



**University Hospitals Birmingham**  
NHS Foundation Trust



# Radical retropubic prostatectomy

Your operation explained

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# Introduction

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This booklet has been written to help you understand the treatment you are about to have. It does not replace the discussion between you and your surgeon but helps you to understand more about what is discussed.

It is essential you read this booklet carefully and if there are any areas that are not clear or if you have any questions, contact your urology specialist nurse. It is important that you understand the operation and its effects on you. The specialist nurses are available even after you are discharged. If you have any questions or concerns please feel free to ring them. They are there to help you through the whole process.

## What is a radical retropubic prostatectomy?

This is an operation for men with early or localised prostate cancer. The operation aims to cure the cancer by removing the prostate. This operation is different to a TURP (transurethral resection of the prostate) which only removes part of the gland and is not an open operation.

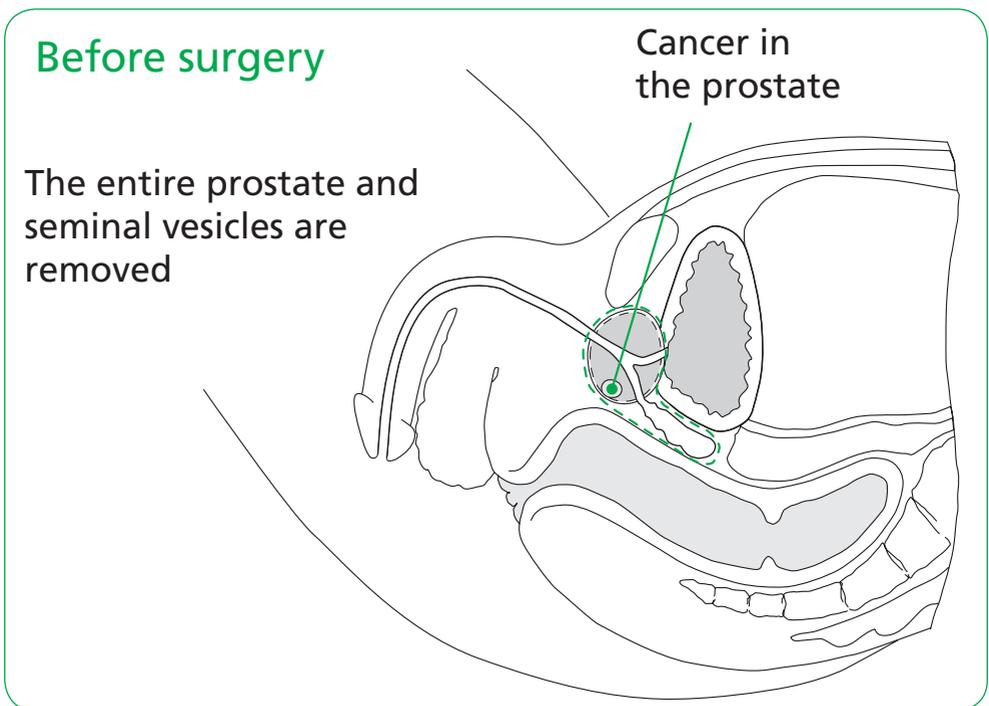
## Why do I need a radical retropubic prostatectomy?

You have been diagnosed with prostate cancer. Your tests indicate that the cancer is confined to the prostate and has not spread. This operation aims to cure your cancer by removing your prostate. Other treatment options will have been discussed with you by your surgeon or in some cases your Clinical Nurse Specialist (CNS).

