



**University Hospitals Birmingham**  
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# Information for patients on Laparoscopic Radical Prostatectomy

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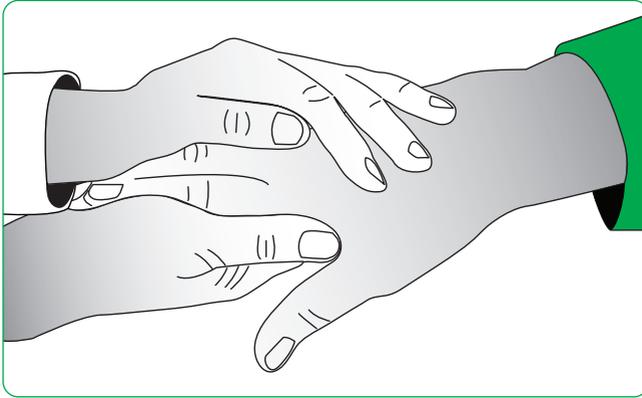
# Contents

<b>Introduction</b>	<b>3</b>
Why do I need a laparoscopic radical prostatectomy?	3
What is a laparoscopic radical prostatectomy?	4
What is nerve sparing?	5
Diagrams before and after surgery	6
‘Buddy’ System	7
Admittance to hospital	7
After your operation	8
Eating and drinking	9
<b>Your catheter</b>	<b>10</b>
Caring for your catheter	10
Convenes/sheaths	12
Removal of catheter (trial without catheter)	12
<b>Pelvic floor exercises</b>	<b>15</b>
Why do the pelvic floor muscles get weakened?	15
How to contract the pelvic floor muscles	16
Doing pelvic floor muscles	17
While doing the exercises	17
<b>What can I do after my operation?</b>	<b>18</b>
<b>Complications of laparoscopic radical prostatectomy</b>	<b>19</b>
Risks	23
Follow up regime	23
Where to get help	24
<b>Glossary of terms</b>	<b>25</b>

## Introduction

It is essential you read this booklet carefully before the operation so that you fully understand the operation and the effect it will have on you.

If you have any questions or concerns about the procedure you can contact the specialist urology nurses at the hospital by telephoning the numbers provided.



The specialist nurses are there to help you throughout the whole process and are available to talk to, even after you have been discharged from hospital. You can contact them at any time if you feel you want to.

## Why do I need a laparoscopic radical prostatectomy?

You have been diagnosed with early stage prostate cancer. We believe that the cancer is confined to the prostate and has not spread to other areas. In this case surgery is an effective way of curing your condition.

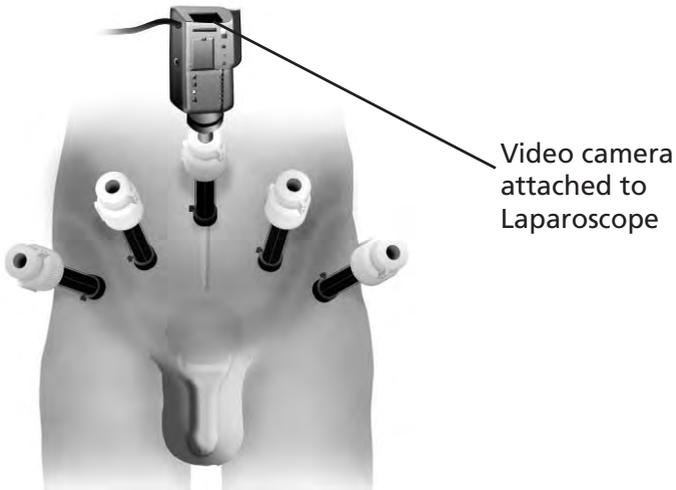
Your consultant will have discussed other alternative treatments with you such as radiotherapy or brachytherapy. You should have been given written information about these options so that you can consider your decision.

## What is a laparoscopic radical prostatectomy?

A radical prostatectomy aims to cure patients with early prostate cancer by removing the entire prostate gland and surrounding tissue. This operation is only suitable if you have no evidence of the disease outside the prostate gland.

