

UCLA Urology

Your Radical Cystectomy Guide

Contents

Introduction	1
About Your Radical Cystectomy Surgery.....	1
Robotic and Open Surgery	1
Urinary Diversion	1
Ileal conduit.....	1
Neobladder	2
Continent catheterizable pouch	2
Preparing for Surgery	3
Oncology Consultation and Chemotherapy	3
Preoperative Medical Evaluation.....	4
Preoperative Conditioning	4
Smoking Cessation	4
Stoma Teaching/Diversion Teaching.....	4
Sexual Health	5
Preoperative Tips to Optimize Nutritional Status.....	5
Importance of Support.....	5
Day before your Surgery	5
Bowel Preparation	6
UCLA Anesthesia Guidelines	6
Carbohydrate Loading.....	6
Day of Surgery	6
Family Waiting Room (Maddie’s Room)	6
Duration of Surgery.....	7
Hospital Course	7
Interdisciplinary Care Team	7
Hospital Course	7
Drains	8
Potential Complications from Surgery.....	9
Planning for Home	9
Medications	9

Contents continued

Diet.....	10
Pathology	10
Incision Care.....	10
Follow-Up Appointments.....	10
At Home	10
Caring for your Urinary Diversion	11
Neobladder and Continent Catheterizable Pouch.....	12
Catheter Care	13
Social Support Resources.....	15

Introduction

According to the American Cancer Society, approximately 75,000 people in the United States are diagnosed with bladder cancer each year, many of which will need to have their bladder removed to control the cancer. The bladder is part of the urinary system, which also includes the urethra, ureters, and kidneys (Figure 1). These organs store and eliminate urine, which helps to maintain chemical balance in the body. The kidneys produce urine, which is carried down two narrow tubes called ureters. Urine then collects within the bladder, a muscular chamber in your lower abdomen. From the bladder, urine is emptied through the urethra during urination.

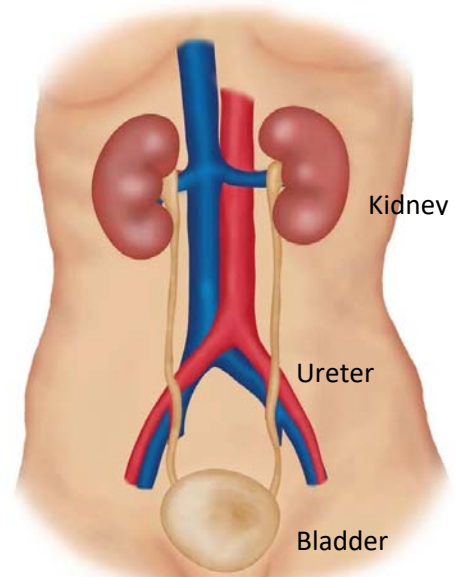


Figure 1. Normal urinary tract anatomy.

About Your Radical Cystectomy Surgery

To treat bladder cancer, your bladder and some surrounding structures will be removed in a procedure called **Radical Cystectomy**.

In men, the **prostate**, **seminal vesicles**, and surrounding **lymph nodes** are removed. In women, the ovaries, fallopian tube, uterus, cervix, part of the vagina, and surrounding lymph nodes are removed.

Robotic and Open Surgery

Surgery can be done using either an open incision or “robotically” depending on your overall health and surgeon preference. In robotic surgery, your surgeon controls a robot and removes your bladder and lymph nodes through 6 small incisions made in the abdomen. An open operation is performed through a single incision made from your pubic bone to your navel. Cancer outcomes are the same with either approach. Robotic surgery is a longer procedure but may decrease blood loss, shorten your hospital stay, and quicken return to full activities. Talk to your surgeon about his or her specific outcomes.

Urinary Diversion

Once the bladder is removed, it is necessary to provide another way to drain the urine. This is often the biggest concern for patients once their bladder cancer has been removed. Several options exist and depend on your overall health, extent of cancer, activity level, and lifestyle goals and needs.

Ileal conduit

For some patients, an **ileal conduit** is the preferred option. An **ileal conduit** is created using a small part of your intestine. The **ureters** are attached to one end. The other end, which is called the **stoma**, protrudes through the side of your abdomen and into a bag. It acts as a funnel to drain urine into an appliance bag attached to your skin. This is a shorter and simpler operation with a lower chance of short- or long-term complications. Patients with an **ileal conduit** typically need to empty the bag 4-5 times per day and replace the bag every 4-5 days.

