New Edition

A Patient's Guide to Radical Prostatectomy for Prostate Cancer

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Tailoring Technology to Treatment

This is a booklet for men who are either considering treatment, or are being treated, for prostate cancer by radical prostatectomy; an operation to remove the prostate gland. It also provides useful advice and information for their families. It is best read in conjunction with the more general booklet in this series, *A Patient's Guide to Prostate Cancer*, which provides an overview of the subject and introduces terms used in this booklet. This booklet may have already been given to you, or it may be viewed and downloaded from the websites: www.prostatecancercentre.com and www.prostatebrachytherapycentre.com

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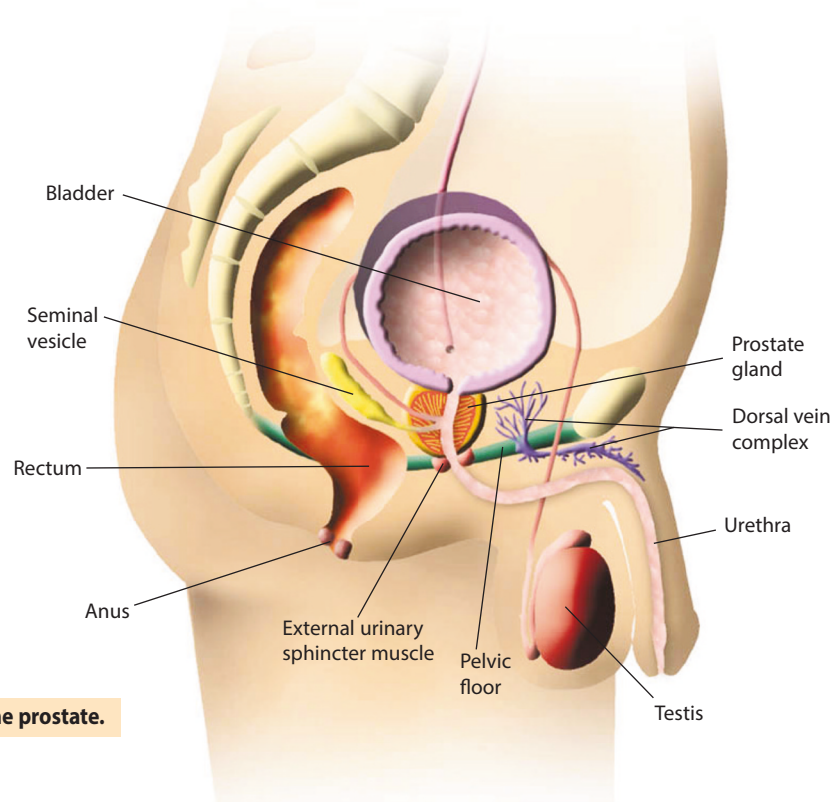


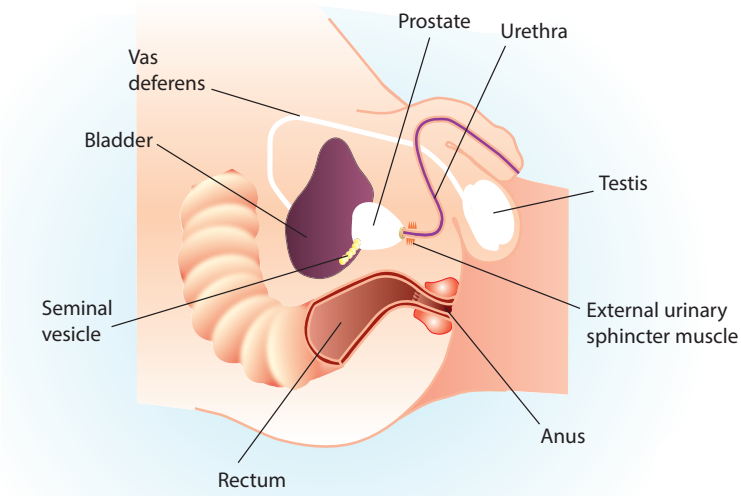
The prostate.

Radical prostatectomy is an operation performed to remove the entire prostate and is usually done for cancer which is thought not to have spread beyond the prostate gland. It should not be confused with transurethral prostatectomy or TURP, which is performed through the penis, using a telescope. A TURP removes only the inner two-thirds of the prostate and is performed when the prostate is

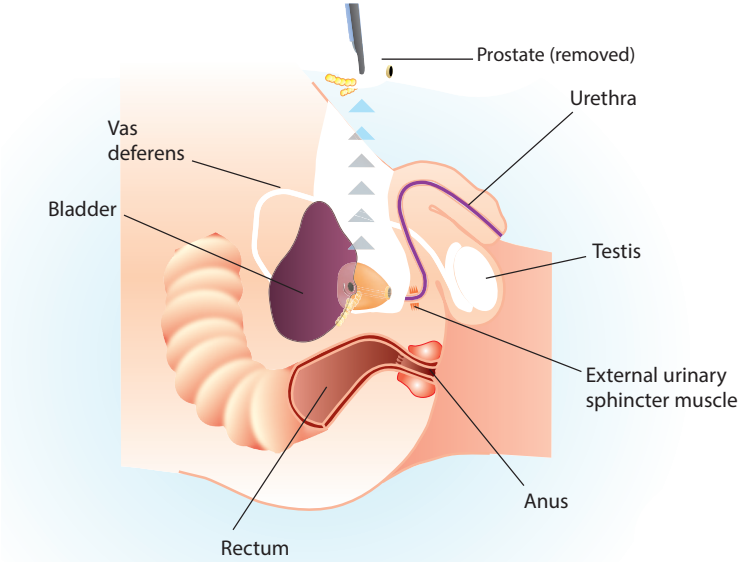
obstructing the flow of urine from the bladder. Radical prostatectomy is a major operation with an excellent safety record when done by an expert.