This operation is carried out using keyhole (laparoscopic) surgery. Keyhole surgery is performed through a series of small portholes rather than an incision (cut) across the abdomen. There will be five holes made in all. Three of these portholes will be very small holes about 0.5 cm across. A slightly larger hole will be made near the umbilicus (tummy button). This is where the camera is inserted. The final hole which is about 5cm wide is usually made on the left side of the abdomen where the prostate is removed using a special bag.

### Laparoscopic Technique



This operation is different to a TURP (Transurethral resection of prostate) which only removes part of the gland and is not an open operation.

## What is nerve sparing?

There are two sets of nerves that run along the prostate and these are responsible for controlling erections. Depending on the position of the tumour it may be possible to save the nerves on one or both sides of the prostate.

If the tumour is growing too close or into the nerve bundles then they will be removed to make sure that the entire tumour is taken out. This will have an effect on your ability to have erections after the surgery and therapies are available to restore your erections.

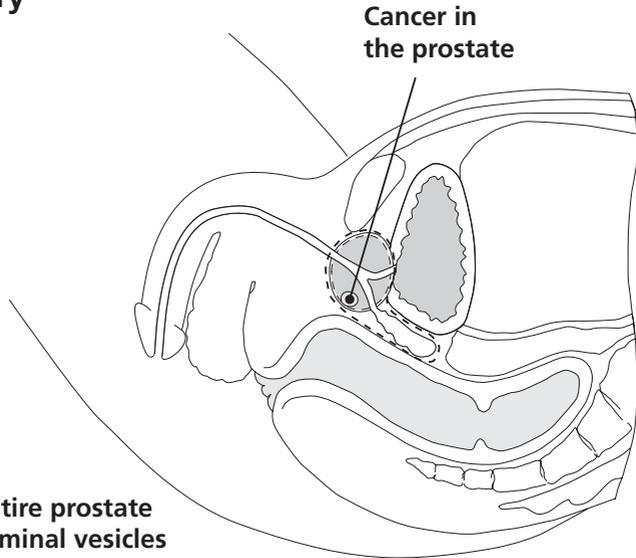
This option will be discussed with your consultant and a decision will be made as to whether it is suitable to save either of the nerve bundles.

If it is possible to remove the prostate without damaging these nerves you will be more likely to have erections however, it can take up to 12-18 months, even as long as 2 years for the nerves to regenerate and recover. During this time your erections may return gradually. Treatments are available and they can be discussed with your consultant or specialist nurse.

Very rarely is it necessary to give patients a blood transfusion during or after the operation (less than 1%).

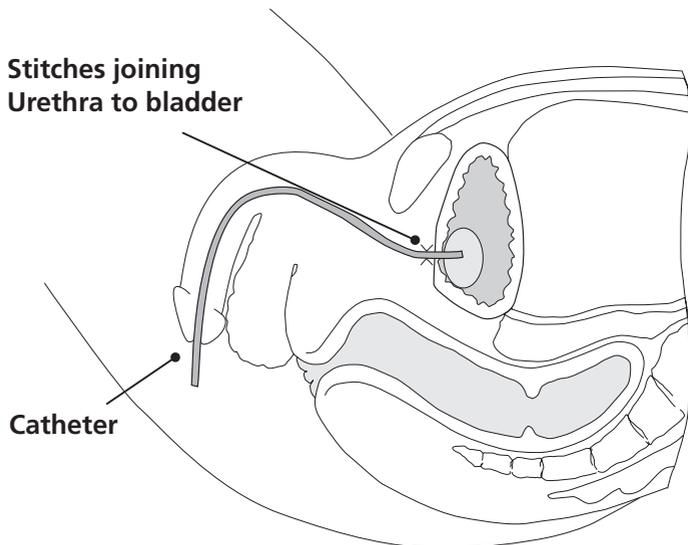
# Diagrams before and after surgery

## Before surgery



The entire prostate and seminal vesicles are removed

## After surgery



## 'Buddy' system

No matter how many booklets and leaflets that you read discussing this operation, there is nothing quite like talking to a patient who has undergone this procedure.

If you feel that talking to one of our patients will be of help to you please ask your specialist nurse to put you in contact with someone.

All 'buddies' have volunteered their service to help other patients through the process.

