Patient Information

Royal Devon University Healthcare NHS Foundation Trust

Transurethral Resection of a Bladder Tumour (TURBT)

+/- mitomycin C

Introduction

We expect you to make a rapid recovery after your operation and to experience no serious problems. However, it is important that you should know about minor problems, which are common after this operation, and also about more serious problems that can occasionally occur. The section ***"What problems can occur after the operation?"*** describes these, and we would particularly ask you to read this. The headings from this section will also be included in the consent form you will be asked to sign before your operation.

What is a TURBT (Transurethral resection of a bladder tumour)?

A transurethral resection of a bladder tumour is an operation to remove a tumour from the inner lining of your bladder. This is done with a telescopic instrument passed up your waterpipe (urethra). Therefore there is no external wound or stitches.

Why do you **need a TURBT?**

You may have had a flexible cystoscopy (bladder examination with a camera) or other tests that show you have a tumour in your bladder. A TURBT is the standard treatment for bladder tumours. We need to remove the tumour and have it examined under a microscope to see if cancer is present.

Reasons for having a TURBT – (e.g. "Is a hernia harmful?")

Removal of the tumour can help prevent issues such as persistent bleeding, pain and bladder irritation.

Most tumours are confined to the surface of the bladder, therefore removal at an early stage can help prevent it from growing into the bladder wall, or recurring in the future.

Alternative treatments

The first treatment for all new bladder tumours is a TURBT. However, if you have had bladder tumours removed previously and develop a recurrence, you may be offered a transurethral laser ablation (TULA) instead.

The TULA is carried out under a local anesthetic in the out-patient department at Ottery St Mary Hospital. This involves a quick visit to the hospital, and is very similar to having a flexible cystoscopy. Therefore you can eat and drink as usual, take your usual medication (including any blood thinners), and drive yourself home.

How is a diagnosis made?

Once removed, the tumour is sent to the laboratory for analysis. The results tell us whether there is cancer present and assesses how deeply the tumour has grown in to the bladder wall. This

helps us to plan any further treatment that may be required.

You may have a CT scan to help with the diagnostic process to see if there are any problems outside of the bladder that may be related to the bladder tumour.

What does the TURBT procedure involve?

You will need an anaesthetic for the operation. Usually this will be with you fully asleep under a general anaesthetic, however it can also be carried out under a spinal anesthetic (which means you are numb from the waist down).

After you have been anaesthetised, your surgeon will pass a cystoscope through your urethra and into your bladder. This enables the surgeon to see your bladder lining.

The visible tumour(s) will be cut away from the lining, and deeper biopsies may be taken. Any bleeding is controlled with diathermy (a mild electrical current) to seal the blood vessels

A TURBT is usually a daycase procedure, and you will come in to hospital on the day of your operation. You will need someone responsible to stay with you that night and will not be able to drive for at least 24 hours afterwards.

The length of the operation depends on the size of the tumour, but is usually 15 minutes up to an hour.

Once the operation is finished, you will be transferred to the recovery room to allow the anaesthetic to wear off. You will then return to the Day Case Unit, or if you need to stay overnight for observation due to any persistent bleeding you will be transferred to a ward.

A single dose of Mitomycin C (MMC), which is a chemical treatment, may be given via a catheter in theatre at the end of the operation to help prevent tumour recurrence. This will depend on the appearance of the tumour, and the bladder lining after surgery.

What about the anaesthetic?

Most people will have a general anaesthetic. This will mean you are unconscious (asleep) during your operation and you will not feel any pain. A spinal anaesthetic involves a needle being inserted in to your back and local anaesthetic is injected around the spinal nerves. This numbs the lower half of your body. You will be awake but unable to feel anything from the waist down. You may also have sedation, which will make you feel drowsy but not put you to sleep.

Your anaesthetist will discuss all your options before your operation.

What happens before the operation?

You will need an appointment with the preparation for surgery nurses to complete all of the necessary safety checks ahead of the anaesthetic. This appointment takes up to 1 hour, and will usually be booked 1-3 weeks in advance of the operation. You may have been offered the opportunity to get this done on the same day as the flexible cystoscopy, depending on which hospital you attended.