Radical prostatectomy

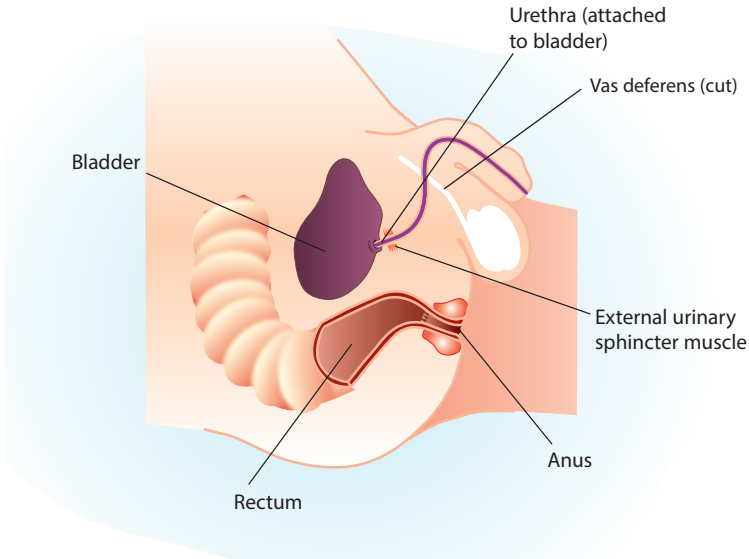
Radical prostatectomy was first performed over a century ago, although it has only been widely used as a treatment for localised prostate cancer worldwide for the past 35 years, and in the UK for the past 25 years. The discovery of prostate-specific antigen (PSA) in the late 1980s and improvements in how the prostate is biopsied mean that we are now able to diagnose prostate cancer early, when it is still curable.



Steps in radical prostatectomy. **A.**


Prostate (removed)
Urethra
Vas
deferens
Bladder
Testis
External urinary
sphincter muscle
Anus
Rectum

B.


Urethra (attached
to bladder)
Vas deferens (cut)
Bladder
External urinary
sphincter muscle
Anus
Rectum

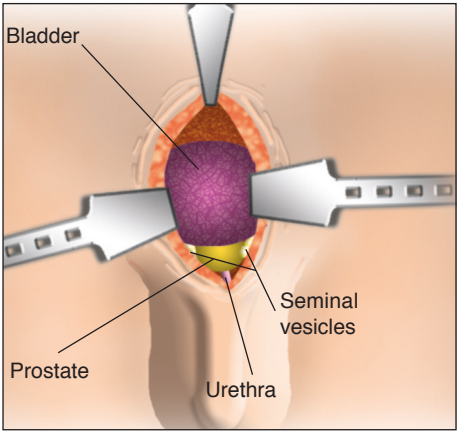
C.

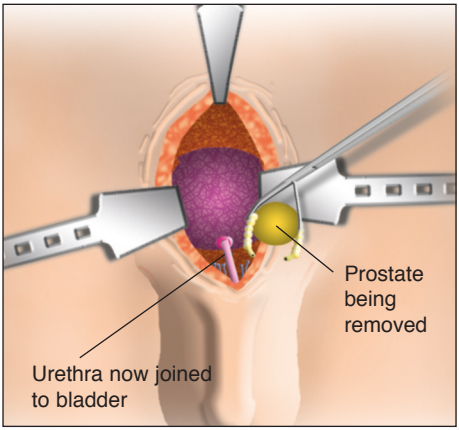
Radical prostatectomy is now the most common major urological procedure performed in many specialist hospitals in the UK, Here at The Royal Surrey all of our surgeries are performed by robotic surgery. Historically it could be performed using any of these 4 routes:

1. Retropubic

This is the term for the 'open' operation with an incision in the lower part of the abdomen.

Retropubic technique.

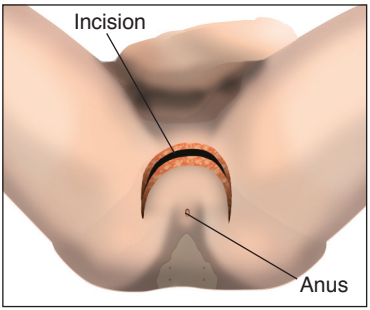


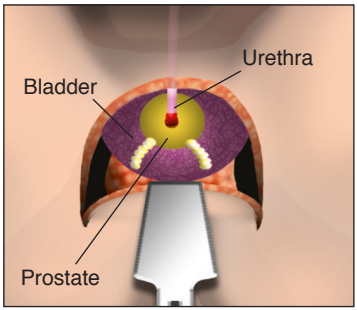


2. Perineal

The operation can be performed through an incision between the scrotum and the anus, although this route is now seldom used.

Perineal technique.

