DR. GORIN'S ROBOTIC RADICAL PROSTATECTOMY DISCHARGE INSTRUCTIONS

Communication with Dr. Gorin: Please do not hesitate to contact me if at any point you have questions or concerns. It is never a bother or inconvenience. There are a number of ways you can reach me. Below is a list of contact methods in the order of my preference:

- MyChart - https://mychart.hopkinsmedicine.org/MyChart/
- Email: mgorin1@jhmi.edu
- Telephone: My cellphone number is (305) 721-9515 and my office number is (410) 502-3017 (Option #4)
- Fax: (410) 502-7711

If you have an urgent issue and are unable to reach me please call (410) 955-6070 and ask for the urology resident on call. For true medical emergencies please call 911.

Medications/Prescriptions

There are 3 prescriptions you will receive at the time of discharge:

1. Oxycodone or Tramadol – These medicines are to be taken if your pain is not controlled with over the counter medications. Prior to taking this medication I encourage patients to start with ibuprofen (Advil or Motrin) and / or acetaminophen (Tylenol), which can be purchased at any pharmacy. Take these medications as instructed on the bottle. I usually recommend taking three 200 mg tablets of ibuprofen three times a day with meals for the first 5 or 6 days. After 5 days, wean off the ibuprofen as this can be harsh on the gastrointestinal tract. If these over the counter medications are not providing adequate pain control you may use the oxycodone as directed on the prescription.

2. Viagra - This medicine is to help with return of erections after surgery and should not be taken if you are on nitrates for heart disease. If you have heart disease, check with your cardiologist before taking Viagra. This medicine should be taken 1 hour prior to attempting sexual activity. It works best when taken on an empty stomach. Viagra tends to be expensive. You can find coupons for this medication online at GoodRx.com.

3. Bactrim or other antibiotic - This medication is prevent an infection which can form as the result of catheter removal. You should start taking this antibiotic 1 day prior to scheduled catheter removal.

Hospital Departure: If you are traveling home from the hospital in a car, stop the car every hour and walk around the car to prevent the blood from pooling in the legs. If you are traveling by air, walk the length of the airplane.

Diet: You may eat and drink whatever you wish. Adjust your diet so that you avoid constipation which can be caused by narcotic pain medications. You may also take an over-the-counter stool softener such as Colace.

Hygiene: You may shower after leaving the hospital. The water will not harm the incisions or the

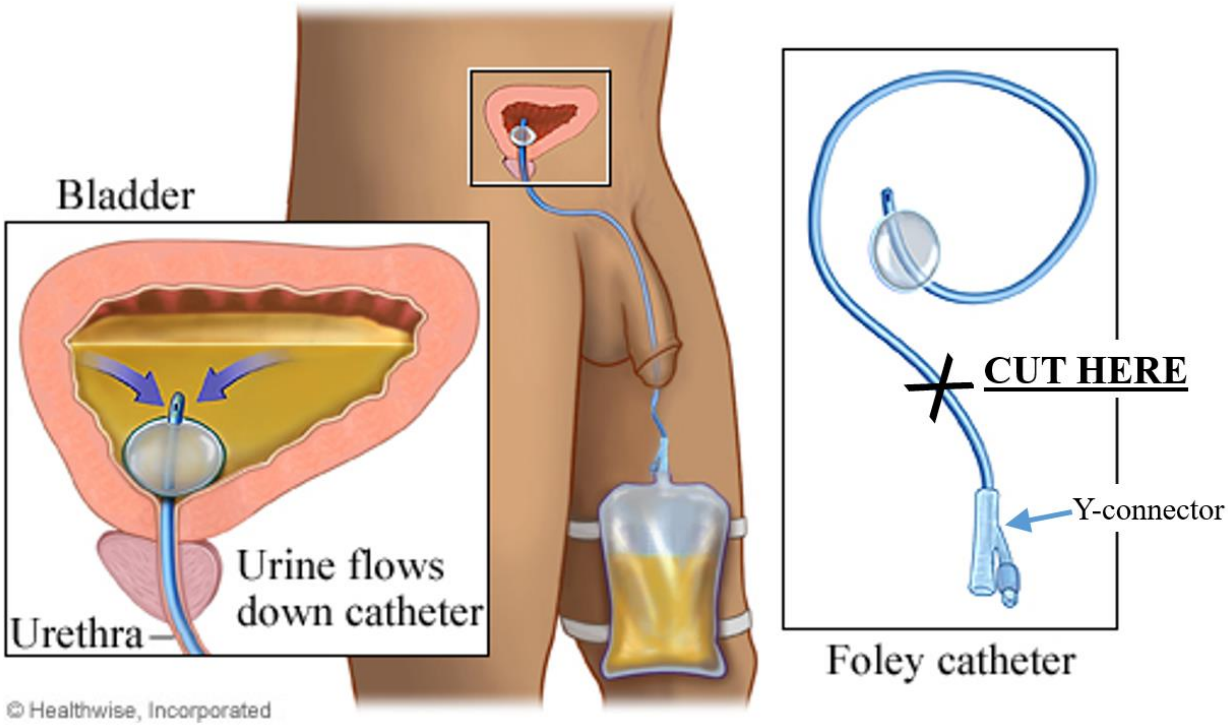
catheter. Pat dry the incisions. Cover the tape holding the catheter to your leg with a "baggie" or plastic wrap to avoid getting the tape wet. It is paramount that you maintain the security of the catheter.

