L'AIISOC en Bref — Printemps 2006 (cont.)

- La réunion d'automne 2006 des conseils exécutif et administratif à Toronto comprendra également une réunion de planification stratégique de deux jours. Le but de cette réunion sera de développer de nouveaux objectifs et de créer un plan d'affaires qui régira l'avenir de l'AIISOC.

- Le comité de normes a terminé la révision du Module 2 visant la prévention et le contrôle de l'infection (*Infection Prevention and Control*), la sortie du module nouvellement mis à jour étant prévue pour cet automne. Le prochain module qui sera révisé est le Module 1 portant sur les croyances et les normes professionnelles de l'AIISOC (*ORNAC Beliefs and Professional Standards*). Si vous avez de l'expertise dans ce domaine, des suggestions de sujets de revue ou que vous aimeriez aider avec la mise à jour, veuillez envoyez un courriel à standards@ornac.ca.

- Les critères de plusieurs nouveaux prix sont également en cours de développement. Informez-vous sur les nouveaux prix ainsi que sur ceux actuellement offerts en visitant www.ORNAC.ca.

- La subvention de recherche Cardinal Health Grant de 2006 sera décernée pendant une conférence provinciale cet automne. Demeurez à l'écoute pour connaître le nom du récipiendaire et les points saillants du projet de recherche.

- En raison de modifications apportées aux règlements relatifs à l'élection du trésorier, pour la première fois notre nouveau trésorier fut élu l'année précédant la conférence et non l'année même de celle-ci. Étant donné que le rôle de trésorier a grandement changé au cours des dernières années, nous avons décidé qu'il serait prudent de ne plus changer de trésorier pendant l'année de la conférence. Le poste de trésorier de l'AIISOC 2006-2008 sera comblé par Alaine Young (ON). Ray Larkins, trésorier actuel, transférera ses responsabilités à Alaine au mois de novembre de cette année.

- Nous sommes contents d'annoncer que plusieurs programmes de formation en soins périopératoires sont en cours d'évaluation pour l'approbation de l'AIISOC. Pour de plus amples renseignements sur l'évaluation, veuillez envoyer un courriel à perioperativeeducation@ornac.ca.

- Notre présidente, Marcy McKay, s'est récemment présentée en tant que représentante de l'AIISOC à plusieurs conférences : la conférence mondiale sur les soins de patients chirurgicaux (*World Conference on Surgical Patient Care*) à Barcelone en Espagne; le congrès de l'AORN à Washington DC; et la conférence de l'association européenne d'infirmières et d'infirmiers de salle d'opération (*European Operating Room Nurses Association*) à Dublin en Irlande, cette dernière étant en association avec la réunion du conseil exécutif de la *International Federation of Perioperative Nurses*. Ici au Canada elle a également assistée aux conférences provinciales en Colombie-Britannique, Alberta, Manitoba et Saskatchewan.

- L'ancienne présidente Margaret Farley et la présidente désignée Linda Socha ont également participé à la réunion du conseil exécutif de l'IFPN à Dublin.

- Marcy McKay et Margaret Farley présenteront un discours le mois prochain à la réunion de *l'Association for Perioperative Practice* (AfPP) à Harrogate au R-U.

- Pour la toute première fois, des représentants de la IFPN présenteront des discours à la conférence nationale de l'AIISOC. De plus, des représentants de deux de nos associations affiliées, les *Canadian OR Leaders* (CORL) et le *Registered Nurse First Assistant Network of Canada* (RNFANC), animeront plusieurs sessions. Gardez l'œil ouvert pour les nouveaux membres de conseil affiliés, et leurs drapeaux, pendant le défilé des cérémonies d'ouverture. Et n'oubliez pas de visiter le kiosque de l'AIISOC pour voir tout ce qu'il y a de nouveau!

PROSTATECTOMIE LAPAROSCOPIQUE RADICALE : UNE TECHNIQUE MOINS EFFRACTIVE

Auteure : *Judy Paré, infirmière autorisée, est la coordonnatrice des soins urologiques périopératoires au Regina Qu'appelle Health District à Regina en Saskatchewan.*

RÉSUMÉ

L'auteure discute de prostatectomie laparoscopique radicale en examinant la sélection et l'évaluation des patients, l'approche, l'expérience périopératoire des patients et en comparant la prostatectomie ouverte et la prostatectomie laparoscopique.