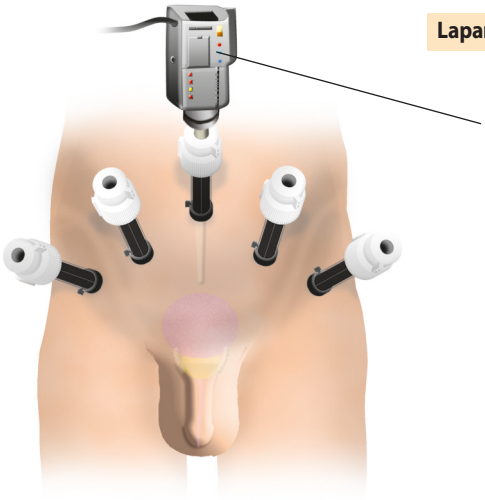




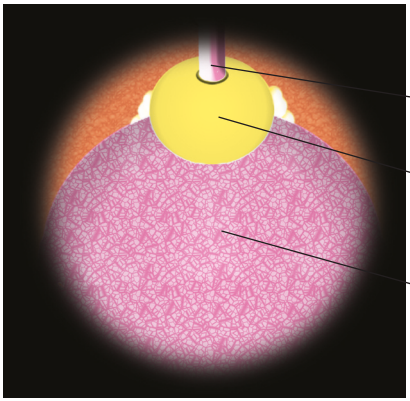
3. Keyhole – Standard Laparoscopic Surgery

A number of small incisions are made in the abdomen

Laparoscopic technique.



through which the camera and instruments pass, which are manipulated by the surgeon and his assistant.

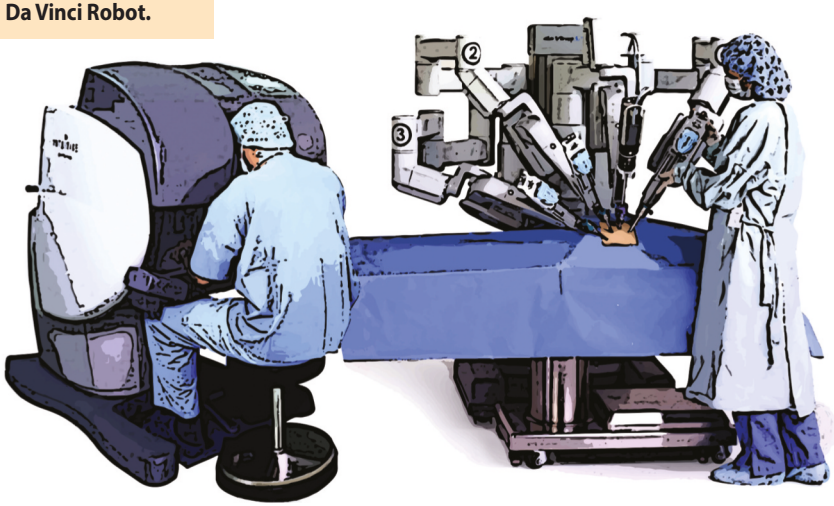


View down the laparoscope.

4. Keyhole – Robotic Surgery

The camera and instruments that pass through the abdomen are connected to and moved by the arms of a robot. The robot is controlled by the surgeon. This is now

Da Vinci Robot.



the most popular way to perform radical prostatectomy as greater precision and accuracy of the surgery can be achieved with the robotic assistance. The surgeon also benefits from having 3D vision from the robotic camera when operating.

End of the probe of a Da Vinci Robot.

Retzius Sparing Robotic surgery

Retzius-sparing radical prostatectomy is a technique that approaches the prostate from below, rather than above, the bladder. This space is small and the position of the prostate and the bladder are reversed, so the anatomy at first sight looks confusing. The technique of re-joining the bladder and urethra after the prostate has been removed is also different from conventional prostatectomy, in that the front aspect of the join has to be completed before the back wall, which is

the reverse of the conventional procedure. The advantages gained by avoiding disturbing the structures in the cave of Retzius allow for early attainment of continence. However when comparing continence rates with patients having conventional approach in 3 months after surgery, the outcomes are similar.

In Guildford, as a centre of excellence in the treatment of prostate cancer, we have the latest technology and all radical prostatectomies are performed by robotic surgery.

However, whichever approach is chosen, a urinary catheter is left in place for between 1-2 weeks after the operation before it is removed. This allows the join (anastomosis) between the bladder and the urethra to fully heal.

The robotic technique is the commonest way that radical prostatectomy is performed in the USA and Europe.

The disadvantage with the robot is the cost; it is the most expensive way of removing the prostate and so surgical robots are not available in every hospital.

Advantages of surgery

- The true stage (extent) and grade (aggressiveness) of the cancer can be determined – see the booklet *A Patient's Guide to Prostate Cancer*, which may be viewed and downloaded from the website: www.prostatecancercentre.com
- If the cancer is confined to the prostate, and the entire gland is removed, surgery should be curative, although follow-up for several years post-operatively will be required to check that there is no sign of any recurrence in the body.

- The prostate-specific antigen (PSA) blood test should fall to less than 0.1ng/ml within 10 weeks of surgery and remain undetectable. If it does not, it suggests that there are cancerous cells left behind and further treatment by radiotherapy or hormone therapy may be necessary.
- If prostate cancer recurs, the PSA will start to rise. This will detect the recurrence of cancerous cells between 3-5 years before symptoms occur. Radiotherapy to the pelvis may be used to treat cancerous cells if they are likely to be localised to where the prostate was situated. If there is spread outside the pelvis, hormone therapy is more commonly used, as it will treat cancerous cells wherever they may be within the body.
- If required, follow-up radiotherapy to the pelvis often causes fewer side-effects for patients compared to patients needing a radical prostatectomy after external beam radiotherapy or brachytherapy. However, surgery is rarely necessary after radiotherapy.
- Surgery corrects any obstruction to the flow of urine from the bladder caused by enlargement of the prostate that may give rise to urinary symptoms such as a poor urinary stream and the need to get up at night to pass urine.
- The advantage of robotic surgery over an open operation is that the risk of needing a post-operative blood transfusion is less. Patients experience less pain with robotic surgery and can make a more rapid recovery to return to normal activities.

