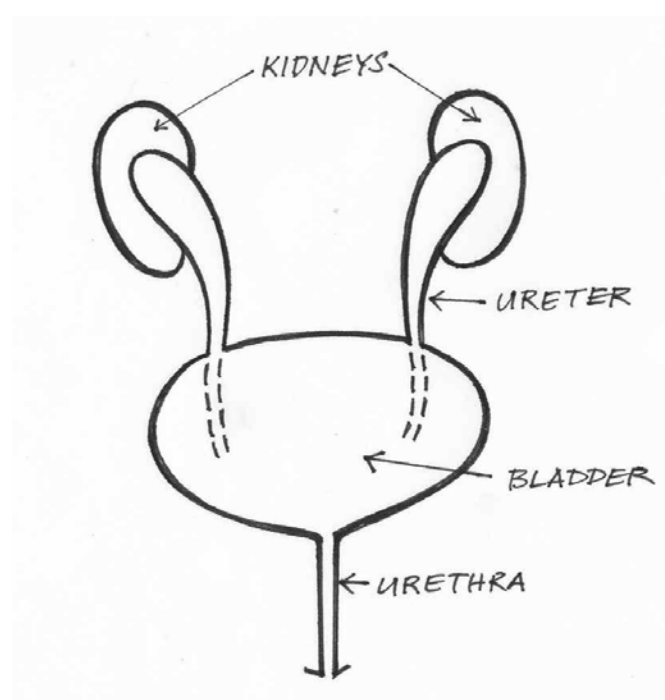


*AUGMENTATION
CYSTOPLASTY
PATIENT
INFORMATION*

The information contained in this booklet is intended to assist you in understanding your proposed surgery; some of the content may or may not apply to you. Feel free to discuss any issues and questions you may have about your surgery with the medical and nursing staff looking after you. If required, your nurse will arrange for an interpreter to assist with explaining the contents of the booklet. The interpreter can also be present for doctors' consultations. Please bring this book with you to hospital as it is a useful guide.

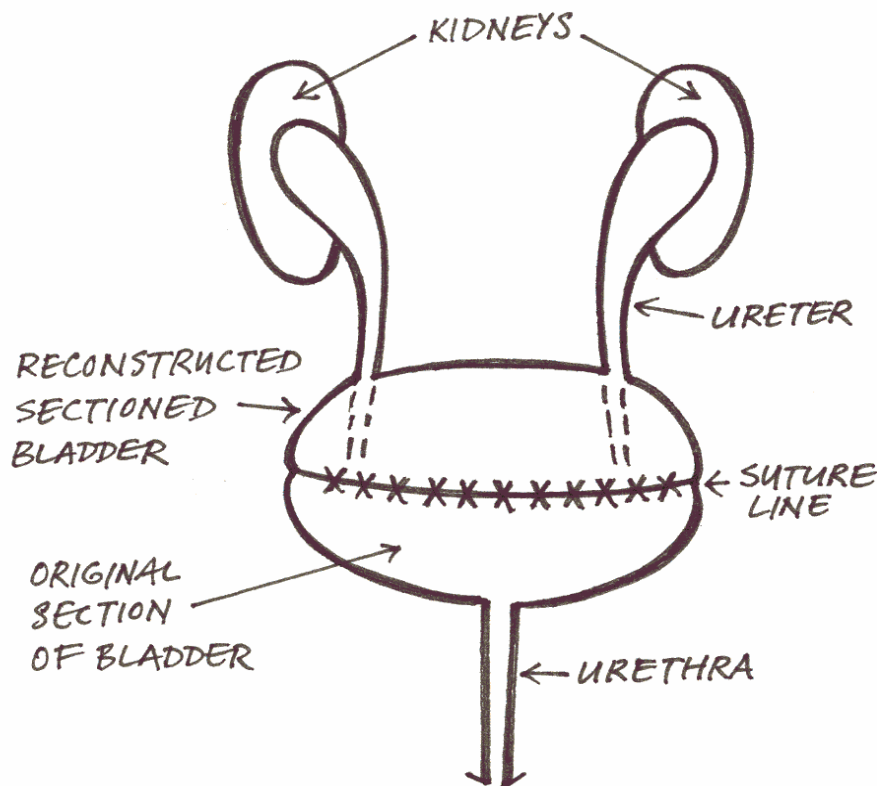
What does the Bladder do?

