Robotic Radical Prostatectomy with Bilateral Pelvic Lymph Node Dissection

What to expect before surgery

Purpose of this guide

This guide explains the surgery, the hospital stay, the catheter, recovery, cancer follow-up, and common quality-of-life issues. It is written to help you and your family know what to expect.

What is this surgery?

A robotic radical prostatectomy is surgery to remove the prostate because of prostate cancer. During surgery, the prostate and seminal vesicles are removed. The bladder is then reconnected to the urethra, which is the tube you urinate through.

A bilateral pelvic lymph node dissection means lymph nodes from both sides of the pelvis are also removed and checked for cancer cells. The robot does not do the surgery by itself - your surgeon controls the instruments the entire time.

Why are lymph nodes removed?

Prostate cancer can sometimes spread to the pelvic lymph nodes. Removing lymph nodes gives more accurate cancer staging and helps decide whether surgery alone is enough or whether additional treatment, such as radiation therapy or hormone therapy, should be discussed later.

Getting ready before surgery

- Follow instructions about blood thinners, aspirin, diabetes medicines, supplements, eating, drinking, and arrival time.
- Arrange for a responsible adult to drive you home and for help at home for the first few days.
- Walk regularly before surgery if you are able and try to avoid constipation going into surgery.
- Learn or start pelvic floor exercises if instructed.
- Buy pads or Depends before surgery. Leakage is expected after the catheter is removed.

Hospital stay

Most patients stay in the hospital for **1-2 nights**. You will wake up with:
- **Foley catheter:** drains urine while the new connection heals. Most patients keep it for **1-2 weeks**.
- **JP drain:** removes extra fluid from the surgery area and is usually removed before you go home.

Walking starts soon after surgery to help prevent blood clots and help the bowels wake up.

Catheter and cystogram

Before the catheter is removed, you will usually have a **cystogram**. This is an X-ray test that fills the bladder with contrast through the catheter to make sure the bladder-to-urethra connection is sealed and healing well.

If there is still a small leak, the catheter may need to stay in longer.

What is life like with the catheter?

The catheter can be annoying or uncomfortable, but it is temporary and important for healing. You will be taught how to use a larger nighttime bag and a smaller daytime leg bag.

It is common to have catheter discomfort, bladder spasms, pink or blood-tinged urine, mild leakage around the catheter, and penile or scrotal swelling or bruising. Bring pads or Depends to the catheter removal visit because leakage usually starts right away.

Appetite, bowels, energy, and pain

A low appetite, bloating, gas discomfort, constipation, and low energy are common. Many patients do not feel fully normal with appetite, bowels, and energy for about **2-3 weeks**, although this usually improves steadily.

Pain is usually manageable. Many patients say the bloating, gas pain, catheter discomfort, and sitting discomfort are more bothersome than the small incisions.

Final pathology

The prostate and lymph nodes are sent for a detailed pathology review. Final pathology usually takes about **3-4 weeks**.

The report helps confirm the final cancer grade, whether the cancer appears fully removed, whether cancer was found outside the prostate or in lymph nodes, the risk of recurrence, and whether any additional treatment may be needed.

Cancer control and PSA follow-up

The goal of surgery is to remove the prostate cancer, but no surgery can guarantee a permanent cure. After surgery, we estimate the risk of recurrence based on the final pathology report and PSA blood tests over time.

The PSA should drop to a very low or undetectable level after the prostate is removed. The first PSA is usually checked about **6-8 weeks** after surgery, then PSA monitoring continues long-term.

Some patients may need additional treatment after surgery. Radiation recommended because of higher-risk pathology is called **adjuvant radiation**. Radiation recommended later if the PSA rises is called **salvage radiation**. Needing additional treatment does not mean the surgery failed - it means the pathology and PSA guide the next best step.

Urine control

Urine leakage is expected after the catheter comes out. Most patients need pads or Depends at first. In my practice, about **80-85%** of patients regain good urinary control. Recovery can take up to **6 months**, and sometimes longer, but many patients improve faster.

Erections and sexual function

Erections usually get worse right after surgery. If it is safe from a cancer standpoint, nerves may be spared, but recovery can take up to **2 years**. A realistic expectation is about **50% of baseline**, depending on age, health, baseline erections, cancer location, and nerve-sparing. Orgasm may still be possible, but ejaculation will be dry and natural fertility is no longer possible.

Activity, driving, work, and exercise

Walking is encouraged right away. Driving, work, lifting, and exercise depend on the catheter, pain level, pain medicine use, and your type of job.

In general, avoid heavy lifting and strenuous exercise for several weeks, do not drive while taking narcotic pain medicine, and expect several weeks before you feel ready for normal daily routines. Desk work may be possible sooner than physically demanding work.

Important risks to understand

Prostatectomy risks

Most patients recover without a major complication, but possible risks include bleeding, infection, blood clots, hernia, injury to nearby structures, longer hospital stay, readmission, or rare need for another procedure.

A urine leak from the new bladder-to-urethra connection can happen. It often heals with more time, but may require a longer catheter, repeat imaging, longer drain use, or rarely another procedure.

Robotic positioning risks

During robotic prostate surgery, the head is lower than the feet. This helps move the intestines away from the pelvis.

This can cause temporary swelling of the face, eyes, throat, or airway and can stress the lungs and heart during anesthesia. It is usually well tolerated, but matters more for patients with significant heart, lung, or weight-related health issues. Rare temporary nerve or joint symptoms can happen from positioning.

Lymph node risks

Lymph node removal can cause a lymphocele, which is a collection of lymph fluid in the pelvis. Other risks include leg, groin, penile, or scrotal swelling; longer-lasting lymphedema; infection of a fluid collection; blood clot risk; longer drainage; and rare injury to nearby blood vessels, nerves, or the ureter.

Many lymph fluid collections are small and go away on their own. Rarely, antibiotics, drainage, or another procedure is needed.

Big picture recovery timeline

Hospital stay: usually 1-2 nights
JP drain: usually removed before discharge
Foley catheter: usually 1-2 weeks
Cystogram: before catheter removal
Appetite/bowels/energy: often 2-3 weeks to feel more normal
First PSA: usually 6-8 weeks after surgery
Final pathology: usually 3-4 weeks
More normal routine: often 3-6 weeks
Urine control: improves over weeks to months
Erection recovery: can take up to 2 years