LAPAROSCOPIC RADICAL PROSTATECTOMY: A LESS INVASIVE APPROACH

Author: *Judy Paré, RN, is the Urology Co-coordinator in the operating room of the Regina Qu'appelle Health District in Regina, SK.*

ABSTRACT

The author discusses laparoscopic radical prostatectomy from the perspective of patient assessment/selection, approach, patient perioperative experience, and a partial comparison between open and laparoscopic prostatectomy.

With the widespread use of the prostate specific antigen (PSA) test since the 1990s, more men are now diagnosed with early prostate cancer. For those who are in reasonable health and expected to live at least 10 years or longer, surgical removal of the prostate remains an excellent treatment option and, in fact, provides many men with the opportunity of a long-term cure.[1]

Opportunities for cure increase when men are more informed of the need for testing. Men should be encouraged to get their PSA checked as often as women go for a mammogram. By encouraging men to talk about their symptoms, and by keeping nurses across the country informed about new techniques, we increase our ability to help the men in our lives survive prostate cancer.

WHAT IS RADICAL PROSTATECTOMY?

The prostate in an older man is a somewhat larger than walnut-size gland wedged in between the lower end of the bladder and the base of the penis. Radical prostatectomy refers to the total surgical removal of the prostate gland and its cancer.

At the point where the lower tip of the prostate meets the base of the penis there is a tubular muscular structure responsible for bladder control, called the external urinary sphincter. In addition, two erectile nerves run closely alongside the prostate from its base to its tip. If these nerves are cut during surgery, the patient stands a good chance of losing his ability to have an erection. The challenge is to remove all the cancer, while assuring the maximal bladder control and erectile function possible.

The surgeon will try to achieve four main goals:

- complete removal of the prostate cancer;
- maximal preservation of the urinary sphincter in order to maintain good bladder control after surgery;
- preservation of the erectile nerves when possible, to allow good return of potency; and
- minimizing patient suffering during the surgery and recovery.

In Canada, three different surgical approaches are available – open radical retropubic prostatectomy, perineal prostatectomy, and laparoscopic radical prostatectomy.

Open radical retropubic prostatectomy is by far the one most commonly used in this country. It was the most common method used prior to laparoscopic surgery. During this procedure the

Isabelle Adams Award For Excellence In Perioperative Nursing

This award is presented at the National Conference, if there is a suitable candidate, to an outstanding nurse who through major commitment has made a significant contribution to perioperative nursing in Canada. The Award winner will reflect the practice and ideals of Mrs. Isabelle Adams of Montreal. The Award was established on the initiative of the Operating Room nurses of Quebec in 1987 and is one of high-profile recognition with no monetary award. **Nomination deadline is December 31st.**

More details can be found at www.ORNAC.ca

Le Prix d'excellence en soins périopératoires Isabelle Adams

Ce prix est décerné lors de la Conférence nationale de l'AIISOC à un candidat qualifié qui s'est distingué par son engagement et par sa contribution significative au domaine des soins périopératoires au Canada. Le récipiendaire sera une infirmière ou infirmier de salle d'opération dont la pratique professionnelle suit les principes de Mme Adams de Montréal. Ce prix hautement reconnu, mais ne comportant aucune récompense monétaire, fut créé en 1987 par l'Association des infirmières de salle d'opération du Québec.
La date limite des soumissions est le 31 Decembre.

Veuillez visiter le site Web de l'AIISOC (www.ORNAC.ca) pour plus de détails.

Laparoscopic Radical Prostatectomy (cont.)

surgeon makes a cut on the lower half of the abdomen, usually from the belly button down to the base of the penis.

In perineal prostatectomy, an incision between the scrotum and the anus allows the surgeon access to the prostate gland.

The newest method, and a less invasive technique, is laparoscopic radical prostatectomy. In this procedure, the surgeon makes only five tiny (stab) incisions (about 1/2 to 1 cm long) and inserts a laparoscope and other laparoscopic instruments through the incisions. Using the Laparoscopic instruments the surgeon then dissects the prostate gland from the bladder and the base of the urethra, places it inside a purse string bag, and then removes it through the incision just under the belly button (the incision will be increased in size if required).