If following your surgery you would like to be a 'buddy' please mention this to your specialist nurse.

## Admittance to hospital

You will be admitted to the hospital the day of your operation. By this time you will have already attended the pre-admission clinic where we take your details, arranged blood tests, heart tracing and chest X-rays in preparation for your surgery.

You will be admitted on the day of surgery, usually to the admissions lounge, where you will meet the anaesthetist who will discuss the most appropriate anaesthetic and pain relief you will need for your surgery.

The surgeon will see you and speak to you again about the operation and you will have the chance to ask questions.

You will be given some stockings for you to wear. This is to reduce the chance of blood clots forming in your legs known as Deep Vein Thrombosis or DVT. A theatre porter will come and collect you and take you to the urology theatre.

## After your operation

When you return to the ward you will be under close observation. The nursing staff will record your blood pressure and pulse at regular intervals.

You will be attached to a drip (intravenous infusion) to provide you with all the fluids and nutrients that you require.

You will experience some discomfort after the operation and you will be given pain relief if you feel it is necessary. Pain relief is usually given in the form of patient controlled analgesia (PCA). You will be given a handset that will allow you to control your pain relief as and when you require it. One of the advantages of keyhole surgery is that the level of pain is much less than with an open operation.

Generally the PCA is in place overnight and then it is removed. If you require pain relief after this please tell a member of the nursing staff and they will give you tablets to help. It is usual that patients don't need pain relief very often when the PCA is removed.

It is possible you will need to have a small wound drain. This is decided at time of surgery by your surgeon. If one is needed it is only usually for 24 hours after your operation and is usually removed the following day if there is little or no drainage.

You will also wake up with a catheter. This is a tube draining the bladder so that the bladder can rest and begin healing. This catheter will need to remain in place for up to three weeks although most are removed after one or two weeks. You will be given a date to come back to clinic to have your catheter removed.

It is important that the catheter flows freely all the time and you will be advised by the nursing staff on how to care for your catheter (see section on catheter care later on in the booklet).

## Eating and drinking

Most patients will be able to drink clear fluids a few hours after their operation. However, if you feel nauseous it may be necessary to wait a little longer before you start drinking again.

You should be able to eat and drink normally by the next morning. As soon as you are able to eat and drink your drip will be removed.

The morning after your surgery, the nursing staff may assist you with a wash and then you will be encouraged to get out of bed and walk around the ward as much as possible. This will help prevent clots forming in your legs and keep your circulation moving.

When your drip and small wound drain has been removed, the nursing staff will attach a leg bag to your catheter and teach you how to start looking after your catheter in preparation for your discharge. It is important that you know how to look after your catheter **before** you leave the hospital. Usually patients are discharged 2-3 days after surgery compared to 4-5 days with the open approach.

If you have family support it may be possible to go home the day after your surgery.

It is natural after may operation to feel frightened and concerned during your initial recovery. A lot of patients experience some discomfort during their recovery. The amount of pain you experience will be less than if you had undergone open surgery. However if you are worried please contact your specialist nurse who will be able to advise you.

We cannot emphasise enough that if you are concerned please do ring the specialist nurses who are there to help at this time.

# Your catheter

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## Caring for your catheter

You have been fitted with a catheter in order to allow your body the chance to heal. Please take time to read this section on caring for your catheter.

### Securing the catheter

It is important that the catheter bag is secured to your leg firmly. This will keep the catheter in the correct position and prevent any pulling. The catheter, tubing and drainage bag should be kept in line with each other. There should be no kinks in the tubing as this can prevent the catheter from draining properly which could cause leakage. You should avoid any strain being put onto the catheter at all times.

It is essential that your catheter does not become blocked. If the catheter stops draining it is **essential** that you ring the urology ward for advice. **Do not let anyone change the catheter other than urology personnel.**

Occasionally the balloon that holds the catheter in position bursts. This is a very rare occurrence but can cause the catheter to fall out. If this happens please ring the urology ward **immediately** for advice. The ward will ask you to attend and see a urology doctor who will be able to re-insert the catheter. (The number is at the back of the booklet.)