The bladder is a hollow, muscular organ in your pelvis situated behind the pubic bone. The function of the bladder is to collect, store and expel urine produced by the kidneys. When the bladder is full, the nerves that supply it send a message to the brain that you need to pass urine. Under your control, the urethral sphincter relaxes and the bladder contracts until it is empty of urine (voiding). The exit tube from the bladder is called the urethra.



What is an Augmentation Cystoplasty?

An Augmentation Cystoplasty is the surgical enlargement of the bladder using a segment of the bowel. During surgery the top or dome of the bladder is opened and a segment of bowel tissue is inserted to make a larger capacity bladder. The two ends of bowel will be rejoined and will continue to function normally. However, you may experience a change in bowel habit with slightly more frequent, looser motions than previously. This is because your bowel has been shortened.



The enlarged bladder will store urine in the same way as before but the volume of urine will be greater. As bowel tissue contains glands that constantly secrete mucus, the urine may now appear

cloudy. The amount of mucous in the urine will vary with each individual.

The bowel tissue is not muscular like bladder tissue so you may need to learn new techniques after surgery in order to empty your bladder fully.

Why do I need an Augmentation Cystoplasty?

Common reasons for an Augmentation Cystoplasty are to treat:

- Neurogenic bladder (the nerves that supply the bladder do not function resulting in a small capacity bladder)
- Instability or reflex incontinence (the bladder muscle is irritable and empties before you are ready so urine is not able to be stored efficiently)
- Interstitial cystitis (the surface of the bladder is inflamed leading to a small bladder capacity)

Potential Complications

All urological surgical procedures carry a small risk of post-operative bleeding and wound, chest and urinary tract infection. You will be monitored for these risks and treated promptly if they occur.

- **Excessive bleeding**
Your wound, drain(s) and vital signs (blood pressure and pulse) will be monitored for signs of excessive bleeding.

- **Infection**

Your chest, wound and urine will be monitored for early signs of infection and intervention will be put in place if it occurs. To reduce the risk of infection antibiotics are given directly into your bloodstream during your operation and continued post-operatively if necessary. You can also assist with the prevention of infection by maintaining good hygiene and doing your deep breathing exercises. Early mobilisation also helps.

- **Prolonged bowel inactivity (paralytic ileus)**

There is a small risk of paralytic ileus following any major surgical procedure that involves handling of the bowel, prolonged anaesthetic time or large amounts of strong pain killing medication. This means the intestinal tract is very slow to return to its normal function. If a paralytic ileus occurs you are likely to experience nausea, vomiting, a bloated abdomen and/or intestinal cramps. These symptoms can be relieved by the use of a nasogastric tube to drain the stomach's normal secretions while the bowel rests and recovers.

- **Incisional hernia**

As a wound heals, scar tissue forms creating a bond between the two sides of the incision. The scar tissue is strong but can still occasionally tear or give way. This leads to a bulge developing along the scar (incisional hernia) usually within one to five years after surgery. A hernia may not cause any discomfort but if it is troublesome it may require repair.

- **Potential urine leak**

The bladder has a good blood supply and usually heals well after surgery. Occasionally when you start to use your bladder again after surgery there may be some slight leakage of urine from the bladder/bowel patch. If this occurs, you may need a

catheter for an extended period of time in order to rest the bladder until it heals completely.

- **Potential bowel leak**

There is a very small risk of a bowel leak as the bowel has been divided to take a segment out and the two ends then joined back together.

