PROSTATIC URETHRAL LIFT (UROLIFT®) IMPLANT

Information about your procedure from
The British Association of Urological Surgeons (BAUS)

This leaflet contains evidence-based information about your proposed urological procedure. We have consulted specialist surgeons during its preparation, so that it represents best practice in UK urology. You should use it in addition to any advice already given to you.

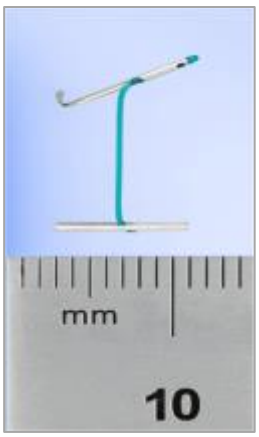
To view the online version of this leaflet, type the text below into your web browser:
http://www.baus.org.uk/_userfiles/pages/files/Patients/Leaflets/Urolift.pdf

Key Points

- The Urolift® procedure involves passing a telescope through your urethra (waterpipe), and putting two to four implants into your prostate to pull the obstructing tissue away from your urethra
- It is designed to improve your urinary flow without the need for burning or removing any prostate tissue
- You do not usually need to have a catheter put in after this procedure
- Sexual side-effects such as retrograde (dry) ejaculation or erectile dysfunction (impotence) are very rare
- In a small number of men who have this surgery, further treatment may be needed at a later stage

What does this procedure involve?

Your prostate gland sits around your urethra (waterpipe) as it leaves the bladder and, when it enlarges, it can block the flow of urine

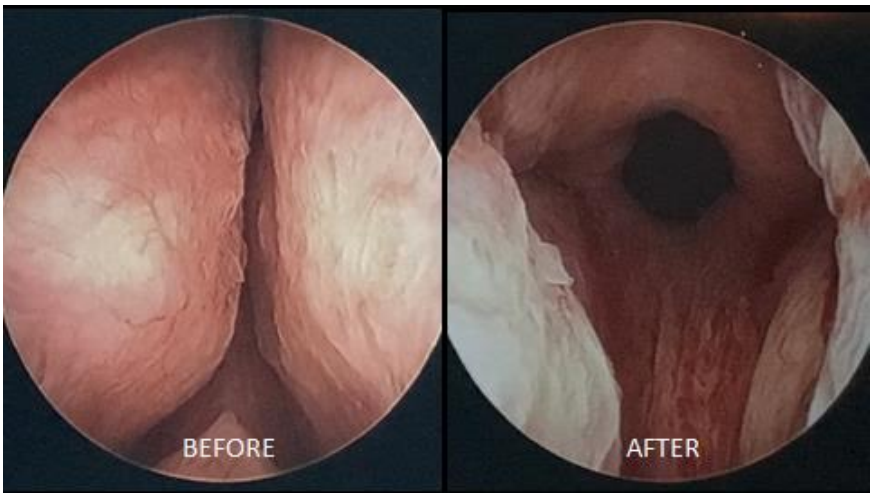


The Urolift®procedure involves passing implants into your prostate, using a telescope passed into your bladder. The implants (pictured) are placed between the inner and outer surfaces of the prostate, so that they pull the obstructing prostate lobes away from your urethra. They become incorporated into the prostate tissue within three months, so they cannot be seen in your bladder after that.

The main benefits of this procedure, compared with other surgical treatments for prostate enlargement, are:

- a short stay in hospital;
- a minimally-invasive (minor) procedure; and
- no sexual side-effects such as retrograde (dry) ejaculation or erectile dysfunction (impotence).

Your urologist can tell you whether the size and shape of your prostate means that this procedure is suitable for you, but it cannot be used in all men with prostate enlargement. The images below [1] show how the obstructing prostate tissue looks before and after the procedure:



What are the alternatives?

- **Conservative treatment** – restricting your fluid or caffeine intake to improve your urinary symptoms and help you avoid surgery
- **Drug treatment** – using either finasteride (to shrink your prostate) or drugs which relax the muscles in the prostate (e.g. tamsulosin) to improve urine flow
- **Transurethral resection of the prostate (TURP)** – removing the central, obstructing part of your prostate with electric current, using a telescope passed along your urethra
- **Holmium laser enucleation of the prostate (HoLEP)** – removing all the obstructing prostate tissue with a laser, using a telescope passed along your urethra
- **Photo-selective vaporisation of the prostate ("green light" laser prostatectomy)** – using a different type of laser to vaporise (burn away) the obstructing prostate tissue, using a telescope passed along your urethra

[1] *Image courtesy of NeoTract*

- **Prostatic artery embolisation** – a technique where an expert radiologist (X-ray doctor) blocks off the arteries to your prostate gland, causing it to shrink over time. This technique is currently under review by NICE and would only be performed as part of a clinical trial.