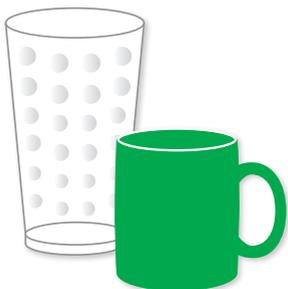
### Hygiene

It is important to keep the area where your catheter enters your urethra (water pipe) clean. It is recommended that you have either a shower (preferably) or bath every day. You should wash the area around your catheter with soap and water using a cloth which is used for this purpose only. Once the area is clean, dry it thoroughly with a towel. Some patients do experience a little discharge around the catheter which then can dry and crust on

the outside. This is nothing to be alarmed about and is caused by the catheter you need to wash this area more frequently during the day.

## **Fluid intake**

It is important when you have a catheter in position to drink an adequate amount of liquid on a daily basis. It is recommended that you drink a glass of water/squash every hour, as well as your normal intake of tea and coffee. This will keep the catheter draining well and prevent any blockages and infection.



## **Bladder spasms**

Sometimes you will experience normal sensations of wanting to pass urine even when the catheter is fitted. This is nothing to be concerned about so long as the catheter is draining well.

When you feel the urge to pass urine relax and let the catheter do the work for you. Do not push or try to pass urine. These small involuntary contractions of the bladder muscle can sometimes cause the catheter to leak. If this becomes a persistent problem then we can give you medication to ease this.

It is quite normal to see small amounts of debris or blood in your urine whilst you are fitted with a catheter. You should try and drink plenty to keep the catheter draining and prevent blockages and infection. It is also common for patients to see some blood around the catheter. This is nothing to be concerned about however, if you are unsure or at all worried about your catheter then please do not hesitate to ring the ward or one of the specialist nurses who will be able to advise you.

## Leakage

It is usual to experience leakage around the catheter from time to time. This is called by-passing. It usually occurs when you have opened your bowels and is nothing to be alarmed about as it is quite normal.

The most common causes of a catheter leaking are as follows:

- Blockages
- Lack of drainage in the bag
- Feeling of wanting to pass urine all the time
- Feeling of fullness
- Swollen abdomen
- Bladder spasms

If you experience any leaking from your catheter **do not** remove the catheter. Contact your district nurse who will visit you to perform a wash out.

If the nurse cannot unblock the catheter then they will need to contact the urology ward for further advice. (Number at back of booklet.)

## Convenes/sheaths

In some patients the leakage initially can be quite a lot and a sheath/condom attached to a catheter bag may be necessary for a short while.

It is advisable if you are having this amount of leakage that you talk to your specialist nurse at the hospital.

## Removal of catheter (trial without catheter)

Your catheter will usually be removed 7-14 days after your surgery. The timing of catheter removal depends on what happens during the surgery and the outpatient clinic

availability. We will arrange for you to attend the urology clinic to have your catheter removed. Once the catheter has been removed you will be asked to pass urine into a machine each time you need to go to the toilet so that the nurse can measure exactly how much you are passing each time.

You may experience any of the following once your catheter has been removed:

### **Frequency in passing urine**

It is quite normal to want to pass urine quite frequently for the first few hours after your catheter has been removed. This can be often as every half an hour to an hour and will settle down over a period of a day or so.

### **Urgency**

This is extremely common after the catheter is removed and means that you get little warning when you want to pass urine and you may have to dash to the toilet. This is completely normal and is experienced by all patients who have had a catheter removed, regardless of the type of operation they have undergone.

### **Urge incontinence**

You may feel a very sudden urge to pass urine. This may take you by surprise and you may not be able to get to the toilet in time. Do not be worried, this will only last for a short period of time. If you had suffered from any sort of incontinence prior to your operation, this may persist. If the condition persists contact your doctor who will be able to prescribe medication to ease this.

### **Incontinence**

After removal of your catheter it may take a few months for you to gain complete control of your bladder. Over a period of months most patients get full control back but some can be left with what is called stress incontinence and in some cases this can be permanent. Stress incontinence is when the neck of the bladder is put under stress and a small amount of urine then leaks into your clothing. This often happens when you laugh,

cough sneeze or lift anything heavy.

During this time it may be necessary for you to wear a pad in your trousers.