THE SURGICAL PROCESS:

The following steps are involved in laparoscopic radical prostatectomy surgery:

Consultation.
Once a biopsy has confirmed a diagnosis of prostate cancer the urologist begins to discuss treatment options with the patient. By factoring in all the relevant available information– the man's age and health, PSA test results, results of the rectal examination, Gleason Score (a measure of the aggressiveness of the cancer) and percentage of positive biopsy cores (how much cancer is in the tissue sample) – the surgeon makes an educated guess about the stage of the cancer and recommends the reasonable treatment options. Once the patient and the surgeon discuss, and agree upon, a surgical treatment the surgeon will provide further important information regarding the best surgical approach, bladder control after surgery and the probability of preserving erectile function. Finally the surgeon will discuss any possible complications that might arise from the operation. These include a 5% incidence of severe urinary incontinence, a 50% incidence of impotency, with minimal perioperative morbidity including bleeding and adjacent organ injury (i.e. tear in the rectum).[2]

Preparation for Surgery:
Approximately one week before the operation, the patient will undergo various blood and urine tests, a chest x-ray, an electrocardiogram and, on occasion, an assessment by a medical specialist, such as an anesthetist or cardiologist, to ensure he's healthy enough to withstand the surgery. On the day prior to the surgery the patient will be restricted to a liquid diet until 8 hours before the surgery, at which time he will be required to fast. On the evening before the procedure he will need to give himself a small fleet enema to empty the rectum.[3]

Intra and Post-Operative Processes:
The patient is admitted on the morning of the surgery and will receive a general anaesthetic. Laparoscopic surgery generally takes about 2 1/2 to 3 1/2 hours.

During the procedure, the surgeon carefully dissects the nerves away from both sides of the prostate gland (nerve sparing, to help keep the man potent after surgery). This is the most difficult part of the surgery and not all surgeons do nerve sparing laparoscopically. The surgeon then dissects the prostate away from the bladder neck and urethra at the base of the prostate and does the anastomosis by rejoining the bladder neck opening to the urethra. The surgeon may also, at this time, inspect the rectum to make sure no tears have occurred from inside. This can be done by placing a sterile glove over the one currently being worn, doing a rectal examination while monitoring visually via the laparoscope. A catheter is then inserted and will remain for on average one week while the anastomosis heals.

Post-operatively, the patient will be taken to the recovery room prior to being sent back to his hospital room. He will have a urinary catheter and a drainage tube (15fr. Round Jackson Pratt drain) in his lower abdomen. The catheter, there to assist with the healing of the urethra until the anastomosis is healed, can usually be removed one week after the surgery. The drainage tube allows the surgeon to detect any urinary leakage at the anastomosis site and, if none is detected,

Continued on Page 36

it is removed the day after surgery. On the evening after the surgery, the patient is allowed to get out of bed, start drinking liquids and have visitors. Most patients will be discharged after breakfast the next morning.

CONVALESCENCE:

The patient's activities are restricted for two weeks – no driving, heavy lifting or strenuous work. Often what's most bothersome is the presence of the urinary catheter but, fortunately, this is usually removed within a week. The exception would be cases where the surgeon felt that there were bleeding complications and the healing process might be slower.

RETURN OF BLADDER CONTROL AND ERECTILE FUNCTION:

Bladder control will not return overnight but will it improve slowly and steadily. About 50% of men who undergo laparoscopic prostate surgery will have full function within three months, and about 90% regain control in six months. During this period, wearing a protective pad will be necessary. Similarly, for patients who have "nerve-sparing" procedures, the return of erectile function is also gradual. Only about one-half- to two-thirds of patient will have full recovery of erectile function, and this can take anywhere from three to 24 months. The man starts to develop a partial erection during this time. Oral medications such as sildenafil, tadalafil or vardenafil can help to speed up recovery.[1]

LAPAROSCOPIC VERSUS OPEN SURGERY:

To date there have not been any studies conducted to document the direct comparison between the two different surgical approaches. While radical retropubic prostatectomy has a longer history than laparoscopic surgery the early results from the newer technique are very promising.[1]

It is now generally accepted that, in experienced hands, both procedures provide equal cancer control, bladder control and preservation of erectile function.

The main advantage of laparoscopy is that it is less invasive. The patient now requires an overnight stay (compared to 5 or more days in hospital for the open procedure) and the incisions are extremely small (compared to an open incision of about 4 inches).