What happens on the day of the procedure?

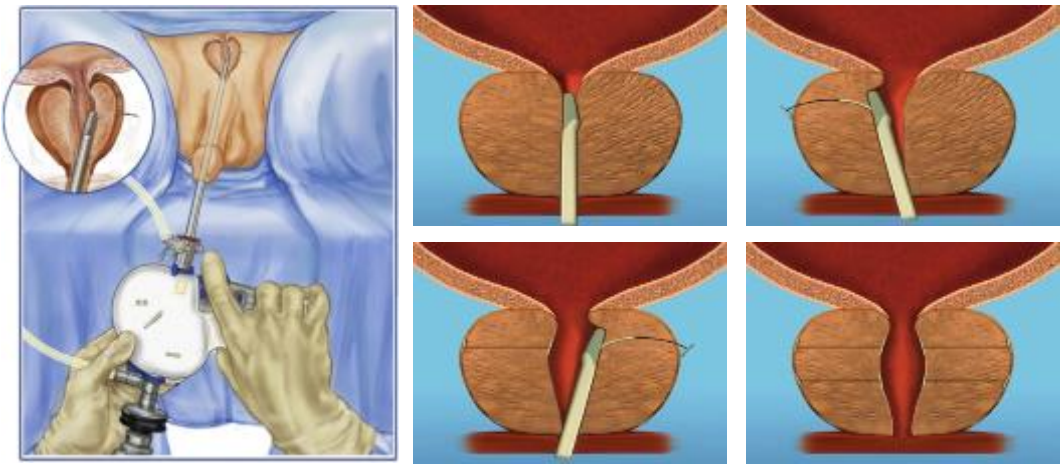
Your urologist (or a member of their team) will briefly review your history and medications, and will discuss the surgery again with you to confirm your consent.

An anaesthetist will see you to discuss the options of a general anaesthetic or spinal anaesthetic. The anaesthetist will also discuss pain relief after the procedure with you.

We may provide you with a pair of TED stockings to wear, and give you a heparin injection to thin your blood. These help to prevent blood clots from developing and passing into your lungs. Your medical team will decide whether you need to continue these after you go home.

Details of the procedure

- we carry out the procedure either under a general or local anaesthetic, according to individual circumstances
- we usually give you an injection of antibiotics before the procedure, after you have been checked for any allergies
- we put a telescope into your bladder through your urethra
- we put two to four implants into your prostate through the telescope, under direct vision, using a special applicator, as shown below [2].



[2] *Images courtesy of NeoTract*

- we do not usually need to put a catheter in your bladder at the end of the procedure (which takes 10 to 15 minutes to complete)

Are there any after-effects?

The possible after-effects and your risk of getting them are shown below. Some are self-limiting or reversible, but others are not. We have not listed very rare after-effects (occurring in less than 1 in 250 patients) individually.

The impact of these after-effects can vary a lot from patient to patient; you should ask your surgeon's advice about the risks and their impact on you as an individual:

After-effect	Risk
Temporary burning and stinging when you pass urine (which may last for 5 to 7 days)	 1 in 3 patients (34%)
Temporary bleeding in your urine (which may last 5 to 7 days)	 1 in 4 patients (26%)
Pain or discomfort in your pelvic area	 Between 1 in 5 & 1 in 6 patients (18%)
Treatment may not relieve all your symptoms, so that you require further treatment within 5 years	 Between 1 in 7 & 1 in 8 patients (13%)
Urgency (a sudden need to pass urine with very little warning)	 1 in 12 patients (7%)
Temporary urge incontinence (leakage associated with an uncontrollable need to pass urine)	 1 in 25 patients (4%)
Inability to pass urine (retention) requiring a short-term catheter in your bladder immediately after the procedure	 Between 1 in 20 & 1 in 35 patients (3 to 5%)
Infection in your urine requiring treatment with antibiotics	 Between 1 in 30 & 1 in 35 patients (3%)

Encrustation (stone formation) on the implant(s) requiring later removal		Less than 1 in 100 patients (< 1%)
Anaesthetic or cardiovascular problems possibly requiring intensive care (including chest infection, pulmonary embolus, stroke, deep vein thrombosis, heart attack and death)		Between 1 in 50 & 1 in 250 patients (your anaesthetist can estimate your individual risk)

What is my risk of a hospital-acquired infection?