It is likely that you will have to provide these yourself but sometimes GP's and District Nurses can supply them. Discuss this with your GP prior to your surgery. **The hospital is unable to provide these.**

It will take most patients up to 12 months to become completely dry but a lot of patients are dry before then.

In order to regain control of your bladder it is essential that you do pelvic floor exercises as this will help. Most patients learn to be dry at night within the first 1-2 weeks. Mornings are also dryer than the afternoons to start with. The evenings are usually when most patients experience leakages. This is because the sphincter muscle is tired from being used throughout the day.

Often returning to work before your body is ready can result in more leakage because your muscles are tired.

# Pelvic floor exercises

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These pelvis floor exercises should be practised as soon as you have decided to have laparoscopic radical prostatectomy. By doing them **before** surgery you will become proficient at them so that after surgery you will know exactly how to do them correctly.

The floor of the pelvis is made up of layers of muscle and other tissues. These layers stretch like a hammock from the tail bone at the back to the pubic bone at the front. A man's pelvic floor supports the bladder and bowel. The urethra (bladder outlet) and rectum (back passage) pass through the pelvic floor muscles. The pelvic floor muscles play an important part in bladder and bowel control (see diagram).

## Why do the pelvic floor muscles get weakened?

The pelvic floor muscles can be weakened by:

- Some operations for an enlarged prostate
- Continual straining to empty your bowels, usually due to constipation
- Persistent heavy lifting
- A chronic cough, bronchitis or asthma
- Being overweight
- Lack of general fitness

You can improve control of your bladder by doing exercises to strengthen your pelvic floor muscles.

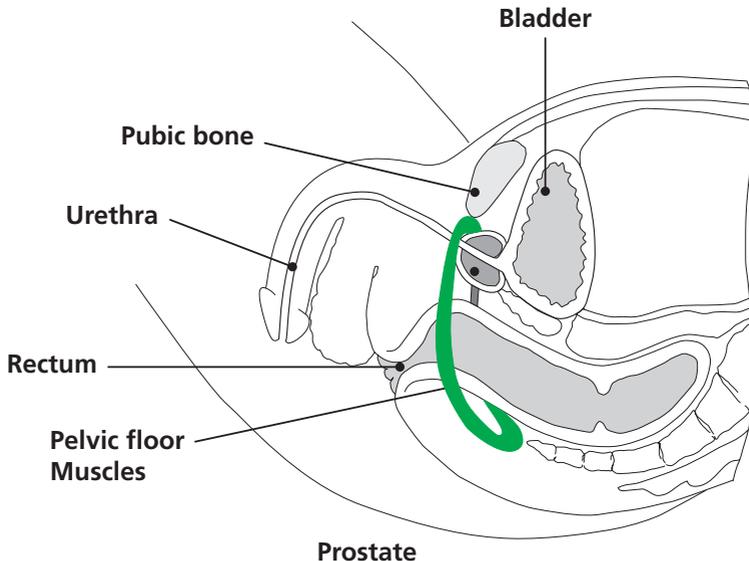
To achieve your best results you may need to seek help from your specialist nurse who then may advise you see a physiotherapist.

## How to contract the pelvic floor muscles

The first thing to do is to correctly identify the muscles that need to be exercised.

1. Sit or lie comfortably with muscles of your thigh, buttocks and abdomen relaxed.
2. Tighten the ring of muscle around the back passage as if you are trying to control diarrhoea or wind.
3. Relax the muscle again. Practise this movement several times until you are sure you are exercising the correct muscle. Try not to squeeze your buttocks (pelvis thrust) or tighten your thigh or tummy muscles.
4. Imagine you are passing urine, trying to stop the flow mid stream, and then restarting it. (You can do this for real if you wish, but do so only to learn which muscles are the correct ones to use and then do it no more than once a week to check your progress, otherwise it may interfere with normal bladder emptying).

If your technique is correct the each time that you tighten your pelvic floor muscles you may feel and see the base of your penis move slightly towards your abdomen.



## Doing pelvic floor exercises

Now you can feel the muscles working you can start to exercise them.