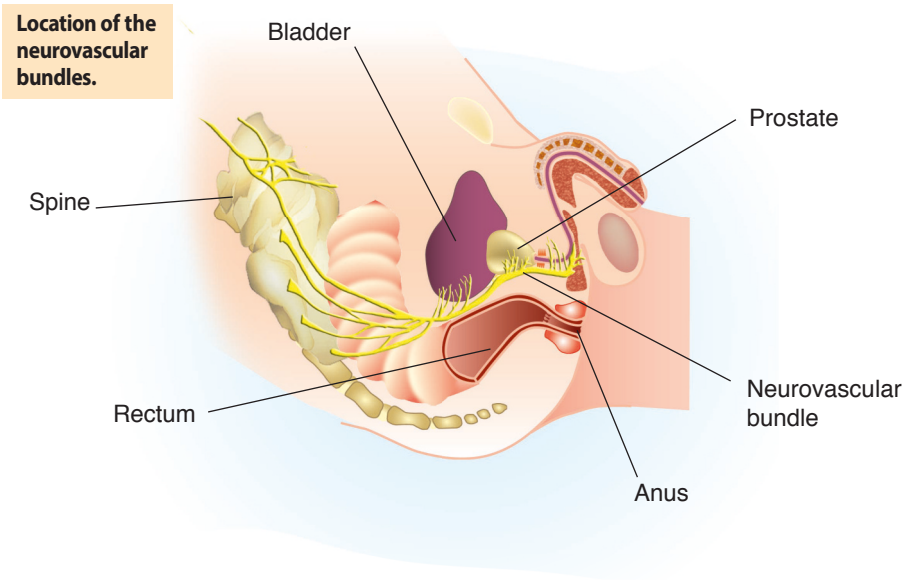
Disadvantages of surgery

- **Wound discomfort**

  The abdominal incisions resulting from keyhole radical prostatectomy normally heal well, within 10 days, and the discomfort soon fades. One of the incisions will be a little larger than the others to allow the prostate to be removed from the abdomen. The keyhole techniques cause the least discomfort; hence their appeal. Wound problems are uncommon and any discomfort can be effectively controlled by painkillers.

- **Urine incontinence**

  Leakage of urine on coughing, sneezing, laughing and standing may initially occur, following removal of the catheter (a tube that drains urine from the bladder into a bag). This is known as 'stress' incontinence and is managed by wearing absorbent pads. It is present because the urethra (tube you urinate through) and bladder are brought together by sutures (stitches) at the end of the operation. This process causes bruising, swelling and impaired function of the sphincter (continence valve). The younger, fitter and slimmer the patient, the faster continence returns. Exercises to strengthen the pelvic floor speed up the return of continence (see page 21 for pelvic floor exercises). Continence rates differ amongst surgeons. Good continence rates would be 70% of patients pad-free at 3 months after surgery, 85% after 6 months and 95% after 12 months. The 1 in 20 (or 5%) of patients not pad-free at 12 months may be offered the insertion of an artificial urinary sphincter, to help regain continence.



Location of the neurovascular bundles.

Risk of impotence

Men have nerves and blood vessels (the neurovascular bundles) that travel very close to the prostate on their way to the penis to provide a normal erection. The trouble with prostate cancer is that it tends to grow down the nerves, as this offers the path of least resistance. Men with higher risk prostate cancer and those who are already experiencing erectile dysfunction are often advised to have the nerves removed with the prostate, so as not to risk leaving any cancer behind. For other patients where there is a low risk that the nerves will be involved with cancer, the nerves may be left behind. This greatly increases the chance that a patient will be able to get an erection post-operatively.

The younger and fitter the patient, the faster erections return. However, this process may take up to 2 ½ years in some patients. Potency (erection) rates differ amongst surgeons. Good potency rates would be 50% of patients, at 12 months after surgery. In Guildford, we have a dedicated psychosexual specialist to help patients regain their sexual function and patients are encouraged to embark on a programme of penile rehabilitation after their operation.

- **Lymphoedema**

This is the term for swelling of the penis, scrotum and/or the legs and occurs temporarily in most men who have their pelvic lymph nodes removed at the time of their radical prostatectomy. It is a long-term problem in approximately 3% of men, in whom it is controlled with compression stockings, leg elevation and massage.

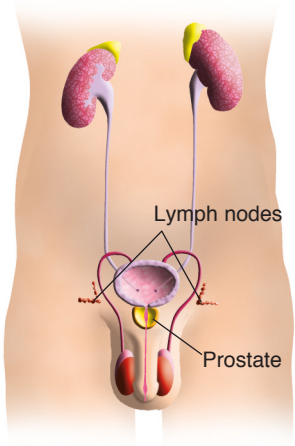
- **General Problems**

General problems relating to any major surgical procedure may rarely occur in patients undergoing radical prostatectomy. Such complications include post-operative bleeding, injury to adjacent organs such as the bowel, any vessels or ureters (tubes collecting urine from the kidneys), a deep-vein thrombosis (blood clot in the legs), a pulmonary embolus (blood clot in the lung) and infections. If you have any of these problems, you may need to stay in the high-dependency unit and your recovery may be delayed.