Mobility/Activity: After you are discharged from the hospital you should --

- Avoid heavy lifting (more than 15 lbs.) and vigorous exercise (calisthenics, golf, tennis, vigorous walking) for total of 6 weeks from the day of surgery. After that you can gradually build up to your pre surgical level of activity but do this gradually.
- Do not ride a bike for 8 weeks from the date of surgery
- Take frequent short walks, 6-8 times during the day (like you did in the hospital) while the catheter is in place. After catheter removal, there is no limitation on walking.
- Sit in a semi-recumbent position (in a reclining chair, on a sofa, or in a comfortable chair with a footstool), while the catheter is in place. This avoids placing weigh on the area of your surgery in the perineum (the space between the scrotum and the rectum).
- There are no other serious restrictions.

Blood Thinners / Aspirin: If you take 81 mg of aspirin daily (baby aspirin) you can resume taking immediately after surgery. If you are on 325 mg of aspirin daily, please resume 5 days after surgery. If you are on any other blood thinners please make sure to mention this to me or my staff and we will provide further instructions on when to resume.

Catheter Removal: You should remove your catheter on the morning of postoperative day 8. Removing your catheter at home is a very safe and easy procedure to do on your own. You should remove the catheter while sitting on the toilet or standing in the shower. The only supplies you will need are a pair of household scissors and some Vaseline or Bacitracin. Place a generous amount of Vaseline or Bacitracin on your glans near the meatus to allow the catheter to move freely. Remove the drainage bag. Sit on the toilet or stand in the shower. Gently but firmly rotate the catheter tube all the way to the left 360°and then all the way to the right 360°at least two or three times. Once you have rotated the catheter tube, cut the catheter at any point between its point of insertion in the penis and the "Y" connector. See the picture below. A small amount of water (10-15 cc) will come out from the area you just cut, allowing the balloon inside your bladder to deflate. Once the water stops (this will take about 20-40 seconds) you can gently pull the catheter out. There may be a slight resistance and stinging sensation at first, just continue to firmly but gently pull. Note, if you see blood in your urine within 48 hours of scheduled catheter removal contact me to discuss whether you should proceed with catheter removal on your own and/or on postoperative day 8. Blood in the urine may be a sign that you need additional time to heal.



Returning to Work: You can work from home when you get home. Most patients who do "office" activities return to work gradually beginning around 3-4 weeks from the date of surgery. If you do strenuous work (e.g., heavy lifting) then you should wait 6 weeks from the date of surgery to return. For those men who travel a lot for business, it is reasonable to wait 4 weeks before returning to a busy travel schedule. You can drive a car after catheter removal. You will not have your "normal" stamina for up to 3-6 months from the date of surgery, so use common sense in returning to pre surgical activity. Activities that seemed effortless prior to surgery will bring on fatigue more quickly and you may need to rest some during the day.