## How is a radical prostatectomy done?

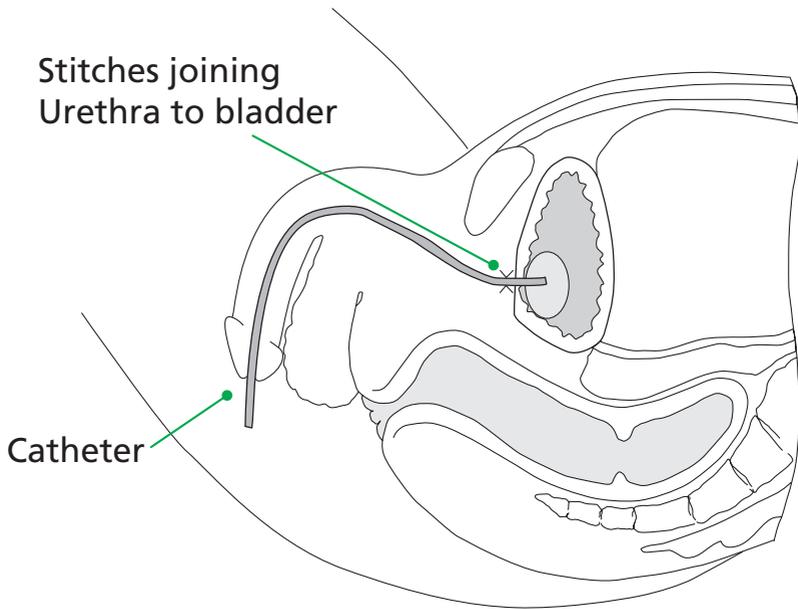
The operation can be performed by keyhole (laparoscopic) robot assisted or open surgery. Laparoscopic and robot assisted prostatectomy are performed using long instruments through 5 or 6 small (1cm) cuts on the tummy. With the robot assisted approach the surgeon operates using a console which directs the robot instruments.

This leaflet describes open surgery only. The diagram below demonstrates where the prostate is and its surrounding structures. You will have an incision (cut) on your abdomen (tummy). Your prostate, containing the cancer, seminal vesicles and surrounding tissue will be removed (this is circled by a green dashed line on the diagram).



The surgeon will then join the neck of your bladder to the urethra (anastomosis). A catheter and wound drain are then placed in position (see diagram on page 6).

## After surgery



## After surgery

Your consultant will discuss whether you are suitable for the laparoscopic or robot assisted approach and will outline the differences between the three procedures. You will be offered a separate booklet describing the other procedures in detail, if necessary.

## Buddy system

Some patients find it beneficial to talk to a patient who has already 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 services 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 or consultant.

## What is nerve-sparing?

There are two sets of nerves that run alongside the prostate and these are responsible for controlling erections. A nerve-sparing operation is when the surgeon tries to spare the nerves that enable you to get an erection. Sometimes it is possible to save the nerves on one or both sides. Even if the nerves are protected on both sides it can take up to 12-18 months for them to regenerate and recover. During this time your erections may return gradually. Treatments are available and can be discussed with your consultant or specialist nurse.

Not all patients are suitable for nerve-sparing. If non-nerve sparing surgery is necessary due to the position of the prostate tumour then this is likely to cause complete loss of your erections. After surgery, therapies are available which may restore your erections.

Your consultant will discuss this issue with you and whether you are suitable to have one or both nerves spared. Once this has been agreed, you will be asked to sign a consent form, agreeing for the surgery to take place.

## Admittance to hospital

You will be admitted to the urology ward the day of your operation. You should already have attended the pre-clerking clinic where all your details will have been taken and blood tests, heart tracings and chest X-rays arranged in readiness for your surgery.

You will have the opportunity to discuss any concerns you have with a qualified nurse.

An anaesthetist will visit you to discuss the type of anaesthetic you will be receiving. The anaesthetist will offer you an epidural infusion or PCA (Patient Controlled Analgesia).

On the day of your operation you will be helped into an operation gown and prepared for theatre. TED support stockings will be given to you to wear. TED stands for thromboembolism

deterrent. These stockings are to reduce the chance of blood clots forming in your legs (deep vein thrombosis also called 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 and the nursing staff will be recording your blood pressure and pulse at regular intervals.

