How I Do It Series NUMBER 8

Day Case Bipolar Saline Prostatectomy Service

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(Original article published 2013, reviewed 2020)

Patient Selection	• Benign prostatic hyperplasia or carcinoma of prostate. • Any size prostate. • Not contraindicated if known large middle lobe enlargement or a raised PSA suspicious of cancer. • Typically an elderly population with significant co-morbidities, but most will be acceptable including many ASA 3.
Anaesthetic Techniques	• Most patients have a general anesthetic with spontaneous ventilation through a LMA. This facilitates rapid recovery and early ambulation. • Some are managed using a spinal technique; due to its shorter duration of block, hyperbaric 2% prilocaine is now the drug of choice for this. • All patients receive IV gentamicin 2mg/Kg. • Patients receive 1 litre of IV normal saline solution during surgery and 1 further litre over the 2 hours following.
Surgical Technique	• A transurethral resection (TUR) technique using saline irrigation, which is not modified for day surgery. • Continuous activation of the loop is best to optimize the cutting potential. Intermittent activation is also an alternative. • 18 French gauge, Coude tip 3-way catheter with 20ml water to the balloon at the end of surgery. This permits irrigation for 1 to 2 hours if needed. • The irrigation port of the catheter is spigotted prior to discharge. • The patient goes home with a catheter for TWOC* at 2 days by either the Day Ward or district nurse / catheter specialist nurse.
Peri-operative Analgesia	• No pre-operative analgesia • Intra-operative fentanyl and IV paracetamol. • Postoperative regular paracetamol with codeine if needed. • Problems managing post-operative pain are uncommon after bipolar surgery.
Take Home Medication	• Paracetamol and codeine as required for 3 days • No post-operative antibiotics unless concern for infection then oral ciproxfloxacin 500mg bd for 5 days

*TWOC = Trial WithOut Catheter

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Organisational Issues	• The surgical technique for inpatient TURP is the same as for Day-case but staff in both the theatre and recovery areas need to be briefed on irrigation and catheter issues. • The onset of pain during the procedure can signify an over-full bladder. Check drainage before giving supplemental analgesia (e.g., 20 μg fentanyl) or sedation. • Patients who were not previously catheterized may need basic catheter care training, which is best done at the pre-assessment visit. Some patients may be planned for 23-hour stay; most can be discharged within 6 hours of surgery with a catheter. • Information leaflets regarding post-operative recovery and help-line numbers are essential
Common Pitfalls	• Excessive talking by the patient can distort the surgical view • Take great care to minimize intra-operative bleeding. Meticulous haemostasis is the key to success.
Anticipated Day Case Rates	• 90%.