PARTIAL CYSTECTOMY PATIENT INFORMATION

Urology Department
Reviewed March 2004

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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 is a Partial Cystectomy?

A Partial Cystectomy is the surgical removal of an unhealthy portion of the bladder.

After this type of surgery, the bladder continues to store urine until it is ready to be passed outside of the body. However, because part of the bladder has been removed, it is smaller in size and cannot hold as much urine as previously. This may mean that you experience the urge to pass urine more frequently and that the volume (amount) of urine that you can hold onto prior to emptying is reduced.

Why do I need a Partial Cystectomy?

The most common reason is the presence of a small muscle invasive bladder tumour that can be completely removed, while still leaving sufficient bladder to function normally.

Potential Complications

All urological surgical procedures carry a small risk of post-operative bleeding and wound, chest and urinary tract infection.

Urology Department
Reviewed March 2004

ACH/2035/2032

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 slight leakage of urine from the internal bladder wound. If this occurs, you may need a catheter for an extended period of time in order to rest the bladder until it heals completely.

- **Reduced bladder capacity**
  After surgery the amount of urine that the bladder is able to store before emptying is reduced. About four weeks after your surgery you will be encouraged to delay passing urine in order to slowly stretch the bladder. The waiting time of four weeks after surgery is to allow the bladder to heal. Bladder volume will usually return to normal within six months.

Length of Stay

The usual length of stay is five to seven 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 required.

Cancer Society
You may wish to contact the Cancer Society if you are being operated on for a cancer. This organisation can provide information, counselling and arrange help such as nursing care and involvement in support groups.

District Nurses
When you are discharged from hospital District Nurses may visit to help you look after your new stoma in conjunction with the Community Stoma Nurse.

General Practitioner (Family doctor)
When you are discharged from hospital you will be under the care of your family doctor who will look after your general health and monitor the treatment of your cancer. Your GP will receive a letter from your hospital doctors, which describes your surgery and progress.

Tests

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Reviewed March 2004

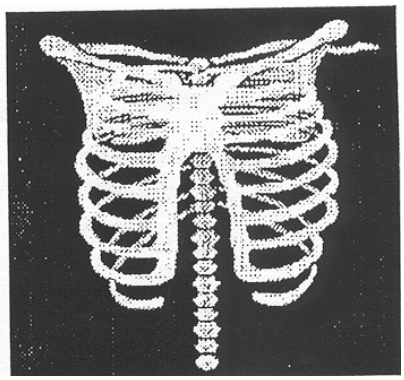
ACH/2035/2032

Blood samples
Samples of your blood will go 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 infection.

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.

CT or MRI scan
If you have not had a recent CT (computerised tomography) or MRI (magnetic resonance imaging) scan as an outpatient, your surgeon may request one.

Other measures

Nil by mouth and bowel preparation
In order that a clean segment of bowel can be obtained to create the ileal conduit (passage), you will be asked to do one of the following the day before your surgery:

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

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

Your wound will be abdominal and the suture line (stitches or staples) will extend from just below the sternum to the pubic bone. Sutures are usually removed seven to ten days after the surgery.

Urology Department
Reviewed March 2004

ACH/2035/2032

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 effectiveness of pain relief
- The level of numbness that an epidural is producing
- The amount of oxygen in your blood
- The amount of urine you are producing
- The colour and shape of your new stoma
- The wound site and wound drains

You may have

Intravenous (IV) fluids

To give you fluids and medications a tube may be placed in a large vein in the neck (central venous line) and a smaller tube will be placed into a vein in the forearm.

Oxygen

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

Wound drains

You will have several wound drains. These will drain blood and fluids from your operation site.

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Reviewed March 2004

ACH/2035/2032

Ureteric stents
Are stents used for this operation?

SPC
Is an SPC used?

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.

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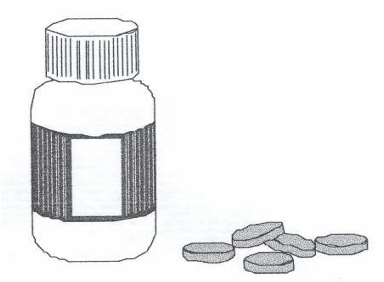
Reviewed March 2004

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 if 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 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 and 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 to a full diet will be gradual starting with sips and progressing to light meals, usually the day after your surgery. It is important to eat

a balanced diet, 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 to walk a short distance within a day or two of your surgery. Your level of activity will increase as you recover.

Removal of drips and drains

Intravenous fluids

This is removed when you are drinking normally. The leur (plastic tube) is removed when you no longer require intravenous medications.

Wound drain(s)

These are removed when the amount of drainage is minimal and the operation area has had a chance to heal.

Urethral catheter

The urethral catheter will be removed when the bladder is fully healed and watertight. When the catheter is removed you will be asked to empty your bladder whenever you get the urge or every two hours (by day) whichever is sooner. The amount of urine you pass and the frequency will be recorded by the nursing staff.

Suprapubic catheter

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Reviewed March 2004

Ureteric stents

These are removed seven to ten days after surgery once the conduit is functioning as expected.

Sutures (stitches or staples)

As previously stated these 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 practice nurse to remove them.

Discharge Advice

- Aim to drink two litres per day to maintain the health of your urinary system and reduce the risk of infection. If you find you are having to get up to the toilet often overnight, reduce your fluid intake from late afternoon.
- 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 after six weeks or when you feel comfortable to do so.
- 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.
- Your hospital doctor will provide your first sickness benefit certificate/medical certificate and will advise you when you are able to return to work.

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