Your risk of getting an infection in hospital is approximately 8 in 100 (8%); this includes getting *MRSA* or a *Clostridium difficile* bowel infection. This figure is higher if you are in a "high-risk" group of patients such as patients who have had:

- long-term drainage tubes (e.g. catheters);
- bladder removal;
- long hospital stays; or
- multiple hospital admissions.

What can I expect when I get home?

- you will be discharged when you have passed urine satisfactorily (usually on the same day as your procedure)
- you will get a little burning and bleeding when you pass urine over the first few days
- most men will get some pelvic discomfort for a few days which can be relieved by simple painkillers such as paracetamol
- if you are unable to pass urine after the procedure, we may need to put a temporary catheter into your bladder for a few days
- if you do need a catheter, we will show you how to manage it at home and will arrange for its removal
- you will be given advice about your recovery at home
- you will be given a copy of your discharge summary and a copy will also be sent to your GP
- any antibiotics or other tablets you may need will be arranged & dispensed from the hospital pharmacy
- you should be able to return to normal activities after five to seven days

The common post-operative symptoms of pain on passing urine, pelvic discomfort and frequent passage of urine are usually mild; they tend to

improve over five to seven days, and normally disappear after the first two to four weeks. If the pain on passing urine gets progressively worse, this may indicate an urine infection for which you should contact your GP.

General information about surgical procedures

Before your procedure

Please tell a member of the medical team if you have:

- an implanted foreign body (stent, joint replacement, pacemaker, heart valve, blood vessel graft);
- a regular prescription for a blood thinning agent (warfarin, aspirin, clopidogrel, rivaroxaban or dabigatran);
- a present or previous MRSA infection; or
- a high risk of variant-CJD (e.g. if you have had a corneal transplant, a neurosurgical dural transplant or human growth hormone treatment).

Questions you may wish to ask

If you wish to learn more about what will happen, you can find a list of suggested questions called "Having An Operation" on the website of the Royal College of Surgeons of England. You may also wish to ask your surgeon for his/her personal results and experience with this procedure.

Before you go home

We will tell you how the procedure went and you should:

- make sure you understand what has been done;
- ask the surgeon if everything went as planned;
- let the staff know if you have any discomfort;
- ask what you can (and cannot) do at home;
- make sure you know what happens next; and
- ask when you can return to normal activities.

We will give you advice about what to look out for when you get home. Your surgeon or nurse will also give you details of who to contact, and how to contact them, in the event of problems.

Smoking and surgery

Ideally, we would prefer you to stop smoking before any procedure. Smoking can worsen some urological conditions and makes complications more likely after surgery. For advice on stopping, you can:

- contact your GP;
- access your local NHS Smoking Help Online; or
- ring the free NHS Smoking Helpline on **0800 169 0 169**.

Driving after surgery

It is your responsibility to make sure you are fit to drive after any surgical procedure. You only need to contact the DVLA if your ability to drive is likely to be affected for more than three months. If it is, you should check with your insurance company before driving again.

What should I do with this information?

Thank you for taking the trouble to read this information. Please let your urologist (or specialist nurse) know if you would like to have a copy for your own records. If you wish, the medical or nursing staff can also arrange to file a copy in your hospital notes.

What sources have we used to prepare this leaflet?

This leaflet uses information from consensus panels and other evidence-based sources including:

- the Department of Health (England);
- the Cochrane Collaboration; and
- the National Institute for Health and Care Excellence (NICE).

It also follows style guidelines from:

- the Royal National Institute for Blind People (RNIB);
- the Information Standard;
- the Patient Information Forum; and
- the Plain English Campaign.

Disclaimer

We have made every effort to give accurate information but there may still be errors or omissions in this leaflet. BAUS cannot accept responsibility for any loss from action taken (or not taken) as a result of this information.

PLEASE NOTE

The staff at BAUS are not medically trained, and are unable to answer questions about the information provided in this leaflet. If you do have any questions, you should contact your urologist, specialist nurse or GP.