Please bring all the medicines that you are taking with you. If you are taking Warfarin or Clopidogrel you will need to stop taking them for a short period. Your pre-operative assessment nurse will discuss this with you. Please do not stop taking any medications unless told to by your doctors/ pre-assessment nurse. They will also provide advice about when to stop eating and drinking before the anaesthetic.

Your Consultant or Registrar will see you on the morning of your operation to discuss the surgery and answer any questions you may still have.

Shortly before your surgery, you will be asked to put on a theatre gown and some tight-fitting anti-thrombus stockings. These will help prevent blood clots forming in your legs post-operatively.

You will then be escorted to theatre by a member of the ward or theatre staff for your operation.

What happens after the operation?

You may have a catheter in your bladder (this is a hollow tube which drains urine from your bladder into a drainage bag). Your urine will be blood stained following this operation.

If there is persistent bleeding, bladder irrigation may be required. This helps to flush debris and blood clots out of your bladder.

You may have a drip in your arm until you are eating and drinking.

Drinking plenty of fluids is encouraged.

Early mobilisation is also encouraged.

The catheter will usually be removed after 24-48 hours (when your urine is almost clear). In most cases your catheter is removed prior to you being discharged. However, in some cases, it may be necessary to have a catheter for a short while to allow your bladder to heal.

The results from the laboratory take approximately 2 weeks to become available. You will usually be seen in an outpatient clinic soon after this to see how you are recovering, and to discuss the result, and whether any further treatment is needed.

Discharge from hospital

If you do not have a catheter in your bladder, it is very important for the nursing staff to ensure that you are passing urine with no problems before sending you home.

If you **do** have a catheter into your bladder, once the urine draining into the catheter bag has minimal visible blood in it, it will be removed. Once you pass urine, you will be able to be sent home.

Common risks

Mild burning or bleeding on passing urine for a short period after the operation.

Temporary insertion of a catheter for bladder irrigation.

Need for additional treatment to the bladder in an attempt to prevent recurrence of tumours including drugs instilled in to the bladder.

Occasional risks

Infection of bladder requiring antibiotics.

No guarantee of cancer cure.

Recurrence of bladder tumour and/or incomplete removal.

Deep vein thrombosis (DVT)

Deep vein thrombosis is a possible problem, but is uncommon. If you are at particular risk then special precautions will be taken to reduce the risk. Moving your legs and feet as soon as you can after the operation and walking about early all help to stop thrombosis occurring.

Rare risks

Delayed bleeding, requiring removal of clots or further surgery.

Damage to ureters (drainage tubes from kidneys) requiring additional therapy.

Injury to urethra causing delayed scar formation and potential narrowing (stricture).

Perforation of the bladder requiring a temporary urinary catheter or open surgical repair.

The risks of a general anaesthetic

General anaesthetics have some risks, which may be increased if you have chronic medical conditions, but in general they are as follows:

Common temporary side effects (risk of 1 in 10 to 1 in 100) include bruising or pain in the area of injections, blurred vision and sickness, these can usually be treated and pass off quickly.

Infrequent complications (risk of 1 in 100 to 1 in 10,000) include temporary breathing difficulties, muscle pains, headaches, damage to teeth, lip or tongue, sore throat and temporary problems with speaking.

Extremely rare and serious complications (risk of less than 1 in 10,000). These include severe allergic reactions and death, brain damage, kidney and liver failure, lung damage, permanent nerve or blood vessel damage, eye injury, and

damage to the voice box. These are very rare and may depend on whether you have other serious medical conditions.

What should you do if you develop problems?

In the first instance contact your GP. Your GP will then advise you whether or not you need to come in to hospital for a review. You can call **111** for advice outside of normal working hours.

If you are passing large amounts of blood or blood clots in your urine, or cannot pass urine at all, then you should visit the Emergency Department.

Do you need to return to hospital for a check?

You will usually receive an appointment to have a "check" cystoscopy 12 weeks post-operatively. This is a test with a flexible telescope while you are awake to look in to your bladder and assess your progress. But we may need to see you before that to discuss additional treatment options.

Who should you contact in an emergency?

Office hours .....your GP or **111**

Out of hours
(evenings, weekends, Bank Holidays) ....**111** or **999**

Dart Ward **01392 402735**

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