Urinary Control: Problems with urinary control are common once the catheter is removed. *Do not become discouraged.* Urinary control returns in 3 phases:

- Phase I-you are dry when lying down at night
- Phase II- you are dry when walking around
- Phase III- you are dry when you rise from a seated position

In the early phases your urinary stream may be weak if the bladder is not filling, that is, most of the urine is leaking into a pad, therefore not having the needed volume. You may also experience more frequent urination after surgery as the bladder capacity increases over time. Everyone is different and, for this reason, I cannot predict when you will be dry.

To speed up your recovery, practice stopping and starting your urinary stream every time you void -- these are kegal exercises. To do this, you must stand up to urinate. To shut off your urinary stream, contract the muscles that you use to keep from passing gas. Until your control returns completely, wear a pad or disposable diaper. You can obtain Depends, an adult diaper, or security pads from your local grocery store or pharmacy.

To help with recovery of urinary control, try emptying your bladder every 2 hours, even if you do not have to go to the bathroom. This will help to keep the bladder as empty as possible, and will not fatigue the muscle needed for continence.

As urinary control returns, it is not uncommon for patients to continue to wear protective pads for "security" even when they don't need them. To make sure that you do not become pad dependent unnecessarily, experiment with not using a pad when you are at home and not working. Many patients will have the sensation that they are leaking urine when, in fact, they will find that there has been no leakage on the underwear.

Until your urinary control returns, avoid drinking excessive amounts of fluids. Also, limit your intake of alcohol and caffeine-both will make the problem worse. Once the catheter is removed, limit fluids to the amount necessary to satisfy your thirst.

One thing not to do is wear an incontinence device such as a condom catheter or a clamp. If you do, you will not develop the muscular control necessary for continence.

If you develop a red painful rash while urinary control is returning, you may have a fungal infection, especially if you were treated with antibiotics. This usually responds well to treatment with Lotrimin cream, a non-prescription formulation that can be purchased over the counter at a pharmacy.

Erectile Function

Erections return gradually (much slower that urinary control), and continue to improve even up to 2 years after surgery. Be patient. As I told you before the operation, the return of sexual function varies depending upon the age of the patient, the extent of the tumor (whether nerves had to be removed), and the level of sexual functioning before the operation. Men who have declining sexual function prior to surgery will have a greater chance of problems with erections after surgery. Erections return gradually and quality improves month by month with effort.

Expectations: After surgery, it is important for men to have realistic expectations of the quality of erections. At first erections will be partial and not likely strong enough for penetration. But a partial erection is success! Open a bottle of champagne if you get a partial erection because with continued effort they will get strong enough for penetration. Most men do not have recovery of an erection that is "exactly" the same as before surgery. Men who recover erections strong enough for intercourse usually have erections that are more difficult to attain and maintain, and because of this it is common for libido (desire for sexual activity) to decrease.

Tactile over visual stimulation: The stimuli for erection during the first year will be different. Visual and psychogenic stimuli will be less effective and tactile sensation will be more effective. Indeed, the major stimulus for erections during the first year postoperatively is tactile sensation. For this reason, do not be afraid to experiment with sexual activity - you can do no harm. If you obtain a partial erection attempt vaginal penetration, many patients find that erections are maintained better when upright (rather than lying down) and that vaginal penetration is easier from behind. Lubrication of the vagina with K-Y jelly can help. Vaginal stimulation will be the major factor that encourages further erections. Do not wait until you have the "perfect erection" before attempting intercourse. In addition, you should be able to have an orgasm even if you do not have an erection. With orgasm there will be no emission of semen because the prostate and seminal vesicles have been removed.

“Erection Rings”: When erectile function begins to return many patients complain that they lose their erections when they attempt intercourse. This is caused by a venous leak. This can be overcome by placing what is known as an “erection ring” at the base of the penis before foreplay. The purpose of this rung is to retain the blood in the penis once blood flow increases secondary to stimulation. Do not worry; the ring will not impede the flow of blood into the penis. The best product is made by UroSciences and is called the UroStop venous flow controller. You can read about it on the web site www.urosciences.com under product information and you can order by calling the number listed on the web site.