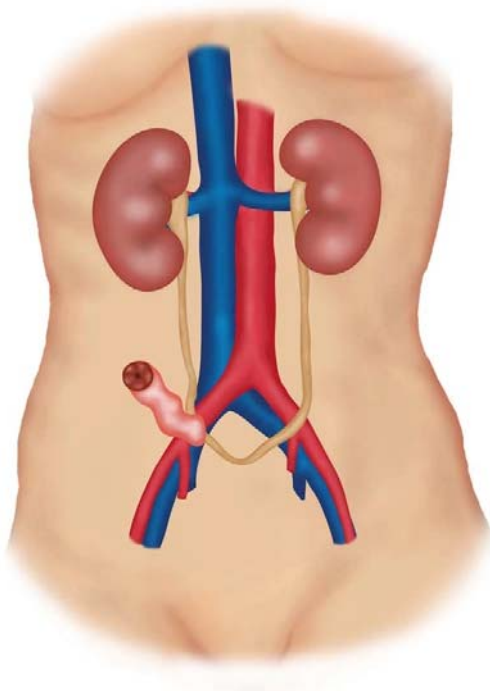


Figure 3. New internal anatomy after your radical cystectomy with ileal conduit.

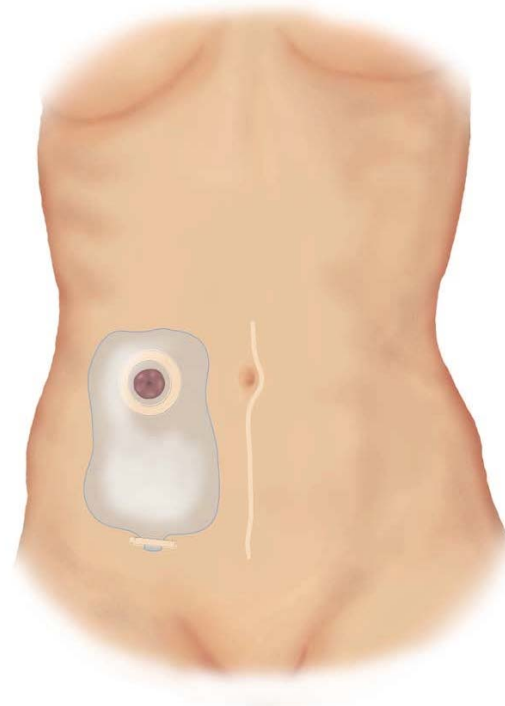


Figure 2. Appearance of the abdomen after your radical cystectomy. The midline scar and ostomy bag on the right are visible.

Neobladder

You may be eligible to have an operation that uses part of the intestines to create a new bladder or **neobladder**. In this operation, the **ureters** are joined to one end of the neobladder and the other end is connected to the **urethra**. Your new bladder is constructed to store urine. You will urinate through your native urethra. No bags or appliances are required. After surgery, you will likely have temporary urinary leakage. At times, you may need to catheterize your neobladder to completely empty it or to irrigate out excess mucus. Production of mucus is normal, especially early after surgery and may persist for some time. Most patients regain their ability to control leakage during the daytime by three months. Nighttime leakage can persist for some patients.

Continent catheterizable pouch

If your cancer has spread to your **urethra** and a **neobladder** is not possible, you may be a candidate for a **continent catheterizable pouch**. This is a highly complex operation in which your new bladder will be connected to a small **stoma** on the front of the abdomen instead of your urethra. Your urethra will be removed if involved with cancer. You can then pass a small catheter through the stoma to drain the new bladder 4 to 6 times a day. No **stoma appliance** is typically needed.

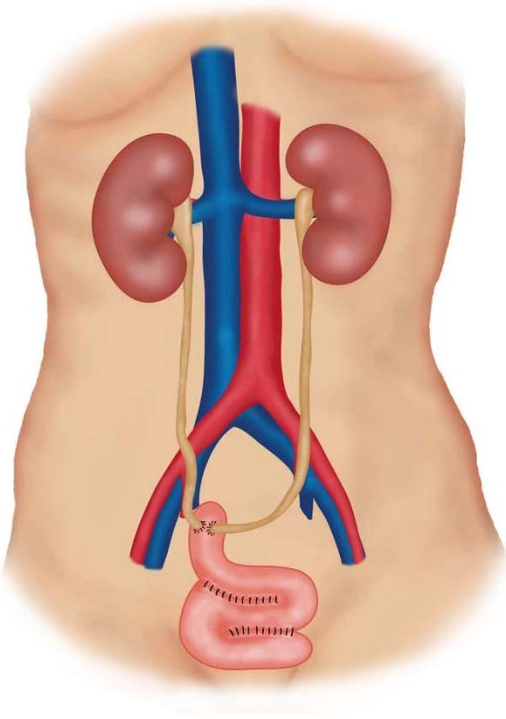


Figure 4. New internal anatomy of a neobladder, which is connected to your urethra.