A radical prostatectomy is a major operation, taking between 3-5 hours to perform, and this alone means that patients will be tired after the procedure for several weeks. It is important to allow time to fully recover.

Patient selection

Patients suitable for radical prostatectomy will usually have organ-confined prostate cancer, where there is no evidence that the cancer has spread away from the prostate gland. Patients will have had an MRI scan and possibly a bone scan to try and identify whether the cancer has spread pre-operatively.



Pelvic lymph nodes.

Occasionally, patients will opt for surgery even though the cancer may have spread a short distance outside the gland or into the adjacent seminal vesicles or lymph nodes; a stage known as locally advanced prostate cancer. However, such patients will frequently need post-operative radiotherapy and/or hormone therapy to optimise their chance of a successful long-term outcome.

Your doctor, working with colleagues who manage and assess prostate cancer (oncologists, pathologists and radiologists), will help you to decide which is the best treatment for your cancer.

Patients who are in poor general health, are very overweight or have existing cardiovascular or breathing problems may be better suited to other forms of treatment. Patients who have recently had prostate surgery, such as a TURP, or those who have troublesome urinary symptoms, such as a poor urine stream, are often best suited to radical prostatectomy that also removes the obstructing gland.

Before the operation

Before surgery, patients are seen in a Pre-assessment clinic. Here, we will assess your suitability and fitness for surgery and the anaesthetic. Tests are carried out to make sure that your heart, lungs and kidneys are working properly. You will often have a chest x-ray, electrocardiogram (ECG), which records the electrical activity of your heart, and have some blood samples taken. Your doctor will explain any further tests you need.

You will need to stop warfarin, clopidogrel, apixaban or any other similar medication that thins your blood (anticoagulants) before the operation. The timing as to when you should stop this medication will be discussed in the clinic.

You will be given written instructions on pelvic floor exercises and advised to start them as early as possible after surgery (see page 21).

On the day of the operation

You will have received written information regarding the timing of the operation and which ward to come to. A member of the surgical team, who will discuss the operation with you and then ask you to sign a standard form, confirming your consent for the operation, will see you. This consent gives the surgeon permission to operate on you and confirms that you understand what the procedure involves and the possible side-effects. If you have any questions or concerns, please ask your doctor or nurse before you sign the consent form.

The anaesthetist, who will explain the anaesthetic process and how any common post-operative problems

such as nausea (sickness) and pain will be treated, will also see you.

Just prior to the operation, you will be asked to put on a gown. When they are ready for you, you will be taken to the Theatre Reception area and from there into the Anaesthetic Room, which is next door to the Operating Theatre itself.

The operation

The robotic radical prostatectomy usually takes around 3-5 hours to perform, depending on the degree of difficulty and the extent of the operation. During the operation, the prostate and seminal vesicles are removed, the neurovascular bundles may be preserved and the surrounding lymph nodes may also be removed. The bladder and urethra are then sutured together over a urinary catheter. At the end of the operation, a temporary drain (silicone tube) may be inserted to drain away any post-operative fluid into a sterile bag.

After the operation

After the operation, when you wake from the anaesthetic, you will be in the Recovery Room. You will have a catheter in your penis, at least one drip in your arm and possibly a drain in your abdomen. You should expect some discomfort, but this can be easily controlled, using the painkilling drugs you will be offered. After approximately 2 hours, you should be ready to return to the ward.

Returning to the ward

Patients are encouraged to eat and drink on the first day following surgery. The surgical team will see you regularly. If an abdominal drain was inserted, it will usually be removed within 24 hours of the operation. The day after the operation, you will be encouraged to take painkillers as prescribed and to get out of bed. Your catheter will be attached to a leg bag to make movement easier. You will be encouraged to mobilise throughout the day.

You will also be encouraged to have three light meals a day. Most patients are ready to go home within 24 hours of their operation.

Before your discharge, you may be taught to give yourself a daily anti-clotting injection such as Dalteparin to reduce the risk of a DVT (Deep Vein Thrombosis). If you meet the criteria set by the EAU (European Association of Urology), who advise patients that are over 75 years of age, have a BMI greater than 35, have ever suffered a blood clot before or have had Lymph nodes removed as part of their Robotic Surgery will require Dalteparin for 28 days.

Going home

When you are ready for discharge, the following will be arranged:

- You will be provided with medication to take home, including pain killers and 4 weeks' supply of daily anti-clotting (Dalteparin) injections if required. You will also have a supply of laxatives to keep your bowels moving and avoid any discomfort.

- A date to return to hospital to have the urinary catheter removed will be arranged, usually 1-2 weeks after the operation.

- A referral to the district nurses will be made. They can be a useful source of information regarding the catheter and wound care.

- An out-patient appointment will be made for 6 weeks post-operation. The ward telephone number and contact details of Helen Casson and Maria Innes, Clinical Nurse Specialist, will be given to you in case there are any concerns or queries; see page 26.

Post-operative advice

Rest and exercise

Following your surgery, you should expect to feel tired for the first 2-4 weeks and you should aim to take an afternoon nap each day for a couple of hours.

It is important that you balance activity and rest. Each day, you should try to take a walk outside, aiming to increase the duration of this each day, with pottering around the house and garden in between.