Prescription assistance: Viagra (or another PDE5 inhibitor like Cialis or Levitra) can be very effective aid to improve erections during the recovery period. Do not take this medication if you are on nitrate to treat heart disease (coronary artery disease). Once you are ready to begin sexual activity, I suggest that you take a 100 mg tablet 1-2 hours prior to activity on an empty stomach. Do not use Viagra more than once daily. Often times insurance companies will not cover these medications- if this is the case, please contact your insurance company to have them fax us the paperwork that they need- we will not call your insurance company. Even with the necessary paperwork, the medication will usually still be denied. You can find excellent coupons for this medication online at GoodRx.com.

Experiment early: It is reasonable to begin experimenting with sexual activity after catheter removal whenever you feel ready. Do not wait for erections to return on their own - they will not without a lot of persistence and perseverance on the part of both partners. Patients who are willing to continue attempts to produce erections- despite lack of a perfect erection- are more likely to

have return of erectile function in the long run. Begin experimenting with erections as soon as possible after catheter removal and this will increase the likelihood for recovery in the long-term (*use it or lose it*).

Long-term Follow-up

Follow-up care is important to monitor for prostate cancer recurrence and to manage the side effects of treatment during the coming months and years. Your initial follow-up appointment will be about 3 months after surgery. I also like to see patients back at 6 to 12 months after surgery. After this, you will be discharged back to your primary care physician or local urologist. Of course I am happy to see you should any issues arise at any point after your treatment. Do not ever hesitate to contact me.

You will need to have a PSA blood test taken one week before each follow-up appointment. The test can be taken at a medical office or laboratory convenient to you. Please make sure the results are received by my office. A copy of the PSA test request form will mailed to you before each appointment.

PSA testing is the cornerstone to evaluating for prostate cancer recurrence. After surgery your PSA level should be undetectable (usually reported as <0.1 ng/mL). If it ever rises to a detectable level this may be a sign that the prostate cancer has returned. Please contact me (even if many years after you surgery) if at any point you learn you have a detectable PSA level. Additional testing and possibly treatment will be required. Thankfully, most patients never face this issue, but it is important to always remain vigilant. In terms of the frequency of PSA testing, for most men I recommend it be performed every 6 months for the first 3 years after surgery. Men who are at a higher risk of recurrence (positive margins, extraprostatic spread, or grade group 4-5 cancer) should be tested every 6 months for 5 years after surgery. After these first 3-5 years, annual testing is generally sufficient. Please forward on all PSA results to my office. E-mail and MyChart is a great way to share these results and check-in after the first year.

Common Postoperative Issues

Issue	Recommendation
Constipation	Your bowel function should return to normal after surgery (over 2-4 weeks). Note, however, pain medications can cause constipation and, therefore, should be discontinued as soon as tolerated. 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 in the urine. Adjust your diet so that you avoid constipation. If you have a problem with constipation you can take Colace, an over the counter stool softener, for prevention after you leave the hospital. If you do become constipated take mineral oil or milk of magnesia. It is important to drink plenty of fluids while the catheter is in place; enough to keep the urine in the tubing (just past the catheter) clear. The urine in the collection bag will almost always be blood tinged, but that is not important as long as the urine in the tubing is pink to clear.
Bloody discharge around the catheter when you strain to have a bowel movement and/or blood in the urine.	This is very common and you should not be alarmed. It may arise from vigorous walking or it may occur spontaneously. Blood in the urine usually has no significance and spontaneously resolves on its own. Drink plenty of fluids. This will dilute out the blood so that it does not clot off the catheter and will encourage the cessation of bleeding.
Leakage around the catheter	This is very common, especially when you're up walking around. The tip of the catheter is not in the most dependent part of the bladder; the balloon that holds the catheter in the bladder elevates the tip of the catheter away from the bladder neck. For this reason, when walking many patients have leakage around the catheter. This can usually be managed through the use of diapers or other absorbent materials
Catheter stops draining completely	Lie down flat and drink a lot of water. If after 1 hour there is no urine coming through the catheter tubing, call me (see below).

