Prostate cancer is the most frequently diagnosed cancer (except for skin cancer) in men in the United States. The risk of having prostate cancer increases as a man gets older. In the past several years, earlier diagnosis and more aggressive treatment have enhanced the opportunities for cure.

**COMMON SIGNS AND SYMPTOMS**
- Prostate cancer can cause enlargement of the prostate, which in turn can result in the following:
  - Weak urinary stream.
  - Increased frequency of urination.
  - Incomplete emptying of the bladder.
  - Blood in the urine or semen.
- These same symptoms can also be caused by benign, noncancerous enlargement of the prostate gland or other benign conditions such as infections of the urinary tract or stones.

**Diagnosis**
This is commonly done by the physician inserting a finger in the rectum to feel the prostate gland. A blood test, prostate-specific antigen (PSA), makes it possible to detect prostate cancer even before it can be felt by rectal examination.

**Diagnostic Tests**
If cancer is suspected, one or more of the following tests will need to be done:
- **Transrectal ultrasonography**: An instrument (a probe) slightly thicker than an examining finger is used. The probe is lubricated and inserted so that its tip lies over the prostate gland. From the tip of the probe, harmless, painless sound waves are beamed in the direction of the prostate. The waves bouncing back (the echoes) are seen on a television screen. This is a reliable way to see abnormalities within the prostate gland.
- **Prostate biopsy**: The skin just below the scrotum (the sac) is made numb with an anesthetic solution. With the help of the ultrasonography, a needle is guided through the numbed skin and to the abnormal area of the prostate and a tiny piece taken (a biopsy) for examination in the laboratory.
  - The following tests are commonly performed when a diagnosis of cancer has actually been confirmed:
- **Bone scan**: A fine needle is used to inject a solution with a tiny amount of a harmless radioactive material into your vein. The solution circulates throughout your entire body and attaches itself to any part of a bone that has something wrong with it. One hour after the injection, you will lie on a table, and a special machine will pass over your entire body taking a photograph (a scan) of all the bones from your skull to your toes. A specialist then examines the scan, looking for any abnormalities.
- **CT scan (computed tomography scan)**: A machine shaped like a huge doughnut is used to take special x-rays. You will lie on a table inside the hole in the “doughnut.” The x-rays are taken as very thin slices through the area of the kidneys and pelvis. This makes it possible to see fine details in this area.

**MRI (magnetic resonance imaging)**: No x-rays are used with this technique. Instead, it is done with harmless magnetic fields and radio waves. A computer develops the pictures to show organs from several angles. This technique is especially useful for examining your blood vessels, nerves, and bone tissue.

**TREATMENT**
If the cancer is limited to just the prostate gland, then treatment of the entire prostate gland by radiation or complete removal of the gland by an operation can be curative.

**Radiation Treatment**
The advantages are as follows:
- No major operation is necessary.
- As with an operation, there is a small (5%) risk of not being able to hold urine as well as you did before.
- A risk of impotence (but not as great as with an operation).

The disadvantages are as follows:
- The entire prostate gland is left in place and so is not available for detailed study to know more certainly that the cancer was localized.
- Determining the success of local treatment is more difficult.
- If radiation treatment fails, performing an operation later to remove the prostate has greater risk than if this area had not received radiation treatment.
- Scarring in the area in and around the prostate can occur later and continue to affect how you are able to hold and pass your urine.

**An Operation**
The advantages of an operation are as follows:
- The entire gland is actually removed and can be studied to determine whether the cancer is confined to the gland. This information can help plan any further treatment as well as more accurately determine the prognosis.
- Once the tissue is removed, very few side effects appear in later years.

The disadvantages are as follows:
- There is the need of an operation.
- A small (5%) risk of not being able to hold your urine as well as you did before the operation.
- A significant risk of impotence (loss of erection).
- In addition, there is the possibility of bleeding, infection, blood clots, and possibly other complications.

After careful consideration of all factors, the recommendation is that you have a radical prostatectomy to attempt to cure your prostate cancer.
PREOPERATIVE PREPARATION
To cure prostate cancer by an operation, the entire prostate must be removed.

The prostate can be removed through a small incision in the lower abdomen (the suprapubic or the retropubic approach) or through a small incision between the scrotum (the sac) and the anus (the perineal approach) (Fig. 1). One advantage of the suprapubic approach is that the lymph nodes in the abdomen (which can be the site of early spread of cancer) can be evaluated before the prostate is removed. If the removed lymph nodes show cancer (while you are still in the operating room), then the prostate usually is not removed. Instead, radiation or hormone therapy is planned. Which technique is chosen will be discussed with you beforehand.

POSTOPERATIVE CARE
- You will be taken to a recovery room and observed. When your blood pressure, pulse, and breathing are stable, you will be taken to a regular hospital room.
- You will have a catheter (a small tube coming from the penis) which drains the bladder until the area can heal completely. This takes approximately 2 to 3 weeks. You’ll be given instructions on caring for the catheter at home (it is not difficult) until it can be removed in the doctor’s office.
- Pain can be controlled with medicine. The nurse will give it to you, or you can give yourself a preset amount of pain medicine when you feel you need it. This is done with a device called patient-controlled analgesia (PCA) that is connected to the tubing giving you intravenous fluids.
- That evening after the operation you will be helped to sit up in bed and on the next day to get out of bed.
- You will be given an incentive spirometer. Breathing into this as you are instructed will help you expand your lungs and reduce the risk of developing pneumonia.
- A liquid diet will be started one day after the operation and will be advanced as you tolerate it.
- You should be able to go home in about 1 week.
- Arrangements will be made for your medicine, follow-up office visits, and stitch or clip removal.

HOME CARE
- Continue with the program started while you were in the hospital.
- Inactivity is not good for you but neither is overdoing it. Don’t try to do too much too soon.
- Eat as you wish, but include plenty of roughage and liquids in your diet to help prevent constipation.
- Take medicine as prescribed for your pain.
- You will be given a night drainage bag for draining the catheter during your first 2 weeks at home. This hangs off the side of the bed and gives better drainage through the night. During the day, you may wish to have the catheter directly connected to your leg bag. Before you leave the hospital, the nurse will instruct you on how to change from one bag to the other.
- During your office visit, let’s discuss when you can resume driving.

CALL OUR OFFICE IF
- The catheter stops draining properly or falls out.
- You develop any unusual signs or symptoms.
- The incision becomes red or swollen, or there is drainage from it.
- You develop a temperature higher than 100°F.
- You have any questions.