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Robotic Assisted Cystectomy/Cystoprostatectomy

A **Robotic Assisted Cystectomy/Cystoprostatectomy** is a major surgical procedure in which the entire bladder is removed. This operation is most commonly performed to treat invasive or high-grade bladder cancer that cannot be managed with more conservative treatments.

Prof Lawrentschuk performs this surgery using the **da Vinci robotic system**, which provides enhanced precision, visual clarity, and control. It is important to note that the robotic system does not operate autonomously; all movements are directed entirely by Prof Lawrentschuk from a console.

Once the bladder is removed, a new way for urine to exit the body must be created. This is usually achieved using a segment of bowel, forming either an external stoma (ileal conduit) or an internal reservoir (neobladder).

Why is a cystectomy required?

Radical cystectomy is generally recommended to **manage aggressive, life-threatening bladder cancer**. In select cases, it may also be used to treat non-cancerous but debilitating conditions, such as severe interstitial cystitis or bladder damage following radiotherapy.

Before surgery

You will be contacted 1–2 weeks prior to your scheduled procedure with specific fasting instructions and hospital admission details. You will also receive a link to complete your online admission forms.

It is important to advise the rooms if you are taking any **blood thinners** or any prescribed medications for **diabetes or weight loss purposes.** The rooms can be contacted on (03) 9329 1197.

During surgery

The procedure is performed under general anaesthetic. To create working space inside the abdomen, carbon dioxide gas is introduced to inflate the abdominal cavity. Surgery is carried out through six small incisions in the abdomen using minimally invasive techniques.

Structures removed can include:

- The entire bladder
- **In men:** the prostate gland and seminal vesicles (**cystoprostatectomy**)
- **In women**: the uterus, fallopian tubes and ovaries
- Occasionally, the urethra
- Regional lymph nodes if the operation is for cancer

Depending on what you have discussed, Prof Lawrentschuk will either create an **ileal conduit** or a **neobladder**. This is where segment of small bowel is reshaped into a urine-holding reservoir, allowing urine to pass through the urethra in a more natural manner.

Following surgery

Hospital stay

You will be admitted on the day of your surgery, with a typical hospital stay lasting 3-5 nights. Post-operatively, patients may spend the first night or longer in the Intensive Care Unit (ICU). Please note that:

- Normal eating is usually delayed for several days due to bowel inactivity (**ileus**), which can take up to a week to resolve.
- If you have an **ileal conduit**, you will be taught by nurses how to manage your stoma before going home.
- If you have a **neobladder**, you or your carer will be trained to flush the bladder using sterile water via the catheter. The catheters are removed approximately 3–4 weeks after surgery.

Recovering at home

Once at home, please note the following:

- **Swelling of the penis and scrotum** is common in men and may take several weeks to resolve
- **Driving** should be avoided for 4–6 weeks
- **Returning to work** is not recommended for at least 6 weeks
- **Vigorous exercise** or heavy lifting should be **avoided** for 6–8 weeks
- **Fatigue** is common - it may take 3–6 months to regain normal energy levels

Possible side effects

Very common:

- Infertility in men, due to removal of the prostate and seminal vesicles (cystoprostatectomy)
- Erectile dysfunction in men, due to possible nerve damage during surgery
- Infertility in women, particularly if the uterus, ovaries, or fallopian tubes are removed
- Shortening of the vagina in women, which may cause discomfort or difficulty with sexual intercourse

Common (1 in 2 to 1 in 10):

- Cancer recurrence, dependent on pathology results
- Incidental discovery of prostate cancer requiring further management
- Ureteric strictures (scarring at the bowel join), possibly needing further intervention
- Recurrent urinary tract infections
- Kidney stones
- Deterioration of kidney function, potentially leading to dialysis

Occasional (1 in 10 to 1 in 50):

- Leg swelling (lymphoedema)
- Adhesions causing bowel obstruction, which may require additional surgery

When to seek help

Please contact **Prof Lawrentschuk's rooms** at (03) 9329 1197 or attend your nearest **Emergency Department** if you experience:

- Signs of infection, including fever, chills and dark, cloudy urine.
- Long-lasting nausea and vomiting.
- Increasing discolouration, swelling, pain or pus from your surgical sites.
- Black, brown or dark purple skin discolouration of your stoma.
- Excessive pain that you can't control with your prescribed medications.
- Inability to urinate or difficulty urinating

Follow-up and monitoring

A follow-up appointment will be scheduled **6-8 weeks** post-surgery to:

- Review your recovery
- Discuss histopathology results of the removed tissue

Pathology results are typically available within 10–14 days. In some cases, your results may be reviewed in a **multidisciplinary team meeting** to determine the most effective next steps. If this occurs, you will be notified and kept informed of the team's recommendations.