Length of Stay

The usual length of stay is seven to ten days. However, if you need to stay longer for a medical reason, your doctor will discuss this with you.

Before Surgery

Informed consent

After consultation with the doctor you will be asked to sign a form to give written consent for the surgeon to perform the operation and for an anaesthetic to be administered. Relevant sections of the form must also be completed if you agree to a blood transfusion and/or if your particular surgery involves the removal of a body part and you wish to have this returned. Our expectation is that you feel fully informed about all aspects of your surgery before giving written consent. The following health professionals are available to help you with this process.

Nurses

A nurse will explain what to expect before and after surgery. Please ask questions and express your concerns; your family or people close to you are welcome to be involved.

When you are discharged from hospital your nurse will arrange for you to receive ongoing support, advice and practical help, if needed.

Tests

Blood samples

Samples of your blood will go to the laboratory to check your general health before surgery.

Blood transfusions

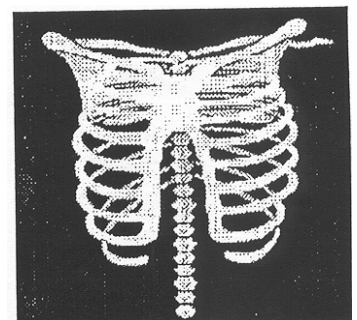
A sample of your blood will go to the blood bank to identify your blood type so this can be matched with donated blood. This donated blood is then ready for transfusion during or after surgery if required. **We will need your written consent before a transfusion is able to take place.**

Midstream urine

A sample of your urine is sent to the laboratory to check that there is no bacteria.

Chest x-ray

If requested by the doctor or anaesthetist, a Chest x-ray will be performed to check on the health of your lungs.



ECG

An electrocardiogram (ECG) of your heart may be required depending on your age and any diagnosed heart conditions.

Other measures

Nil by mouth

As your stomach should be empty before an anaesthetic, you must not eat anything or drink milk products six hours prior to surgery. You may, however, be able to drink clear fluids up to two hours before surgery - the Pre-Admission Clinic or ward nurse will clarify this with you.



Bowel preparation

In order that a clean segment of bowel can be obtained to create the enlarged bladder, your surgeon will ask you to do one of the following the day before your surgery:

- drink a special bowel cleansing solution
- consume clear fluids only

Breathing exercises

Your nurse or physiotherapist will teach breathing exercises to you pre-operatively. They are important as they help to keep your lungs clear of fluid and prevent chest infection. They should be carried out regularly after surgery by supporting your abdomen with a soft pillow, taking four to five deep, slow breaths, then one deep cough.

Leg exercises

Leg exercises help keep muscle tone and promote the return of blood in your leg veins to your heart. These include pedalling the feet, bending the knees and pressing the knees down into the mattress.

Do not cross your legs - this squashes your veins causing obstruction to the blood circulation

Anti-embolus stockings

These are special stockings that help prevent clotting of the blood in your veins while you are less mobile. The stockings are used in combination with leg exercises and are fitted by your nurse before your surgery. If you currently have leg ulcers, please let your nurse know as the stockings may not be suitable for you. Along with anti-embolus stockings, you may be prescribed a blood thinning medication.

Wound site - What to expect

Your wound will be abdominal. The suture line (stitches or staples) will extend from just below the umbilicus to the pubic bone.

After Surgery

You are transferred to the Recovery Room next to the theatre. Your condition is monitored and when you are awake and comfortable a nurse and an orderly will escort you back to the ward on your bed.