A strong sudden desire to urinate with pain over the bladder area and simultaneous leakage of urine or blood around the catheter	This is called a *bladder spasm* and commonly occurs at the time of a bowel movement. While the catheter is in place, this is not an unusual occurrence. You should lie down until the discomfort passes. If bladder spasm becomes frequent and bothersome, Motrin or Advil can be used to help stop the spasm.
Drainage from an incision	This can either be clear fluid (a seroma) or a mixture of blood and pus. In either instance it usually can be treated simply. If the wound should open or the edges separates, obtain some hydrogen peroxide and Q-tips; soak the Q-tip in the hydrogen peroxide and place it through the opening in the wound to clean the open area and then remove the Q-tip. This will keep the opening from closing until all the material has drained. I suggest that you shower in the morning washing this area thoroughly (you cannot hurt it). After your shower use the Q-tip and then place a dressing or band-aid over the site. Repeat the Q-tip and dressing before you go to bed that night.
Pain in your calf or swelling in your ankle or leg	During the first 4-6 weeks after surgery, the major complication that occurs in 1-2% of men is a clot in a vein deep in your leg (deep venous thrombosis). These clots may break loose and travel to the lung producing a life threatening condition known as pulmonary embolus. A pulmonary embolus can occur without any pain or swelling in your leg. If you develop any of these symptoms or pain/swelling in your leg, call me. *Also*, you should immediately call your local physician or get to an emergency room and state that you need to be evaluated for deep venous thrombosis or pulmonary embolism. If the diagnosis is made early, treatment with anticoagulation is easy and effective.
Chest pain (especially when you take a deep breath), shortness of breath, the sudden onset of weakness or fainting, and/or coughing up blood.	During the first 4-6 weeks after surgery, the major complication that occurs in 1-2% of men is a clot in a vein deep in your leg (deep venous thrombosis). These clots may break loose and travel to the lung producing a life threatening condition known as pulmonary embolus. A pulmonary embolus can occur without any pain or swelling in your leg. If you develop any of these symptoms or pain/swelling in your leg, call me. *Also*, you should immediately call your local physician or get to an emergency room and state that you need to be evaluated for deep venous thrombosis or pulmonary embolism. If the diagnosis is made early, treatment with anticoagulation is easy and effective.

Burning at the tip of the penis / pain with urination	Urinary tract infections (UTI) can occur with a catheter in place. With these symptoms prior to catheter removal you may have a UTI. Urinary tract infections (UTI) can occur with a catheter in place. Contact me if you think you have a UTI as you may require an antibiotic
Sediment in the urine	Urinary sediment is not uncommon to see. This can be manifested in a number of different ways. Old clots may appear as dark particles that occur after the urine has been grossly bloody. There are normal substances in the urine called phosphates. They precipitate out in alkaline urine and form cloudy masses in the urine. If you see these periodically do not be concerned. This is a normal phenomenon. With hydration these will usually clear spontaneously and are of no concern. Finally, if the urine is persistently cloudy this suggests that an infection may be present (see above re: UTI).
Abdominal pain	This is common. The pain is from irritation of the abdominal muscles; sometimes it is where the drainage tube exited. It will resolve spontaneously, but it is not uncommon to have sensitivity around the incisions for 3-6 months after surgery. You may take the oxycodone you were written for at the time of discharge. Prior to taking this medication I encourage patients to start with ibuprofen (Advil or Motrin) and / or acetaminophen (Tylenol), which can be purchased at any pharmacy. Take these medications as instructed on the bottle. I usually recommend taking three 200 mg tablets of ibuprofen three times a day with meals for the first 5 or 6 days. After 5 days, wean off the ibuprofen as this can be harsh on the gastrointestinal tract. If these over the counter medications are not providing adequate pain control you may use the oxycodone as directed on the prescription.
Discomfort in the perineum (between the scrotum and rectum), especially after sitting.	This common pain is coming from the area where the operation took place and will disappear with time but may be present for 1-2 months after surgery Avoid sitting for a long time if it is bothersome or sit on a "doughnut" (round cushion)
Discomfort in the testicles	This is very common after radical prostatectomy because the spermatic cord (attached to the testicle) is stretched during the operation. This discomfort will disappear in time but can last 3-6 months after surgery. If bothersome, use Motrin or Advil.

Swelling and discoloration of the scrotum and the penile skin	This is simply fluid that has not been absorbed by the body. It is not harmful. If the scrotum is swollen, put a rolled hand towel underneath the scrotum to elevate it when lying down.