

THE UROLOGY GROUP

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POSTOPERATIVE INSTRUCTIONS for CYSTECTOMY and NEOBLADDER

PREOPERATIVE INSTRUCTIONS

Preoperative work up: You will need to obtain bloodwork, an EKG and chest xray as directed by the Preoperative Department. You may need to contact a primary care provider for a **Medical clearance** to be sure your overall health is optimized for surgery. You may also be directed to contact a cardiologist for a **cardiology (heart) clearance** and/or pulmonologist for a **pulmonary (lung) clearance**.

Stoma nurse: We strongly recommend patients meet with a Stoma Nurse prior to surgery for educational purposes and selection and marking of the ostomy site.

Bowel prep: A bowel prep will be necessary before surgery to clean out the intestine. A clear liquid diet is started two days prior to surgery.

Take half a bottle of **Fleets Phospho-Soda** by mouth at 3:00 pm the day before surgery. Take the other half three hours later at 6:00 pm. You can purchase this over-the-counter at a drug store. On the same day oral antibiotics (erythromycin and neomycin) are taken at 4:00 pm, 7:00 pm and 10:00 pm.

HOSPITALIZATION

Hospital stay: Patients can expect to stay three to seven days in the hospital. Hospitalization can be as long as two weeks if bowel function is slow to return.

Breathing tube: Sometimes a breathing tube is left in overnight if the surgery takes awhile or is later in the day or if there is any difficulty with breathing. The tube is typically removed the following day in the Intensive Care Unit once the Hospitalist doctor is sure you are breathing well.

Nasogastric tube: A clear tube called a nasogastric tube (NG tube) is placed from the nose to the stomach before surgery. This is usually left in place for a day or two after surgery to remove stomach secretions the intestines are not ready to handle yet. Medications may be given through this tube.

DRAINS

Catheters: There will be a **urethral (foley) catheter** coming out urethra (bladder tube) to drain the neobladder. Another catheter called a **suprapubic tube (SP tube)** will also drain the neobladder. It is important to keep both of these catheters secured with a plastic clip and sticker called a Stat lock or with a strap around the leg called a leg strap. If either of the catheters are not well secured or are pulling or tugging, notify your nurse so they can secure them correctly.

Stents: Thin plastic tubes called ureteral stents are placed in the ureters (kidney tubes) and exit out the abdomen. They are connected to a drainage bag. These promote urine drainage and healing where the ureter is connected to the neobladder. These are typically removed two weeks after surgery.

Jackson-Pratt (JP) drain: A surgical drain called a JP drain is placed to drain excess fluids from the abdomen. It is normal to have leakage around the drain. The gauze over the JP drain will be changed as needed when saturated. This will be removed once the drainage decreases.

Sometimes it is removed during hospitalization and sometimes it is removed in the office after discharge. If you are discharged with the drain, the nurse will show you how to care for the drain. Keep a record of the output each day and bring the record to your postoperative appointment.

There will be **skin staples** in the abdominal incision. These will be removed at your postoperative visit.

Incentive Spirometer: This is a breathing machine the nurses will show you how to use. Exhale, then inhale to pull air into the machine, taking a slow deep breath in. Try to get the indicator in the correct spot and hold it there. This helps re-inflate lung pockets that can close during anesthesia. The incentive spirometer helps prevent pneumonia. Do this exercise ten times per hour while awake.

Doing the breathing exercises may make you cough, this is a good thing as it helps clear the lungs of mucous. Holding a pillow to your abdomen during coughing helps decrease the pain from surgery.

Take the Incentive Spirometer home and continue to do the breathing exercises for a week or two.

Activity: It is important to get out of bed to a chair and to walk as soon as possible after surgery. Walking helps with wound healing and return of bowel function. It also helps prevent pneumonia, blood clots in the leg or lung and infections. **Try to walk six times a day.** The nursing staff will help you.

Diet: After surgery the intestines take time to recover. Passing **gas** out the bottom is a sign that the intestines have recovered. Your diet will start with liquids and advance to solid food. If you feel full or nauseated, stop drinking and eating. You do not have to finish what is served on your tray. Try to be patient while your intestines recover. Walking, being out of bed and chewing gum has been shown to help with the return of bowel function.

MEDICATION

Pain medication: While in the hospital you will have intravenous (IV) and eventually, oral pain medicine. You may also have a button you can press as needed for pain medicine or **Patient Controlled Analgesic (PCA)**.

You may also have a pump that slowly delivers pain medicine directly to the incision over 3-4 days, an **On-Q pump**. This is typically removed before you go home.

Once taking pain medicine by mouth, try to use this before asking for IV pain medicine. Pain medicine by mouth lasts longer. These narcotic pain medications slow the return of bowel function and can make you groggy. Take what you need to be comfortable enough to walk six times a day, but do not take more than what you need.

Prevention of blood clots: You will receive shots of blood thinner called **heparin** or **Lovenox** while in the hospital. This helps prevent blood clots in the leg (Deep Venous Thrombosis (DVT) or lung (Pulmonary Embolus (PE)). Stockings called **TEDs** and leg massagers called **Sequential Compression Devices (SCDs)** or "squeezers" also help prevent these clots. Being out of bed and walking as much as possible also helps prevent these clots which can be life-threatening.

NEOBLADDER CARE

Neobladder care is taught by our team of doctors, nurses and the Stoma Nurse during your hospitalization. It is important that you and your family learn how to irrigate and care for the neobladder. Try to take over the irrigation early on. Have your nurse watch you irrigate and make suggestions.