On the ward

Your nurse will check the following regularly:

- Vital signs - your blood pressure, pulse, respiration rate and temperature
- The severity and location of any pain or discomfort
- The level of numbness that an epidural is producing
- The effectiveness of pain relief
- The amount of urine you are producing
- The wound site and wound drains
- The amount of oxygen in your blood

You may have

Intravenous fluids

A small tube (leur) is placed into a vein in the forearm to give you fluids and medications. This will stay until you are able to eat and drink

Oxygen

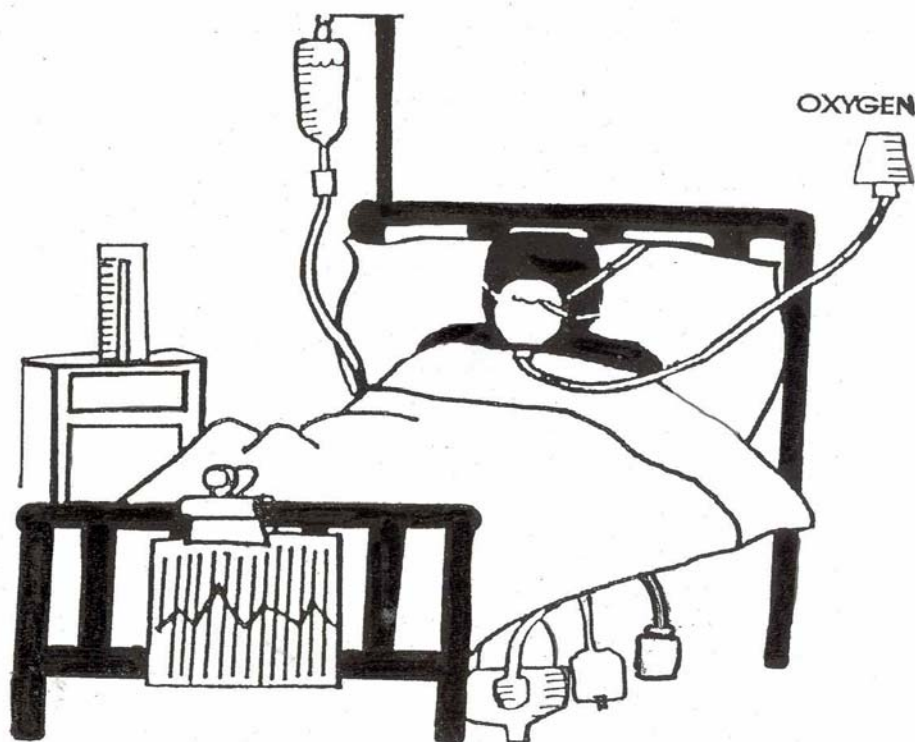
Oxygen is often given for the first 24 hours after surgery via nasal prongs or a facemask to help with breathing and healing.

Urinary catheter (IDC)

You will have a tube in your bladder that will drain the urine (urethral catheter). This can be secured to your leg for comfort.

Suprapubic catheter (SPC)

A suprapubic catheter is similar to a urethral catheter except that it comes out through the abdominal wall. It also drains urine from your bladder. When your urethral catheter is removed, the suprapubic catheter is used to empty your bladder if you are unable to empty it fully under your own control.



Nasogastric tube (NG tube)

A nasogastric tube is a tube down your nose into your stomach. It helps to drain stomach secretions while you are unable to eat or drink.

Wound drains

You may have one or more wound drains. These will drain blood and fluid from your operation site. Good drainage will promote healing.

Pain relief after your surgery

Your nurse will work alongside your doctors and the anaesthetist to keep your pain at a minimum.

The **PAIN SCORE** is a way of your nurse establishing how much pain you are experiencing by asking you to grade your pain from 0 to 10 where 0 = no pain and 10 = the worst pain you can imagine.

The following methods of pain relief may be used singly or in combination with each other.

Patient controlled analgesia (PCA)

This infusion machine has a button you press each time you need pain relief. It will help your pain by immediately delivering a specific amount of pain relief into your blood stream. The pump is programmed according to your anaesthetist's instructions.

Epidural

An epidural is a very small tube inserted by your anaesthetist into the epidural space in your back. A local anaesthetic is infused through this tube via a pump for the first few days after surgery relieving pain at your operation site by numbing it.