You will have a drip in place providing you with all the fluids you require. Sometimes, it is necessary to give patients a blood transfusion during or after this operation. This is decided by the anaesthetist.

Pain relief is usually given in the form of an epidural infusion or PCA. This allows you to be pain free in the first 24-48 hours after surgery without the need for any other pain relief injections. After this time the epidural infusion will be removed and you will be given pain relief in the form of tablets or a suppository. Please do ask the nursing staff if you need anything for pain relief.

You will wake up with a catheter in place and a tube drain. The catheter is to allow urine to drain out until healing has taken place and the drain allows any fluid collection in the area of operation to be emptied. The catheter will need to remain in place between one to two weeks depending on the amount of leakage at the anastomosis. In a small number of cases a cystogram (bladder X-ray with dye injected via the catheter) may be required prior to catheter removal. It is important that urine drains freely via the catheter at all times.

Wound drains are usually removed between one to two days. In a small number of patients, this may need to be kept in for longer but this should not delay discharge from the hospital.

Initially the nurse will wash you and see to your hygiene needs but it will not be long before you are well enough to do this for yourself.

Patients after radical prostatectomy operation can drink fluids and eat solid food straight away after returning to the ward depending on how they feel. The intravenous drip is usually removed the next day and active mobilisation started to minimise the risk of complications. This also coincides with teaching catheter care/leg bag care and connecting the overnight urine drainage bag.

Significant emphasis is given to pain relief after the operation. Pain relief can be given in a variety of ways including oral tablets and patient controlled analgesia pumps. This results in early mobilisation which in turn will lead to early discharge.

It is important that you know how to look after your catheter before you leave the hospital. Usually, patients are discharged between 2-5 days, depending on individual circumstances.

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## Your catheter

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### Caring for your catheter at home

All patients are discharged with a catheter connected to a leg bag. It is essential that the catheter flows and does not block. This will allow the anastomosis (the join between the bladder neck and the water pipe) to heal. If the catheter stops draining it is essential that you ring for advice the urology ward where you were treated. Do not let anyone change the catheter other than Urology personnel.

Very rarely, the balloon that holds the catheter in position bursts and the catheter can fall out. If this happens please ring the urology ward immediately for advice. You may need to attend the hospital to have it re-inserted depending on how long after the operation this occurs.

It is usual to experience leakage around the catheter at times. This is called bypassing. This usually occurs when you have your bowels opened and is nothing to be alarmed about. You may

also experience blood oozing from around your catheter. This is also normal and is nothing to be alarmed about. However, if the bleeding persists contact the ward staff or your CNS.

Occasional, blood in your urine is to be expected. You may also notice little bits of debris in your urine. This is nothing to be alarmed about but with either of these situations, try and drink plenty of fluids to keep the catheter draining and prevent blockages and infection. If you are unsure or concerned 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.

## Hygiene

It is important to keep the area where your catheter enters your water pipe clean. It is therefore recommended that you have a daily shower or bath. Wash around this area with soap and water using a cloth for this purpose only. Dry thoroughly with a towel. Some patients do experience a little discharge around the catheter which can dry and crust on the outside. This is nothing to be alarmed about and is caused by the catheter rubbing the inside of the urethra (water pipe). If you have a discharge 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 fluid 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 blockages and infection.

## Leakage (bypassing)

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

### 1. Blockages

If this occurs you will experience one or several of the following:

- No drainage in the bag
- A feeling of wanting to pass urine all of the time
- A feeling of fullness
- Distended (bloated) abdomen
- Leakage around the catheter

If any of these occur, contact the urology ward where you were treated. The catheter must not be removed.

### 2. Bladder instability

Leakage mainly occurs if you try to 'help' the catheter to drain. It is normal to experience feelings of wanting to pass urine naturally. If you get the feeling of wanting to pass urine naturally, relax and let the catheter do all the work for you. Don't try and push as this will increase the pressure in your abdomen which will then push onto your bladder and cause the catheter to leak around and into your clothing. As long as the catheter is draining, there is no real concern. If you find that these 'spasms' are persistent, we can give you medication to calm the bladder down. Please ring your nurse specialist at the hospital for advice if you are unsure.