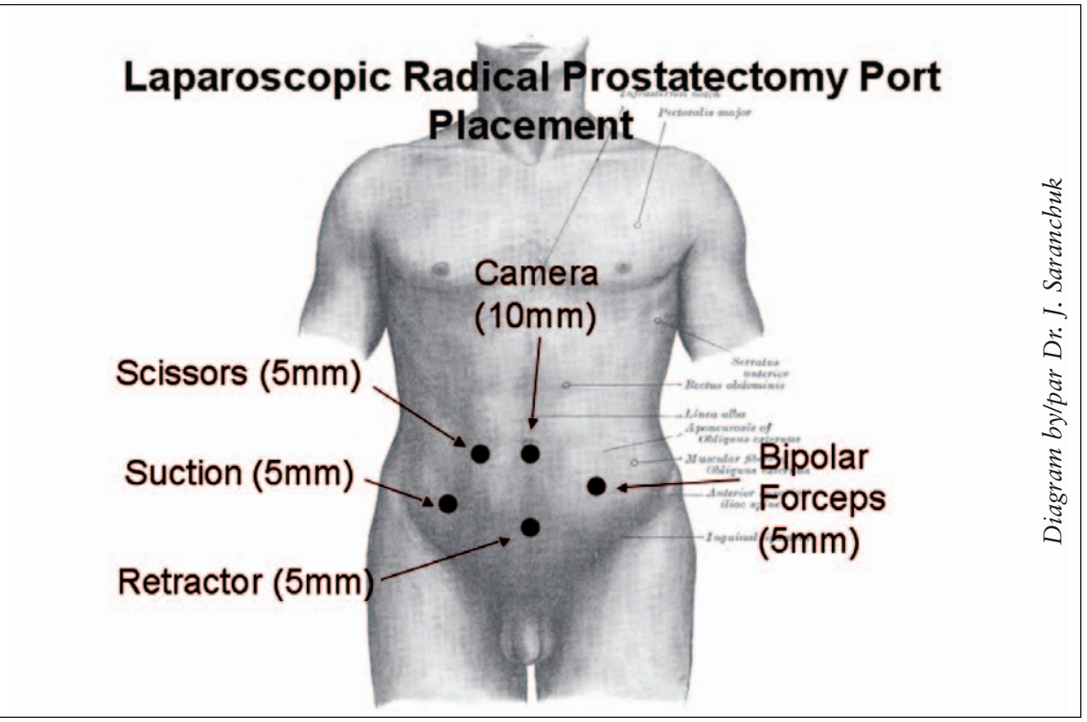

Diagram by/par Dr. J. Saranchuk

On the other hand, laparoscopic surgery takes longer to perform than open surgery resulting in the patient being under general anaesthesia for a longer period of time. But the future looks bright for the laparoscopic approach. With the 12-times magnification capability it offers, surgeons have the unique opportunity to perform meticulous dissection and the potential for continuing to improve the surgical results.

BENEFITS OF LAPAROSCOPIC SURGERY (COMPARED WITH OPEN SURGERY) FOR PROSTATE CANCER:

- equal cancer control, bladder control and preservation of erectile function compared with open surgery;
- minimally invasive;
- smaller chance of requiring blood transfusion;
- less need for postoperative pain medication;
- shorter hospital stay;
- faster recovery time; and
- smaller chance of developing complications (e.g. narrowing at the point where the bladder is rejoined to the base of the penis).[1]

As this paper is being written more new techniques and ideas are being tried to perfect this operation to enable a man to be cancer free from the prostate, to have almost complete, if not total, control back of his bladder function, and to be potent post operatively. The author's healthcare facility had, as of June 2006, completed over 600 of these procedures.

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1. *Our Voice* – Special Edition.
2. Ed Tse, M.D. and Russel Knaus M.D. "Laparoscopic Radical Prostatectomy – results of 200 consecutive cases in a Canadian Medical Institution". *The Canadian Journal of Urology,* 11.2 (2004) : 2177.
3. *Ibid*, page 2173.

UPCOMING EVENTS

For details visit www.ornac.ca

PROVINCIAL & REGIONAL CONFERENCES

Alberta	Red Deer	October 25-28, 2006
Quebec	Laval	November 7-10, 2006
Atlantic Conference	Halifax	October 4-7, 2006

ORNAC CONFERENCES

www.ornac.ca

20th National	Victoria, BC	April 23-27, 2007
21st National	St. John's, NL	June 7-12, 2009

INTERNATIONAL CONFERENCES

ACORN	Surfer's Paradise, Australia	May 21-24, 2008
AORN (www.aorn.org)	Orlando, USA	March 11-14, 2007
NATN (www.natn.org)	Harrogate, UK	October 9-13, 2006

ANAESTHESIA

CAS (www.cas.ca)	Calgary, AB	June 22-26, 2007