You should avoid any strenuous exercise, contact sports, and heavy lifting for 8 weeks. Cycling should be avoided for 12 weeks.

Constipation

This is common after any major operation and should not concern you. Take the laxatives that you have been given on discharge regularly to reduce effects of constipation. We do not want you to strain.

Blood in the urine

This is common both before, and for several weeks after, your catheter has been removed. Do not worry, but increase your fluid intake to dilute the urine and prevent any clots forming.

Continence

You will probably not be continent immediately after the catheter has been removed but, by performing regular pelvic floor exercises, continence should return over the next 6 months (see page 21 for information on pelvic floor exercises). The number of pads you need to use will reduce with time.

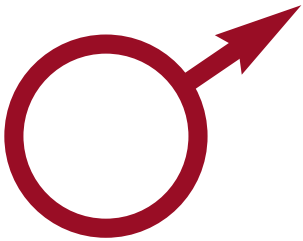
Caffeine-containing drinks (tea, coffee, cola, hot chocolate etc.) can aggravate urinary frequency and urgency and are best avoided for at least 3 months after the operation.

Driving

You should refrain from driving for at least 10 days and until you can comfortably and safely perform an emergency stop. Check your insurance details as some policies say longer after major surgery.

Erections

Do not be afraid to experiment with erections and sex at any time after the operation (apart from whilst the catheter is in, as this may be uncomfortable, but do not worry if you do get an erection at this time), but remember that it can take up to 2½ years for erections to return and that intercourse is much easier with lubrication jelly. You should also be aware that you do not need to have an erection or ejaculate to have an orgasm. The orgasmic sensation will still be enjoyable and fulfilling, but no fluid will come out. You will be sterile, so contraception is unnecessary.



Remember also that, if erections do not return naturally, most men can be made potent somehow, using either creams, injections, pumps or even implants. Dr Nicola Valentine, a psychosexual specialist, is available to all our patients in Guildford to advise on a programme of penile rehabilitation.

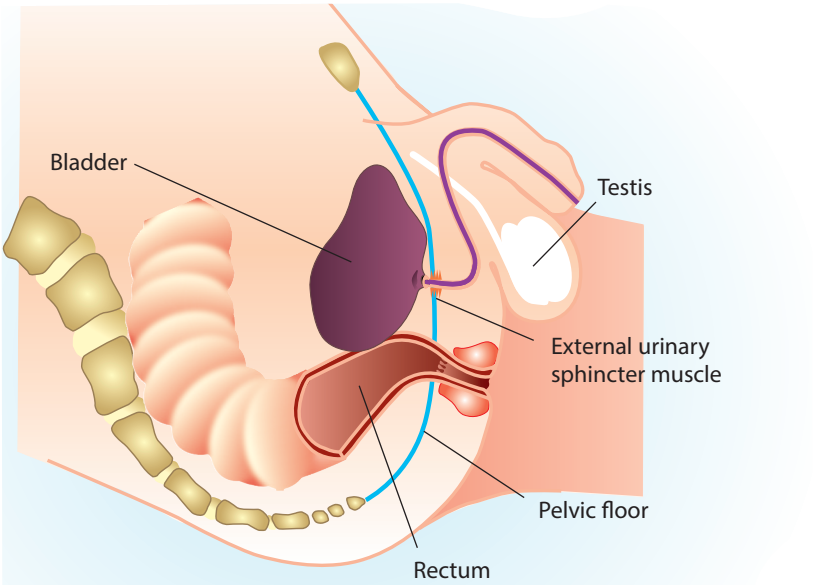
Work

It is sensible to allow yourself adequate time to recover from your major surgery. We suggest that you take a minimum of 3 weeks off, but most men need to take up to 6 weeks. If you require a certificate on discharge, please ask the doctors.

Follow-up plan post-operatively

Your first outpatient appointment will be approximately 6 weeks after surgery, when the results of the laboratory analysis (histology) of your prostate should be available at this appointment. The surgeon will also inquire about your continence and your potency. He will instruct you when to have your PSA checked. Your first post-operative PSA test should be taken just prior to your 3 month follow up appointment. You will typically be seen with an up-to-date PSA test every 3 months for a year and then every 6 months for 4 years. Your GP might be asked to check your PSA annually for another 5 years.

We will also ask that you complete a Male Health Inventory form each time we see you in clinic to ensure that all of your symptoms are addressed (see pages 24-25).



Location of the pelvic floor.

Other Information

Pelvic floor (or Kegel's) exercises

- To do these exercises effectively, you need to first relax your abdominal and buttock muscles.
- To identify and correctly contract the pelvic floor muscles, imagine that you are trying to hold back bowel movements or stop passing wind. Another way to identify the muscles is to imagine squeezing a finger placed in the rectum, or stopping the urinary stream mid-flow.
- During this action, you should feel the anus contract, but the abdominal or buttock muscles should remain relaxed.
- The pelvic floor muscles need to be exercised for strength, speed and stamina (endurance). Therefore, you need to do some **slow holding contractions** and some **quick short contractions**.

Slow contractions:

- Tighten and draw in the muscles around the anus and urethra, lifting the muscles up inside.
- Count to five, then release and relax. You should have a definite feeling of letting go.
- Repeat this up to a maximum of 8-10 squeezes, resting for 5-10 seconds after each tightening of the muscles.

Quick short contractions:

- Tighten and draw in the muscles around the anus and urethra,lifting the muscles up inside.
- Now try 5-10 short, strong squeezes in quick succession.