1. Tighten and draw in strongly the muscles around the anus and the urethra all at once. Lift them up inside. Try and hold this contraction strongly as you count to five, then release slowly and relax for a few seconds. You should have a feeling of 'letting go'.
2. Repeat (squeeze and lift) and relax. It is important to rest in between each contraction. If you find it easy to hold the contraction for the count of five then try and hold for the count of ten.
3. Repeat this as many times as you are able to up to a maximum of 8-10 squeezes. Make each tightening a strong, slow and controlled contraction.
4. Now do 5-10 short fast but strong contractions, pulling up and immediately letting go.
5. Do the whole exercise routine at least 4-5 times every day. You can do it a variety of positions-lying, standing or walking for example.

## While doing the exercises

- **Do not** hold your breath
- **Do not** push down instead of squeezing and lifting up
- **Do not** tighten your tummy, buttocks or thighs

Good results take time. In order to build up your pelvic floor muscles to their maximum strength you will need to work hard at these exercises. You will probably not notice an improvement for several weeks, but do not get disheartened, your control will improve.

- **Do your exercises well**
- **The quality is important**
- **These exercises can help you gain control of your bladder after your operation.**

# What can I do after my operation?

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- Avoid heavy lifting for 8 weeks after surgery e.g. suitcases or shopping
- Avoid driving a car for 2-3 weeks after surgery (consult your insurance company)
- Avoid heavy gardening for 6 weeks
- Take gently exercise. Gradually increase the distance you walk over a couple of weeks for example
- Eat a healthy balanced diet
- Avoid playing golf for 4-6 weeks after surgery and then introduce it gradually
- Avoid any contact sports e.g. football for at least 12 weeks after surgery
- Avoid constipation
- Avoid travelling abroad for 6 weeks after surgery (contact your travel company and insurance company) after this time you need to contact your GP about your fitness to travel abroad. It is sometimes advisable for patients to wear support stockings (available from most chemists) and take a low dose of aspirin before a flight. Your GP will advise you on this
- Drink plenty of fluid while the catheter is in position. When the catheter is removed drink normal amounts of fluids and avoid alcohol as this can irritate the bladder and make you want to go to the toilet more often
- Do pelvic floor exercises regularly

Many patients feel low or tearful following major surgery and it is quite common for patients to get depressed. This usually improves as you recover. If you want any advice please feel free contact the specialists nurses who will be able to talk to you about this.

# Complications of laparoscopic radical prostatectomy

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## Incontinence

Most men find initially that they have little warning that they want to pass urine, and are incontinent, especially when the catheter is first removed. This generally improves rapidly with time and it is important that you perform pelvic floor exercises regularly to improve control.

It is rare that a patient needs to wear any protection in their underwear long term. About 1% of patients whom have undergone this operation will have severe incontinence where continual protection is needed and about 10% will have mild-moderate incontinence, i.e. a few drops of urine leak on coughing, laughing or sneezing or getting up rapidly from a sitting position.

It can take 3-6 months before full bladder control has been achieved although most men find they have complete control before this time. It is common for men to experience what is described as "stress incontinence" where a little urine may leak when the patient is doing physical activity e.g. digging the garden, lifting heavy objects. This small amount of leakage can occur even when the patient coughs, laughs or sneezes. This can be a long standing / permanent situation. This occurs because the surgery has altered the natural anatomy at the neck of the bladder. (See diagram in the section "How is it done".)

## Impotence

(Inability to achieve or maintain an erection sufficient for satisfactory sexual intercourse)

The nerves that enable a man to achieve an erection run along the outside of the prostate at the back and they can be damaged during surgery. If these nerves are damaged then erection failure will occur. With the nerve sparing operation

where the surgeon tries to spare the nerves that enable you to get an erection, there is usually a delay of up to 12 months before men do notice erections returning and it is possible that the erections do not return to full strength. Full erectile activity may take as long as 12-24 months to be completely restored.

If the remaining erectile nerves are saved on both sides there is a 70% chance of maintaining potency but again this may take some time. Men who no longer have erections do not need the nerve sparing technique. It is possible to restore the erections with treatment and there are lots of treatments available on the market for example Viagra, Cialis, MUSE, injections and vacuum devices.

