urine satisfactorily. Less than 1% of patients have urinary retention (cannot pass urine) and need to have a catheter reinserted for another 10 days or so.

Please bring some spare continence pads, underwear and trousers to this appointment. You can expect to be at this appointment for at least half of the day.

If you have problems with continence after surgery, practising the pelvic floor exercises regularly will help. Almost all patients have some incontinence when the catheter is taken out, so please do not feel embarrassed. We recommend that you continue the pelvic floor exercises as soon as your catheter is removed and repeat them several times a day. Your continence will improve with time and persisting with the exercises. As discussed before your operation a small minority of patients will experience severe incontinence after the procedure. If this is the case additional support and follow-up can be arranged.

When can I have sex again?

You may begin sexual activity again three weeks after your operation, as long as you feel comfortable. At first it will be more difficult for you to have an erection in comparison with before your surgery.

If a nerve sparing procedure has been performed and you wish to regain erectile function, you will be given a prescription for a daily dose of Viagra 25mg when you attend for your catheter removal. This should be taken as directed to encourage blood flow to the penis. Your Specialist Nurse will also offer you an appointment to attend for instruction on the use of a Vacuum Erection Device to assist in restoring erectile function. Please report progress when you attend for follow up. If the combined treatment of Viagra and the Vacuum Device is unsuccessful arrangements can be made for you to be seen in an Erectile Dysfunction Clinic to discuss other treatments eg. injections.

When will I have a follow-up appointment?

Your follow-up appointment will be four to six weeks after your surgery. At this appointment your surgeon or a member of his team will give you the pathology results. All pathology results will have been discussed in detail at a Multi-disciplinary Meeting to confirm your further management.

After this you will be reviewed every three months for the first year, then at six monthly intervals for the next two years. You will need a PSA blood test taken one week before each appointment. Following the operation PSA values should remain near zero as the prostate has been removed. If the PSA rises, this indicates a return of the cancer which may need further treatment by radiotherapy or drugs.

When your Urology team are satisfied that your PSA is stable and any incontinence or erectile dysfunction issues have been addressed you will be discharged to your GP. It will be your responsibility together with your GP to ensure that your PSA is checked annually until ten years following your operation.

If you have any further questions that you wish to ask please do not hesitate to speak to the nursing or medical staff. If you feel there is information that should be included in this information leaflet please let us know, or fill in a comment sheet prior to your discharge home.

Useful telephone numbers:

Sally Sawyer, Tessa Rodgers, Jo Gainsford, Kelly Murrey, Nicola Jebbett, Urology Nurse Specialists – Tel: (01323) 438246 (answer phone) or (01323) 417400 (Switchboard) and ask for bleep 8246 (Urgent calls only)

Kelly Smith, Enhanced Recovery Urology Nurse Practitioner

Tel: (01323) 417400 Ext 4767(answer phone) or (01323) 417400 (Switchboard) and ask for bleep 0159

Hailsham 4 Urology Ward – (01323) 417400 Ext 4056/ 3413

Urology Assessment Unit – (01323) 417400 Ext 4747

Mr Rimington Secretary – (01323) 413700

Mr Garnett Secretary at Eastbourne DGH – (01323) 413701

Mr Garnett Secretary at Conquest Hospital – (01424) 755255 Ext 8344

Acknowledgement

The British Association of Urological Surgeons (BAUS) Available online at:
http://www.baus.org.uk/patients/information_leaflets/category/8/prostate_procedures
The above information source was used to assist with compiling this leaflet.

Sources of further information

Prostate Cancer UK provides support and information for men with prostate cancer.

Tel: **0800 074 8383** or visit - **www.prostatecanceruk.org**

Macmillan Cancer Support provides information and support to anyone affected by cancer.

Tel: **0808 808 0000** or visit - **www.macmillan.org.uk**

Cancer Research UK has a patient information website, with information on all types of cancer and treatment options, as well as a book list for further information.

Visit - **www.cancerresearchuk.org/cancer-help/**

Eastbourne Prostate Cancer Support Group

Tel: **01323 749258** or visit - **www.pcasoeastbourne.org.uk/**

Important information

The information in this leaflet is for guidance purposes only and is not provided to replace professional clinical advice from a qualified practitioner.

Your comments

We are always interested to hear your views about our leaflets. If you have any comments, please contact the Patient Experience Team – Tel: (01323) 417400 Ext: 5860 or by email at: esh-tr.patientexperience@nhs.net

Hand hygiene

The Trust is committed to maintaining a clean, safe environment. Hand hygiene is very important in controlling infection. Alcohol gel is widely available at the patient bedside for staff

use and at the entrance of each clinical area for visitors to clean their hands before and after entering.

Other formats

If you require any of the Trust leaflets in alternative formats, such as large print or alternative languages, please contact the Equality and Human Rights Department.

Tel: 01424 755255 Ext: 2620

After reading this information are there any questions you would like to ask? Please list below and ask your nurse or doctor.

Reference

The following clinicians have been consulted and agreed this patient information:

Mr P D Rimington, Consultant Urologist, Mr S H Garnett, Consultant Urologist,
Miss A Gidlow, Urology Nurse Specialist

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Responsible clinician/author: Alison Gidlow, Urology Nurse Specialist, Jocelyn Jaun, Urology Nurse Specialist

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