Repeat the slow and quick squeezes around 4-5 times a day.

- ***The'Knack':***
  Sometimes, you may leak on getting out of bed or a chair and also during coughing or sneezing. The Knack exercise can be useful to prevent this.
  To perform the Knack, contract the pelvic floor muscles before and during any activity that increases the intra-abdominal pressure, such as coughing, sneezing or even before getting out of bed or a chair, to prevent leakage of urine.
- During the first week of the programme, perform the exercises whilst lying down, but later while sitting and standing. After the initial learning period, perform the exercise when you need to, i.e. just before sneezing, coughing or straining.

Commonly asked questions you may like to ask the doctor

- Will I be given hormone treatment prior to surgery?
- How will the operation be performed and how long does the operation take?
- Am I likely to have a blood transfusion?
- How many of these operations do you do a year?
- Will you be removing anything other than my prostate and seminal vesicles, such as my pelvic lymph nodes?
- Will nerve-sparing surgery be possible? In your experience, how successful is this procedure?
- What are your results in respect of impotence and incontinence?
- How long will I be in hospital?

- Will I have much pain after surgery and how will it be controlled?
- If I go home with a catheter, when will it be removed and by whom?
- How soon is my follow-up appointment after discharge?
- If I have continence problems after the surgery, how would these be managed and by whom?
- How often will my PSA be checked?
- What should the PSA be after surgery? What would it mean if it doesn't reach that level? What would you do then?

Summary

Radical prostatectomy is an effective treatment for early prostate cancer. Following the operation, the PSA value should be undetectable, as the entire prostate has been removed. However, it requires regular monitoring for at least 5 years at which point, if it is still unrecordable, this suggests that the patient is cured. Persisting side-effects of radical prostatectomy can often be effectively treated or eliminated. Robotic techniques have the advantage over open surgery in reducing recovery times, but do require a specialist surgical team.

PLEASE COMPLETE THIS QUESTIONNAIRE FOR THE **PAST MONTH**

MALE HEALTH INVENTORY

These questions are designed to assess your **ease of urination**.

1. **Incomplete Emptying** Over the past month, ***how often*** have you had a sensation of not emptying your bladder completely?

Not at all	Less than 1 time in 5	Less than half the time	About half the time	More than half the time	Almost always
0	1	2	3	4	5

2. **Frequency** Over the past month, ***how often*** have you had to urinate again less than 2 hours after you finished urinating?

Not at all	Less than 1 time in 5	Less than half the time	About half the time	More than half the time	Almost always
0	1	2	3	4	5

3. **Intermittency** Over the past month, ***how often*** have you found you had stopped and started again several times when you urinated?

Not at all	Less than 1 time in 5	Less than half the time	About half the time	More than half the time	Almost always
0	1	2	3	4	5

4. **Urgency** Over the past month, ***how often*** have you found it difficult to postpone urination?

Not at all	Less than 1 time in 5	Less than half the time	About half the time	More than half the time	Almost always
0	1	2	3	4	5

5. **Weak Stream** Over the past month, ***how often*** have you had a weak urinary stream?

Not at all	Less than 1 time in 5	Less than half the time	About half the time	More than half the time	Almost always
0	1	2	3	4	5

Name..... Date of birth..... Current PSA level..... Date..... (Or affix Patient Details Label here)

These questions are designed to assess whether you are experiencing **erectile dysfunction** or **impotence**. Tick the response that best describes your own situation.

1. Could you get an erection sufficient for intercourse? **Yes** **No**
2. Are you currently taking Viagra, Levitra or Cialis? **Yes** **No**
3. Over the past month, how do you rate your confidence that you can get and keep your erection?

Very low	Low	Moderate	High	Very high
1	2	3	4	5

4. Over the past month, when you had erections with sexual stimulation, ***how often*** were your erections hard enough for penetration?

No sexual activity	Almost never or never	A few times (much less than half the time)	Sometimes (about half the time)	Most times (much more than half the time)	Almost always or always
0	1	2	3	4	5

5. Over the past month, during sexual intercourse, ***how often*** were you able to maintain your erection after you had penetrated (entered) your partner?

Did not	Almost never	A few times	Sometimes	Most times	Almost

6. **Straining** Over the past month, ***how often*** have you had to push or strain to begin urination?

Not at all	Less than 1 time in 5	Less than half the time	About half the time	More than half the time	Almost always
0	1	2	3	4	5

7. **Nocturia** Over the past month, ***how many times*** on average did you get up each night to urinate?

None	1 time	2 times	3 times	4 times	5 times or more
0	1	2	3	4	5

The following questions are designed to assess your level of **urinary incontinence**.

1. Do you need to use incontinence pads? **Yes** **No**

2. If so, how many in 24 hours?

1	2	3	4	4+
0	1	2	3	4

3. Does urine leak before you can get to the toilet?

Never	Occasionally	Sometimes	Most of the time	All of the time
0	1	2	3	4

4. Does urine leak when you cough or sneeze?

Never	Occasionally	Sometimes	Most of the time	All of the time
0	1	2	3	4

Quality of Life due to Urinary Symptoms If you were to spend the rest of your life with your urinary condition just the way it is now, ***how would you feel*** about that?

Delighted	Pleased	Mostly satisfied	Mixed (Equally satisfied & dissatisfied)	Mostly dissatisfied	Unhappy	Terrible
0	1	2	3	4	5	6

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partner?