## 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. There should be a nice straight line from the catheter onto the tubing and into the drainage bag. There should be no kinks in the tubing as this can cause the catheter to drain incorrectly and therefore cause leakage. Avoid any strain being put onto the catheter.

## Removal of the catheter

This usually occurs one to two weeks after your surgery. We will arrange for you to attend the hospital to have your catheter removed, depending on space in the outpatient clinic.

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. This is so that the nurse can measure exactly how much you are passing each time.

**Once the catheter has been removed, you may experience one or more of the following:**

- **Frequency**

It is quite normal to want to pass urine quite frequently for the first few hours. Sometimes this can be as often as every half an hour to an hour. This is nothing to be concerned about and does settle down over a period of one to two days.

- **Urgency**

This is extremely common after catheter removal and means that you get little warning when you want to pass urine. You may have to hurry to the toilet. Again this is normal and takes a few hours to settle. All patients get this when their catheter has been removed, whether they have had surgery or not.

- **Urge incontinence**

This is when the urgency catches you and you can not make it to the toilet in time. Again this is quite usual and does settle down. Very occasionally, the urgency can persist particularly if it was a problem before surgery and you may need medication to help this.

- **Incontinence**

Incontinence does tend to settle down but can take several months to do so. Following this operation, most patients notice gradual improvement over time. It is essential that you carry on doing your pelvic floor exercises regularly as this will help your control. Most patients learn to be dry at night within the first one

to two weeks. Mornings are also dryer than afternoons to start with. The evenings are usually more problematic for leakages because the sphincter muscle is tired by the day's activity. Sometimes going back to work too early can result in more leakage for the same reasons. Over a period of months most patients get full control back but some can be left with what is called stress incontinence.

This is when the neck of the bladder is put under stress, this generally happens when you laugh, cough, sneeze or lift anything heavy. A small drop of urine then leaks onto your clothing.

Sometimes men will wear a small pad to protect themselves especially if they know they will be doing heavy work like gardening for example. Stress incontinence can be permanent after a radical prostatectomy.

## Pads

After removal of your catheter it may take a little while for you to gain complete control of your bladder. During this time it may be necessary for you to wear a pad in your underwear.

The hospital is unable to provide pads and it is increasingly difficult to get pads from Primary care. Discuss this with your GP before your surgery.

## Conveens/sheaths

Initially, some patients may experience a lot of leakage and a sheath condom attached to a catheter leg bag may be necessary. If you are having this amount of leakage, talk to your specialist nurse at the hospital.

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# Pelvic floor exercises

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

Pelvic floor exercises should be practiced as soon as you have decided to have a radical prostatectomy. By doing them before surgery you will become proficient and will know exactly how to do them correctly following surgery. 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 the bowel. The water pipe and the rectum (back passage) pass through the pelvic floor muscles. The pelvic floor muscles play an important part in bladder and bowel control.

## Why pelvic floor muscles become weak

Pelvic floor muscles can be weakened by:

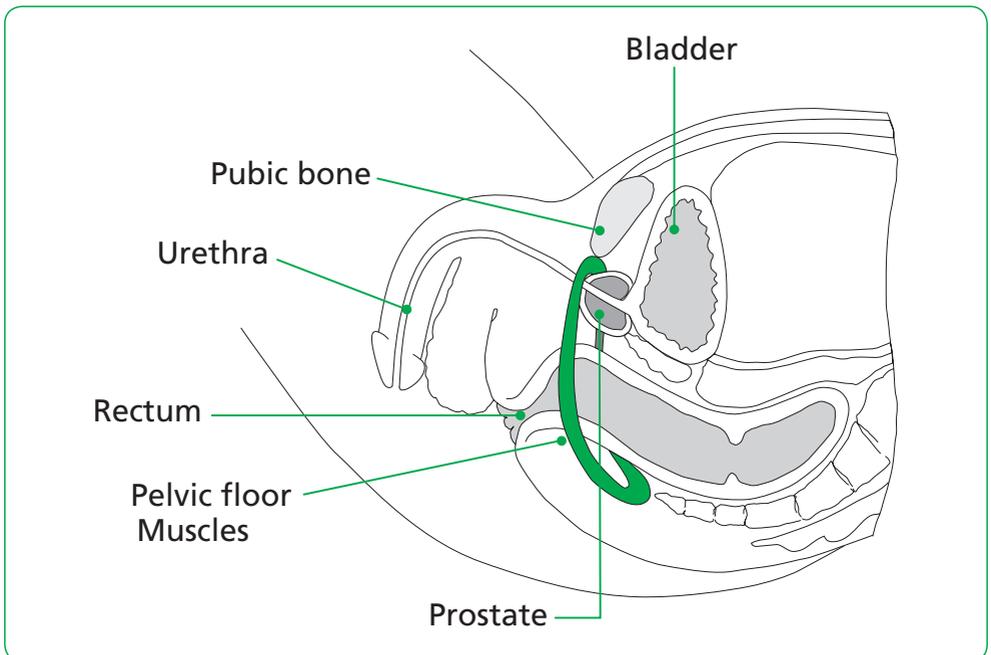
- Some operations for an enlarged prostate
- Continual straining to empty your bowels, usually due to constipation
- Persistent heavy lifting
- A chronic cough, bronchitis or asthma
- Being overweight
- Lack of general fitness

To achieve the best results you may need to seek help from your specialist nurse who may advise that 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 the muscles of your thighs, buttocks and abdomen relaxed.
2. Tighten the ring of muscle around the back passage as if you are trying to control diarrhoea or wind. Relax it. Practice this movement several times until you are sure you are exercising the correct muscle. Try not to squeeze your buttocks (pelvic thrusts) or tighten your thighs or tummy muscles.
3. Imagine you are passing urine, trying to stop the flow mid-stream, then restart it. (You can do this for real if you wish, but only do so to learn which muscles are the correct ones to use. Do this no more than once a week to check your progress, otherwise it may interfere with normal bladder emptying). If your technique is correct then each time that you tighten your pelvic floor muscles you may feel 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 water pipe 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 definitely 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, up to a maximum of 8-10 squeezes. Make each tightening a strong, slow and controlled contraction
4. Now do 5 to 10 short, fast but strong contractions, pulling up and immediately letting go
5. **Do this whole exercise routine at least 4 to 5 times every day. You can do it in a variety of positions: lying, standing or walking**

## 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.

Do your exercises well. The quality is important as these exercises can help you gain control of your bladder soon after your surgery.

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# What can I do after my operation?

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- Have a healthy diet with plenty of fluids and avoid constipation
- Do pelvic floor exercises regularly, as instructed
- Avoid activities such as heavy lifting, gardening and contact sports for 12 weeks after surgery. You can take gentle exercise e.g. walking and gradually increasing the distance
- Avoid driving a car for 6 weeks after surgery. You should be able to make an emergency stop without discomfort to your wound before you consider driving. You should speak to your insurance company regarding any restrictions following surgery
- Avoid travelling abroad for 6 weeks after surgery

After this time you need to consult your GP about your fitness to travel abroad. It is sometimes advisable for you to wear support stockings (available from chemists) and take a low dose Aspirin for a flight. Your GP will advise you. We recommend that you speak to your travel insurance company about your policy in relation to your recent surgery.

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# Complications of Radical Prostatectomy

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A lot of patients experience aches and twinges during their recovery period of approximately three months. These can be frightening but are normally due to tissue and muscle inside healing together. If you are concerned, please do not hesitate to ring the specialist nurses for advice. We do not want you to worry unnecessarily.

