

Transurethral Prostatectomy (TURP) for Benign Disease

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Na żądanie ta ulotka może zostać udostępniona
w innych językach/formatkach.

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What is the evidence base for this information?

This publication includes advice from consensus panels, the British Association of Urological Surgeons, the Department of Health and evidence-based sources. It is, therefore, a reflection of best urological practice in the UK. It is intended to supplement any advice you may already have been given by your GP or other healthcare professionals. Alternative treatments are outlined below and can be discussed in more detail with your Urologist or Specialist Nurse.

What does the procedure involve?

This operation involves the telescopic removal or incision of the obstructing, central part of the prostate with heat diathermy and temporary insertion of a catheter for bladder irrigation.

What are the alternatives to this procedure?

Drugs, use of a catheter/stent, observation or open operation, laser enucleation of the prostate (HoLEP).

Students

There may be students present during your consultation as part of their on-going training. Please let the staff know if you wish to be seen by a doctor only.

Are there any other important points?

This publication provides input from specialists, the British Association of Urological Surgeons, the Department of Health and evidence-based sources as a supplement to any advice you may already have been given by your GP. Alternative treatments can be discussed in more detail with your urologist or Specialist Nurse.

Who can I contact if I have a problem when I get home?

If you experience any problems related to your surgery or admission once you have been discharged home, please feel free to contact 4A or 4B ward for advice from the nurse in charge. They will assist you via the telephone, advise you to return to your GP or ask you to make your way to the Emergency Department (ED) at Whiston Hospital depending upon the nature of your concern.

4A Ward – 0151 430 1420 – Ring switchboard ask for extension 1619

4B Ward (Monday to Friday only) – 0151 430 1440 – Ring switchboard ask for extension 1624

It is often helpful to start pelvic floor exercises as soon as possible after the operation since this can improve your control when you get home. The symptoms of an overactive bladder may take 3 months to resolve whereas the flow is improved immediately. If you need any specific information on these exercises, please contact the ward staff or the Specialist Nurses.

It will be at least 14-21 days before the pathology results on the tissue removed are available. It is normal practice for the results of all biopsies to be discussed in detail at a multi-disciplinary meeting before any further treatment decisions are made. You and your GP will be informed of the results after this discussion.

Most patients require a recovery period of 2-3 weeks at home before they feel ready for work. We recommend 3-4 weeks' rest before resuming any job, especially if it is physically strenuous and you should avoid any heavy lifting during this time.

Driving after surgery

It is your responsibility to ensure that you are fit to drive following your surgery. You do not normally need to notify the DVLA unless you have a medical condition that will last for longer than 3 months after your surgery and may affect your ability to drive. You should, however, check with your insurance company before returning to driving. Your doctors will be happy to provide you with advice on request.

What should I expect before the procedure?

If you are taking Aspirin or Clopidogrel on a regular basis, you must discuss this with your urologist because these drugs can cause increased bleeding after surgery. There may be a balance of risk where stopping them will reduce the chances of bleeding but this can result in increased clotting, which may also carry a risk to your health. This will, therefore, need careful discussion with regard to risks and benefits.

You will usually be admitted on the day before your surgery although some hospitals now prefer to admit patients on the day of surgery. You will normally receive an appointment for pre-assessment to assess your general fitness, to screen for the carriage of MRSA and to perform some baseline investigations. After admission, you will be seen by members of the medical team which may include the Consultant, Specialist Registrar, House Officer and your named nurse.

You will be asked not to eat or drink for 6 hours before surgery and, immediately before the operation, you may be given a pre-medication by the anaesthetist which will make you dry-mouthed and pleasantly sleepy.

Please be sure to inform your surgeon in advance of your surgery if you have any of the following:

- An artificial heart valve
- A coronary artery stent
- A heart pacemaker or defibrillator
- An artificial joint
- An artificial blood vessel graft
- A neurosurgical shunt
- Any other implanted foreign body
- A regular prescription for Warfarin, Aspirin or Clopidogrel (Plavix)
- A previous or current MRSA infection
- A high risk of variant-CJD (if you have received a corneal transplant, a neurosurgical dural transplant or previous injections of human-derived growth hormone)

At some stage during the admission process, you will be asked to sign the second part of the consent form giving permission for your operation to take place, showing you understand what is to be done and confirming that you wish to proceed. Make sure that you are given the opportunity to discuss any concerns and to ask any questions you may still have before signing the form.

What happens during the procedure?

Either a full general anaesthetic (where you will be asleep throughout the procedure) or a spinal (where you are awake but unable to feel anything from the waist down) will be used. All methods minimise pain; your anaesthetist will explain the pros and cons of each type of anaesthetic to you.