Did not attempt intercourse	Almost never or never	A few times (much less than half the time)	Sometimes (about half the time)	Most times (much more than half the time)	Almost always or always
0	1	2	3	4	5

6. Over the past month, during sexual intercourse, ***how difficult*** was it to maintain your erection to completion of intercourse?

Did not attempt intercourse	Extremely difficult	Very difficult	Difficult	Slightly difficult	Not difficult
0	1	2	3	4	5

7. Over the past month, when you attempted sexual intercourse, ***how often*** was it satisfactory for you?

Did not attempt intercourse	Almost never or never	A few times (much less than half the time)	Sometimes (about half the time)	Most times (much more than half the time)	Almost always or always
0	1	2	3	4	5

These questions relate to your **bowel function**.

1. Have your daily activities been limited by your bowel problems?

Not at all	A little	Quite a bit	Very much
1	2	3	4

2. Have you had any unintentional release (leakage) of stools?

Not at all	A little	Quite a bit	Very much
1	2	3	4

3. Have you had blood in your stools?

Not at all	A little	Quite a bit	Very much
1	2	3	4

4. Did you have a bloated feeling in your abdomen?

Not at all	A little	Quite a bit	Very much
1	2	3	4

Thank you for completing this questionnaire

Useful website addresses and support networks

CancerBACUP **www.cancerbacup.org.uk**
'Helping people live with cancer.'

CancerSupport UK **www.cancersupportuk.nhs.uk**
'Coping with cancer at home.'

PCaSO **www.pcaso.com**
'To improve the diagnosis,treatment,care and support to those troubled by this cancer.'

The Continence Foundation **www.continence-foundation.org.uk**
'For people with bladder and bowel problems.'

The Prostate Project Charity **www.prostate-project.org.uk**
A charity based in Guildford that has raised several million pounds to raise the awareness and improve the care of men with prostate cancer.

The Prostate Cancer Charity **www.prostate-cancer.org.uk**
The National UK Prostate Cancer Charity with many valuable patient information aids.

The Sexual Dysfunction Association **www.impotence.org.uk**
'To help sufferers of impotence (erectile dysfunction) and their partners.'

Useful telephone numbers/contact details

During office hours: 9.00am - 5.00pm

For enquiries relating to patient care or problems after surgery, please contact:

Royal Surrey County Hospital, Guildford
Helen Casson/Maria Innes
Prostatectomy Nurse Specialist
Telephone: 01483 571122 Ext: 4841
Email: helen.casson1@nhs.net/
maria.innes@nhs.net

Ashleigh Butler/Laura Curtis
Robotic Prostatectomy Booking Co-ordinators
Telephone: 01483 464005
Email: ashleigh.butler1@nhs.net/
laura.curtis5@nhs.net

St Richard's Hospital, Chichester
Claire Manwaring/Annette Martyn/
Trudi Cunningham
Telephone: 01243 788122 Ext: 3143
Pager: 01243 788122 bleep 257

Worthing Hospital
Andrew Hart/Jane Saville
Telephone: 01903 205111 Ext: 84716
Email: mac.urology@wsht.nhs.net

For clinic and general administrative matters, please contact the appropriate medical secretary:

Private patients

For Prof Langley and Mr Patil:
Melanie Sargeant and Vicki Scott
Guildford Nuffield Hospital
Telephone: 01483 575511
Email: secretary@specialisturology.com

For Prof Eden:
Aleksandra Stosic
Santis Health
Telephone: 02033 895860
Email: info@santishealth.org/
sec@santishealth.org

For Mr Perry:
Tracey Glaysher
Nuffield Health Guildford
Telephone: 07808 697653
Email: matthewjaperry@gmail.com
Website: www.matthewjaperry.com

For Dr Nicola Valentine *(Psychosexual Specialist)***:**
Sue Scovell
Guildford Nuffield Hospital
Telephone: 01483 569238
Email: info@ear2hear.org.uk

For Mr Moschonas:
Tracey Glaysher
Nuffield Health Guildford
Telephone: 07795 899360
Email: moshurology@gmail.com/
moshurologypa@gmail.com

For Mr Hicks:
Julia Grant, Jennifer Ross, Gilly Norris
Chichester Nuffield Hospital
Telephone: 01243 753054/753014

NHS patients

For Prof Langley:
Toni Manley
The Royal Surrey Hospital
Telephone: 01483 402770
Email: amanley@nhs.net

For Mr Perry and Mr Patil:
Kathryn Thistlewaite
The Royal Surrey Hospital
Telephone: 01483 571122 Ext 2647
Emails: k.thistlewaite@nhs.net

For Prof Eden and Mr Moschonas:
Vanessa Furlonger
The Royal Surrey Hospital
Telephone: 01483 571122 Ext 4467
Email: vanessa.furlonger@nhs.net

For Dr Nicola Valentine *(Psychosexual Specialist)***:**
Kathryn Thistlewaite
The Royal Surrey Hospital
Telephone: 01483 571122 Ext 2647
Emails: k.thistlewaite@nhs.net

Generic email address for all RSCH Urology Secretaries: rsch.urologysecretaries@nhs.net

Out of office hours

For enquiries relating to patient care or problems, please contact:

Private patients:

Surgical Ward
Guildford Nuffield Hospital
Telephone: 01483 571122 Ext 4941

NHS patients:

Urology Ward - Compton
The Royal Surrey Hospital
Telephone: 01483 555881

Patient Notes

Patient Notes

Tailoring Technology to Treatment

The Robotic Prostate
Cancer Centre