During your follow up period the doctor or specialist nurse will ask you about your erections and if you want to restore your activity then all treatment will be explained to you and you can start treatment when you feel ready. You may also wish to discuss these issues with your partner before you make a decision. There is some evidence to suggest that if you start treatment for erection failure sooner rather than later there is a better chance of restoring erections quicker but it is still down to patient choice.

Although we can often restore your erections we will however not be able to restore the fact that when you climax you will not be able to ejaculate. This is permanent. However you will still have the sensation of orgasm. If you need to discuss this issue or explore the possibility of sperm banking then speak to your consultant or specialist nurse **before** surgery. This is only necessary if you want more children.

### **Internal scarring (bladder neck stenosis)**

Some men will have problems emptying their bladder due to scarring at the anastomosis (joining together) of the urethra (water pipe to the neck of the bladder. If this occurs then you will notice that your flow becomes poor and you have difficulty emptying your bladder. It is important to mention this when you attend your review clinic. It can occur some time after

surgery. If this occurs your consultant will arrange for you to come into hospital and have a small procedure to open the neck of the bladder up again. This will be done under general anaesthetic and you may need to stay in hospital for a day or so. A catheter is usually necessary for 24-48 hours. The procedure is done through your water pipe (urethra).

### **Urinary anastomosis leak**

On some occasions when the join (anastomosis) between the bladder and urethra (water pipe) has not quite healed, a leak can develop. If this happens then we would leave your wound drain in position longer than normal to allow the area to drain properly.

Sometimes it may be necessary to arrange an X-ray of the bladder called a cystogram. This involves inserting some dye through your catheter and X-raying the bladder and anastomosis.

### **Wound infection**

There is always a possibility of infection with any operation involving incisions (cuts). With the keyhole approach this possibility is reduced as the portholes are small in comparison with the incision made during open surgery. If one of the portholes becomes infected then you will need to take a course of antibiotics.

Occasionally one of the portholes may produce a discharge. Although this can be alarming and unpleasant for the patient it really is better for the infection to drain away as that way it can clear up quicker.

If you develop an infection in one of the portholes after being discharged from the hospital, you should contact your own doctor who will arrange antibiotic therapy. The doctor will also arrange for the district nurse to visit you in order to monitor the wound. If you are in any doubt please contact the specialist nurse.

## **Urine infection**

Patients undergoing any type of surgery to their urinary tract (kidneys, bladder or prostate) are very susceptible to developing a urine infection. After your surgery you will need to have a catheter for approximately 7-14 days. While the catheter is in position the possibility of a urine infection is quite high. It is therefore important that during this time you drink plenty of fluids. You need to have a fluid intake of about 2-3 litres per 24 hours. This keeps the catheter draining and the urine clear and can flush away debris before it has time to develop into an infection.

If you experience very cloudy or offensive urine, please contact your specialist nurse or your GP as you may need a course of antibiotics.

## **Blood clots**

Any pelvic operation carries a risk of the patient developing clots. These are usually taken the form of a DVT (Deep vein thrombosis).

This is where a clot forms in the deep veins of the leg, usually the calf, resulting in pain and swelling.

Although this can be treated there is always the worry that part of the clot can break free and travel to other parts of the body. If this happens a pulmonary embolism can occur where a clot travels to the lungs. This is serious and can be life threatening.

To try and prevent any clots from forming the nursing staff will fit you with support stockings called TED stockings before surgery. These will support your veins while you are in theatre and following your operation. You will be encouraged to get out of bed the day after your surgery as this again can prevent clots from forming. It is important that while you are in bed after your operation that you move your legs and wiggle your toes as much as possible. This will keep your circulation going. With the keyhole approach the risk of a DVT is reduced.

## Bowel perforation

Rectal (back passage) perforation is very rare; less than 2% of patients are affected. If the rectum (bowel) is injured during surgery this will usually be repaired at the same time. In such cases the urinary catheter will be left in place for a further 3 weeks to allow the injury to heal fully. If the injury is not recognised a recto-urethral fistula (a false opening between bowel and water pipe) may form. In these cases urine will leak into the rectum, in other words you will pass urine from your back passage. This usually heals just by leaving the catheter for about 3 months. Occasionally another operation is needed to close the connection.