When you leave hospital, you will be given a 'draft' discharge summary of your admission. This holds important information about your inpatient stay and your operation. If you need to call your GP for any reason or to attend another hospital, please take this summary with you to allow the doctors to see details of your treatment. This is particularly important if you need to consult another doctor within a few days of your discharge.

Most patients feel tired and below par for a week or two because this is major surgery. Over this period, any frequency usually settles gradually.

What else should I look out for?

If you experience increasing frequency, burning or difficulty on passing urine or worrying bleeding, contact your GP immediately.

About 1 man in 5 experiences bleeding some 10-14 days after getting home; this is due to scabs separating from the cavity of the prostate. Increasing your fluid intake should stop this bleeding quickly but, if it does not, you should contact your GP who will prescribe some antibiotics for you. In the event of severe bleeding, passage of clots or sudden difficulty in passing urine, you should contact your GP immediately since it may be necessary for you to be re-admitted to hospital.

Hospital-acquired infection

- Colonisation with MRSA (0.9% - 1 in 10)
- Clostridium difficile bowel infection (0.2% - 1 in 500)
- MRSA bloodstream infection (0.08% - 1 in 1250)

The rates for hospital-acquired infection may be greater in high-risk patients e.g. with long-term drainage tubes, after removal of the bladder for cancer, after previous infections, after prolonged hospitalisation or after multiple admissions.

What should I expect when I get home?

- By the time of your discharge from hospital, you should:
- Be given advice about your recovery at home
- Ask when to resume normal activities such as work, exercise, driving, housework and sexual intimacy
- Ask for a contact number if you have any concerns once you return home
- Ask when your follow-up will be and who will do this (the hospital or your GP)
- Ensure that you know when you will be told the results of any tests done on tissues or organs which have been removed

A telescope is passed into the bladder and the central part of the prostate removed piecemeal using heat diathermy. The prostate fragments are evacuated using suction and sent for pathological analysis. A catheter is usually inserted after the procedure. The procedure takes 45-60 minutes. You will usually be given injectable antibiotics before the procedure, after checking for any allergies.

What happens immediately after the procedure?

In general terms, you should expect to be told how the procedure went and you should:

- Ask if what was planned to be done was achieved
- Let the medical staff know if you are in any discomfort
- Ask what you can and cannot do
- Feel free to ask any questions or discuss any concerns with the ward staff and members of the surgical team
- Ensure that you are clear about what has been done and what is the next move

There is always some bleeding from the prostate area after the operation. The urine is usually clear of blood after 48 hours, although some patients lose more blood for longer. If the loss is moderate, you may require a blood transfusion to prevent you from becoming anaemic. You will be able to eat and drink the morning after the operation although this may be allowed earlier after a spinal anaesthetic.

The catheter is generally removed after 2-4 days, following which urine can be passed in the more normal way. At first, it may be painful to pass your urine and it may come more frequently than normal. Any initial discomfort can be relieved by tablets or injections and the frequency usually improves within a few days.

It is not unusual for your urine to turn bloody again for the first 24-48 hours after catheter removal. A few patients are unable to pass urine at all after the operation. If this should happen, we normally pass a catheter again to allow the bladder to regain its function before trying again without the catheter.

The average hospital stay is 2 days for a routine admission.

Are there any side-effects?

Most procedures have a potential for side-effects. You should be reassured that, although all these complications are well-recognised, the majority of patients do not suffer any problems after a urological procedure.

Common (greater than 1 in 10)

- Temporary mild burning, bleeding and frequency of urination after the procedure
- No semen is produced during an orgasm in approximately 75%
- Treatment may not relieve all the prostatic symptoms
- Poor erections (impotence in approximately 14%)
- Infection of the bladder, testes or kidney requiring antibiotics
- Bleeding requiring return to theatre and/or blood transfusion (5%)
- Possible need to repeat treatment later due to re-obstruction (approx 10%)
- Injury to the urethra causing delayed scar formation

Occasional (between 1 in 10 and 1 in 50)

- Finding unexpected cancer in the removed tissue which may need further treatment
- May need self-catheterisation to empty bladder fully if the bladder is weak
- Failure to pass urine after surgery requiring a new catheter
- Loss of urinary control (incontinence) which may be temporary or permanent (2-4%)

Rare (less than 1 in 50)

- Absorption of irrigating fluids causing confusion, heart failure (TUR syndrome)
- Very rarely, perforation of the bladder requiring a temporary urinary catheter or open surgical repair