As the wound heals, some patients may develop scar tissue along the wound. This can feel like a lump along the wound. This can be frightening but if you are concerned either see your GP or speak to your consultant or specialist nurse at your next appointment. It is natural after any operation to feel frightened and concerned during your initial recovery.

Some patients can get depressed following major surgery and feel low and even tearful. This is a natural and common reaction. Most patients begin to feel better emotionally as they recover. If not then speak to one of the specialist nurses.

## • Incontinence

Initially, most men find 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, as instructed, to improve control.

It is rare that a patient needs to wear any protection in their underwear long term. About 1% of patients who 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, sneezing or getting up rapidly.

It can take three to six months before full bladder control has been achieved although most men find they have complete control before this. 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 activities 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.

- **Impotence**

Impotence is the 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 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 notice erections returning and it is possible that the erections do not return to full strength. If the remaining potent nerves are saved on both sides there is a 70% chance of maintaining effectiveness. Men who no longer have erections do not need the nerve sparing technique. It is possible to offer treatment with the aim of restoring your erections. This treatment is not successful in every case.

There are lots of treatments available on the market e.g. Viagra or MUSE. During your follow up period the doctor or specialist nurse will ask you about your erections and if you want to restore your activity, all treatments will be explained to you. You can start treatment when you feel ready. You may also want to discuss these issues with your partner before you make a decision.

Although we can often restore your erections, when you climax you will not be able to ejaculate. This situation is permanent. However, you may still have the sensation of climax. If you need to discuss this issue or explore the possibility of sperm banking, 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 of the water pipe to the neck of the bladder. If this occurs you will notice that your flow becomes poor and you will have difficulty in emptying your bladder. It is important to mention this when you attend your review clinic. This 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 a day or so. A catheter is usually necessary for 24 to 48 hours. The procedure is done through your water pipe.

- **Urinary anastomosis leak**

This is where the join (anastomosis) between the bladder and water pipe has not quite healed. If this happens we would leave your wound drain in position longer than normal to allow the area to drain. Sometimes we need to arrange an X-ray of the bladder called a cystogram. This involves inserting a dye through your catheter and X-raying the bladder and anastomosis.

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# Complications following a major operation

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- **Wound infection**

This is a possibility following any open operation. If this occurs you will need to have antibiotics to clear the infection. The antibiotics could be either tablets or injections. Occasionally the wound may discharge and although this can be alarming and unpleasant for a patient, it is better for the infection to drain away as this allows it to clear up faster. If you develop a wound infection after discharge, contact your GP who will arrange for antibiotic therapy and for the district nurse to visit to monitor the wound. If you are in any doubt please ring your specialist nurse.

- **Urine infection**

Patients undergoing any type of surgery to their urinary tract (kidneys, bladder or prostate) are very susceptible to develop a urine infection. After a radical prostatectomy you will need to have a catheter for approximately one to three weeks. Whilst the catheter is sited, the possibility of a urine infection is quite high. It is therefore important that you drink plenty of fluids during this time. You need to have a fluid intake of about two to three 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 smell, please contact your specialist nurse or your GP as you may need a course of antibiotics.

- **Blood clots**

Any major pelvic operation carries a risk of developing clots. These usually take the form of a deep vein thrombosis (DVT). 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 a 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 forming the nursing staff will fit you with TED stockings before surgery. These will support your veins while you are in theatre and following the operation. You will be encouraged to get out of bed the day after your operation as this can prevent clots forming.

Whilst you are in bed after the operation, it is important that you move your legs and wriggle your toes as much as possible. This will keep your circulation going. You will usually be given low molecular weight heparin (LMWH) and will continue for a month after discharge. This is a medication used to reduce the risk of thrombosis occurring.