Intravenous (IV) pain relief

Intravenous pain relief can be administered to supplement a PCA or epidural or on its own to manage pain that is not controlled by tablets or suppositories alone.

Rectal pain relief

Pain may also be controlled by the insertion of suppositories whilst you are not able to take tablets orally.

Oral pain relief

When you are able to drink, you may have tablets by mouth (orally).



Comfort cares after your surgery

To help keep you comfortable your nurse will give you bed washes, linen changes and assist you to move you around in the bed regularly.

Medications are available for the relief of nausea and vomiting if they occur. You will be given mouthwashes and ice to suck while you are not eating or drinking.

You will be reminded about and assisted with deep breathing exercises. These should be performed every hour while you are awake.

Food and fluids

After your surgery your food and fluid intake will be restricted until your bowel function returns to normal. Resumption of a full diet will be gradual starting with sips and progressing to light meals over a day or so. It is important to eat a balanced diet and chew

thoroughly and eat slowly. If you have any special dietary needs, a dietician will be involved to assist in your recovery.

Mobility

You will usually be up in a chair for a short time and assisted by your nurse or Physiotherapist to walk a short distance within day or two of your surgery. Your level of activity will increase as you recover.



Removal of drips and drains

Nasogastric tube

The nasogastric tube is removed when there are indications that your bowel function is returning to normal and you are drinking small amounts of fluid without difficulty.

Intravenous fluid

The intravenous fluid is removed when you are drinking normally. The line (plastic tube) is removed when you are no longer requiring intravenous medications.

Catheters and wound drains

The urethral catheter will be removed when the bladder is fully healed and watertight. You will be asked to attempt to empty your bladder in a normal manner. The amount of urine left in the bladder (residual) will be measured via the suprapubic catheter. If you are able to empty the bladder fully and without any difficulty, your wound drains and suprapubic catheter will be progressively removed over the next few days. **NB** - Sometimes a special x-ray of your bladder (cystogram) is required before any drains are removed to ensure that all joins are healed and watertight.

If you are unable to pass urine or have a large amount of urine left behind after voiding, you may need to be taught to insert a small catheter to empty your bladder fully. Some people also need to be taught to flush the bladder once or twice a day. This is because the bowel patch in the bladder produces mucus and the urethra may become blocked. If mucous production is troublesome, medications may also be helpful.

Sutures (stitches or staples)

Sutures are usually removed seven to ten days after surgery. If you are not going to be in hospital at this time, you will be given a date for you to arrange for your family doctor (GP) or District nurse to remove them.

Discharge Advice

- Drink two to three litres of fluid daily to assist with flushing mucous from your bladder.
- See your GP promptly if you experience chills, fever or pain in your bladder or back, or your urine is cloudy and offensive smelling. These symptoms may be indicative of a urinary tract infection and require treatment.
- The majority of wound strength is reached within the first six weeks after surgery so it is important to avoid strenuous activity, heavy lifting and straining during this period. This includes such things as contact sports, mowing lawns, gardening, vacuuming and lifting heavy washing baskets.
- Sexual activity may be resumed when you feel comfortable to do so.
- Your hospital doctor will provide your first sickness benefit certificate/medical certificate and will advise you when to return to work.

Follow-up

Discharge letter

You and your GP will receive a copy of a letter outlining the treatment you received during your hospital stay. This will be posted to you if it is not completed by the time you leave hospital.

GP

When you are discharged from hospital you will be under the care of your GP who will look after your general health and monitor your progress.

District Nurse

Your nurse will make arrangements for you to be visited by a District Nurse. If required, the District Nurse will assist you with bladder irrigations and provide catheter supplies.

Outpatients appointments

You will receive an appointment to attend Urology Outpatients approximately six weeks after discharge. This will be posted to you.



3 References: Mosby's Genitourinary Disorders, Clinical Nursing, Mikel Gray 1992
Urological Nursing 3rd Edition, Urological Nursing' 2004
Campbell's Urology 7th Edition, Urology, 1998