Irrigation: A neobladder is made of intestine. This segment of intestine continues to secrete mucous just like it did when it was part of the intestinal tract. Mucous in the neobladder needs to be irrigated out as it can lead to clogging of tubes, urinary tract infection and stone formation. The nursing staff and Stoma Nurse will teach you how to irrigate your neobladder to evacuate mucous and ensure proper drainage.

A **Toomey syringe** is used to irrigate sterile saline in and out of the bladder. The saline must be sterile, do not use tap water. The syringe holds up to 70 cc (milliliters) of saline. Gently push the saline into the bladder then pull back. Saline mixed with urine and mucous should come back into the syringe.

If it does not, the catheter may be stuck up against the wall of the neobladder. In that case, place two syringe-fulls of saline into the bladder. To do this, inject one syringe-full of saline into the neobladder. Then place your thumb over the catheter or pinch the catheter shut to keep the first syringe-full in the bladder. Draw up a second syringe-full of saline and inject this into the bladder. Then pull back one syringe-full of saline. Then inject a syringe-full again. Continue irrigating leaving one syringe-full of saline in the bladder.

Continue irrigating until all mucous is cleared from the bladder. Irrigate at least once a day or as often as needed to keep mucous from building up in the bladder. Some people need to irrigate up to three times per day initially. The mucous production will decrease over the coming months and years.

PATHOLOGY REPORT

The pathologist will process the bladder and lymph nodes, look at it under the microscope and write a report of the findings. This usually takes 3-7 business days. It can take longer if special stains or processing is required. Once the pathology report is final, it will give more information about the disease and if any additional treatment is recommended, such as chemotherapy.

DISCHARGE

Medications: Once discharged, you may use over-the-counter acetaminophen (Tylenol) as needed for pain. You will also be prescribed a narcotic pain medication. Take this as needed for pain management that will allow walking. The narcotic also contains acetaminophen – do not exceed 4000 mg acetaminophen per day.

You will also be given a **stool softener** or laxative upon discharge. Hold this medication if experiencing diarrhea or loose stools. Use prune juice, your own regimen or over-the-counter stool softeners as needed to prevent constipation.

Diet: Be sure to drink plenty of fluids and stay hydrated. Your appetite and sense of taste will be slow to return following surgery. Eat small, frequent meals. Avoid large heavy meals.

Home Health Care with a visiting nurse may be arranged prior to discharge to continue neobladder education.

Activity: Walk at least six times per day. Avoid strenuous activity or lifting more than a gallon of milk (10 pounds) for eight weeks. You may go up stairs.

Bathing: The first several days the nurse will assist you with sponge bathing. Try to do as much of this yourself as possible to familiarize yourself with your new anatomy. You may shower once all the drains have been removed. Remove all dressings. Let warm soapy water run over the incisions and conduit. Do not rub or scrub the incisions. Once out of the shower, pat the area dry. No dressing is necessary but you may place an over-the-counter gauze and tape over incisions if they have a bit of clear or bloody fluid. This is part of the healing process.

Tub baths are not to be taken until your incision is completely healed.

Postop appointments: Call the office to make an appointment for stent removal if you do not already have an appointment. At your first visit, the JP drain may be removed and the staples may be removed from the incision. The drain site will take a few days to seal. Place over-the-counter gauze and tape over the site as needed for drainage. Change the dressing once saturated, at least daily.

Strong band-aids called **Steri strips** will be placed over the incision. These will fall off on their own in one to two weeks. You may shower with the Steri strips in place. Let warm soapy water run over the strips, do not scrub them. Pat dry with a towel once you are done bathing.

The **suprapubic catheter** and **ureteral stents** are typically removed 1-3 weeks after surgery.

The **urethral (foley) catheter** is typically removed 3 weeks after surgery.

Timed voiding: The neobladder doesn't have the same nerve supply as your normal bladder so you will not have the same sensation of the need to urinate. For the first few months after surgery, you should urinate "by the clock" rather than waiting for the urge to go to the bathroom. After the urethral (foley) catheter has been removed in the office, you should urinate every 2 hours, day and night for the first week. During the second week, urinate every 3 hours, and during the third week you can stretch the period between voiding to 3 to 4 hours. You should continue to get up twice a night to empty the bladder.

The neobladder continues to enlarge and function better even over the first one, two, and three year, so you must be patient. However, initially patients have more incontinence during the night and most of them will wear an incontinence pad. Leakage of urine during the day is unlikely and usually improves quickly.

Also, the neobladder doesn't contract (squeeze out the urine) like a normal bladder does. To urinate, you need to relax the sphincter muscles and push with the abdominal muscles, the same as if you were having a bowel movement. Take your time to make sure the bladder is emptied well. Kegel exercises can help you learn how to do this.

Leakage of urine: You may notice leakage of urine from the neobladder, particularly at night. This will decrease with time. To minimize this, be sure to irrigate the neobladder before bed. Be sure to completely empty the bladder before bed, either by urinating or with the catheter. Kegel exercises can also help decrease leakage.

Catheterization: Sometimes the neobladder does not empty completely on its own. In this case, **clean intermittent catheterization** will be needed. This is performed by placing a well-lubricated catheter in the neobladder. Sometimes this is needed each night before bed to evacuate residual urine that has built up. This can be done at the same time as irrigation.

Sometimes the neobladder does not empty on its own at all. In this case, clean intermittent catheterization is performed every six hours.

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References: Davis CB, Breyer BN and Konety BR: Urostomy Creation and Management of Complications. AUA Update Series 2010, Lesson 35, Volume 29. © 2010 American Urological Association, Education and Research Inc., Linthicum, MD.

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