## Rare complications

Most people will not experience any serious complications from their surgery. However, risks do increase with age and for those who already have heart, chest or other medical conditions such as diabetes or if you are overweight or smoke. Rectal injury is a possible but rare complication from having this surgery, your surgeon will discuss this with you.

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 you have a history of either of these your surgeon will arrange for a review before surgery with the anaesthetist at the outpatient clinic. This is to find out if you need any specific tests or medication change before being booked for surgery.

## Follow up care

Once your surgery has been carried out and you have recovered sufficiently to be discharged, your consultant will arrange for you to be admitted for your trial without catheter and will see you in the outpatients department. This will give you the opportunity to discuss the results of the laboratory tests on your prostate.

Following your first post-operative visit, you will need to attend at regular intervals for check ups. This will include measuring your PSA (Prostate Specific Antigen) blood level. You will be asked to have this checked one to two weeks before each appointment so that when you attend the clinic we have the result 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 medical team will arrange for your continued care and will monitor your progress over the next 3 years. After 3 years we will aim to refer you for PSA surveillance by your GP. After your initial follow up consultation with your consultant, your other check ups will be with a specialist nurse or other members of the team.

## Where to get help

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

You will already have the number of your specialist nurse who will support you through the process of surgery and recovery. She/he is there if you need any help, support or advice at any point.

## Urology specialist nurses

Telephone: 0121 371 6926 Office and answer phone.

## Other Information

If you want financial support/information please contact the CNS team for advice.

Cancer patients can have free prescriptions.

# Glossary of medical terms

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Anastomosis	Joining of two structures.
Bladder neck stenosis	Narrowing of the neck or outlet of the bladder usually due to scar tissue following surgery.
Catheter	A hollow tube used to drain urine from the bladder.
Conveen	A sheath or condom worn to collect urine in incontinent men.
Epidural	A type of anesthetic commonly given during childbirth, which gives pain relief from the lower spine downwards. This involves having an epidural cannula inserted into the spine.
Impotence	The inability to achieve or maintain an erection for sexual intercourse.
Incontinence	The inability to control the bladder resulting in leakage of urine to varying degrees.
Intravenous infusion	Commonly called a 'drip', is a method of giving fluids via a vein.
Prostate gland	Small gland in males, usually the size of a walnut, that sits under the bladder and in front of the rectum.
PCA (Patient Controlled Analgesia)	A means for patients to self administer pain medications by using a computerised pump, which introduces specific doses into an intravenous line (into a vein).

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<b>PSA (Prostate Specific Antigen) test</b>	PSA is a protein made by the prostate gland, which naturally leaks out into the bloodstream. The PSA test measures the level of PSA in the blood.
<b>Pulmonary embolus</b>	A clot that has travelled from somewhere else in the body to the lungs. Semen: fluid that is ejaculated during sexual intercourse.
<b>Seminal vesicles</b>	Small tubes used to help transmit semen.
<b>Specialist nurse</b>	A qualified nurse who has vast experience in one area of nursing e.g. pain relief.
<b>Sperm banking</b>	Collection and storage of semen to be used for fertilisation at a later date.
<b>ThromboEmbolism Deterrent stockings (TED stockings)</b>	Stockings to reduce the chance of blood clots forming in the legs.
<b>TURP</b>	Transurethral Resection of Prostate. An operation performed via a thin telescopic tube passed up the urethra via the penis which removes part of the prostate gland.
<b>TWOC</b>	Trial Without Catheter – removal of catheter.
<b>Urethra</b>	Structure that drains urine from the bladder.
<b>Urinary tract</b>	Collective name for the kidneys, ureters, and bladder.
<b>Ureters</b>	Tubes that drain urine from the kidneys into the bladder.

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**Urgency**

The need to pass urine with little warning.

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**Urge incontinence**

The inability to get to the toilet on time when you need to pass urine.

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Please use the space below to write down any questions you may have and bring this with you to your next appointment.

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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)

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