## Risks

With any major operation there is always a risk that the unlikely will happen, so it is possible that some patients will have a heart attack or stroke under the anaesthetic or afterwards.

If any patient has a history of either of these conditions we normally arrange for an anaesthetic opinion to make sure it is safe for you to have your surgery.

## Follow-up regime

Once your surgery has been carried out and you have recovered sufficiently to be discharged from hospital, your consultant or specialist nurse will arrange for you to come back to a clinic for your trial without catheter. Following this we will arrange for your consultant to see you in Outpatients approximately 6 weeks after your surgery. This will give you the opportunity to discuss with your consultant the results of the laboratory tests carried out on your prostate.

From then on you will need to attend periodically for check ups. This will include measuring your prostate specific antigen (PSA) blood tests. You will be asked to have this checked 1-2 weeks **before** each appointment so that when you attend clinic

we will have the results available. A request form will be given to you at each visit, ready for the next visit. The PSA blood test is the most reliable way for us to monitor the success of your operation and your progress. Your consultant will then arrange for your care to be done by a senior specialist nurse who will continue to monitor your progress over the next 3 years.

It is important that you have your blood taken at the Queen Elizabeth Hospital Cancer Centre outpatients department as we have a very sensitive machine that can record your PSA very accurately. This can help us to monitor your care very precisely over the years. You do not need an appointment for a blood test. Blood during the following times with your request form, Monday-Friday 09:00-16:30.

After your initial follow-up appointments with your consultant or their assistant, all your other check ups will be with a senior specialist nurse.

## Where to get help

We hope you have found this booklet useful in preparing you for your laparoscopic radical prostatectomy.

You will already have the number of your specialist nurse who will support you through the process of surgery and recovery. The nurse is there to help you if you need any support or advice along your journey in the treatment of prostate cancer.

## Urology specialist nurse office

0121 371 6926

Ask to speak to your individual specialist nurse

# Glossary of terms

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<b>Prostate gland</b>	Small gland in males, usually the size of a walnut, lying at the neck of the bladder
<b>Seminal vesicles</b>	Small tubes used to help transmit semen
<b>TURP</b>	Transurethral resection of prostate
<b>Catheter</b>	Hollow tube used to drain urine from the bladder
<b>Urethra</b>	Structure that drains urine from the bladder
<b>Incontinence</b>	Inability to control the bladder resulting in leakage of urine to varying degrees
<b>Impotence</b>	The ability to achieve or maintain an erection for sexual intercourse
<b>Sperm banking</b>	The process whereby semen is collected stored so that it can be used at a later date for fertilisation of an egg
<b>Semen</b>	Fluid that is ejaculated during sexual intercourse
<b>Orgasm</b>	Climaxing during sexual intercourse
<b>Bladder neck stenosis</b>	The narrowing of the neck or outlet of bladder usually due to scar tissue following surgery
<b>Urinary tract</b>	Collective name for the kidneys, urethra and bladder
<b>Urethra</b>	Tubes that drain urine from the kidneys

<b>Deep vein thrombosis or D.V.T</b>	Clots in the deep veins of the leg
<b>Pulmonary embolus</b>	A clot has travelled from somewhere else in the body to the lungs
<b>Intravenous infusion</b>	A method of giving fluids via a vein commonly called a drip.
<b>Anastomosis</b>	The joining together e.g. of two structures
<b>T.W.O.C.</b>	Trail without catheter (removal of catheter)
<b>Urgency (of micturition)</b>	The need to pass urine with little warning
<b>Urge incontinence</b>	The inability to get to the toilet on time when you need to pass urine
<b>Specialist nurse</b>	A qualified nurse who has vast experience in one area of nursing e.g. pain relief, urology
<b>Stress incontinence</b>	A small leakage of urine when the bladder is put under pressure. e.g when you laugh, cough, sneeze, lift heavy objects, do keep fit





The Trust provides free monthly health talks on a variety of medical conditions and treatments. For more information visit [www.uhb.nhs.uk/health-talks.htm](http://www.uhb.nhs.uk/health-talks.htm) or call 0121 371 4957.

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