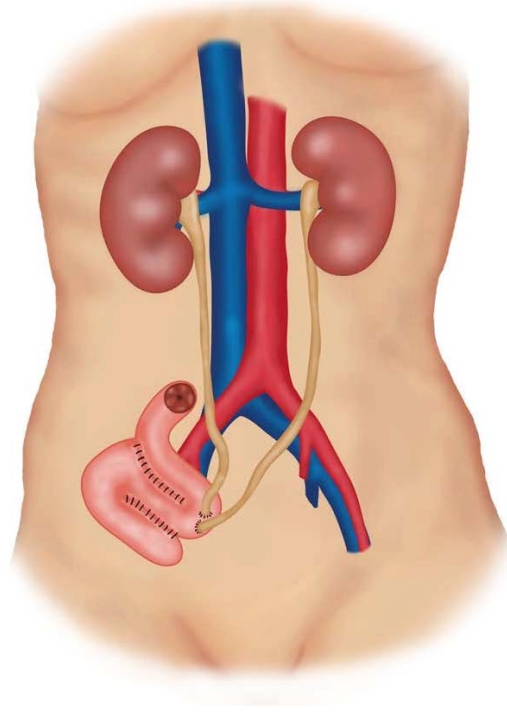


Figure 5. New internal anatomy of a continent catheterizable pouch.

Despite the differences in types of urinary diversion, studies have shown that quality of life for patients with each type of diversion is similar. Talk to your surgeon about which type of diversion is best suited for your lifestyle. Please visit the Bladder Cancer Advocacy Network (BCAN) website at <http://www.bcan.org/udvideos/> for a series of videos on “The New Normal: Living with a Urinary Diversion.”

Preparing for Surgery

Every member of the UCLA healthcare team is committed to working with you during your radical cystectomy journey.

Radical cystectomy with urinary diversion is a major operation. Preparing for surgery can significantly improve your recovery. See below for the steps you should take to prepare.

Oncology Consultation and Chemotherapy

Some patients benefit from chemotherapy given before surgery (“**neoadjuvant chemotherapy**”). Other patients may need chemotherapy after radical cystectomy if their disease is aggressive. The preferred chemotherapy regimens are **GC (Gemcitabine, Cisplatin)** or **MVAC (Methotrexate, Vincristine, Adriamycin, Cisplatin)**. Speak to your surgeon to see if you need chemotherapy before your surgery.

Depending on the pathology results after surgery, your surgeon will discuss with you about the possibility of chemotherapy after surgery, if needed. Visit chemocare.com to find out more information on potential side effects of each medication and how to deal with these.

Preoperative Medical Evaluation

Before your surgery, you will also be evaluated by a medicine doctor to ensure that you are healthy enough to undergo surgery. This evaluation may be done by your internist or by our UCLA medical team. Depending on your health, you may need to be evaluated by other services such as cardiology and anesthesia.

Preoperative Conditioning

Walking will be an important part of your recovery. In preparation, we recommend that you consider a regular walking schedule from now until the day of surgery. **Please walk at a comfortable pace for 30 minutes each day, increasing your pace as tolerated.** For more active patients, continue your normal exercise routine until the day of your surgery. Dedicated conditioning programs or physical therapy may also be available to you.

For those residing in Los Angeles, the Stay Active and Independent for Life (S.A.I.L.) program may be an option. This is a 45-minute fitness class followed by a 15-minute educational discussion twice a week designed especially for seniors

Location: Santa Monica YWCA Auditorium, 2019 14th Street, Santa Monica, CA
Phone Number: (424) 259-7140

Smoking Cessation

We know that smoking contributes significantly to the development of bladder cancer. Studies have also shown that smoking after treatment leads to poorer outcomes and a more difficult recovery. Programs are available to help you quit smoking.

At UCLA, we offer the “Freedom from Smoking” program, which was designed by the American Lung Association. This is an 8-session program built to help you quit. For more information, call (310) 825-0014. The state of California also has free quit smoking services by calling 1-800-NO BUTTS. Speak with your surgeon about other ways to help you quit, including medications.

Stoma Teaching/Diversion Teaching

At UCLA Health, we are dedicated to easing your transition to your new stoma or bladder. We will work with you as early as possible so you feel confident with your surgery. In some cases, you may meet with a stoma nurse prior to your operation to receive **stoma appliance** teaching. For a neobladder or a continent catheterizable pouch, it may be helpful for you to learn how to self-**catheterize** before your operation. Your surgeon will discuss your options with you.

Sexual Health

In addition to changes in your urinary drainage, you may also experience changes in your sexual health. This may include difficulties with sexual intercourse. For men this may include difficulties with attaining and maintaining erections or being unable to ejaculate. For women, removing the reproductive organs and part of the vagina may make sexual intercourse painful. These issues contribute significantly to quality of life for both men and women undergoing radical cystectomy. Sexual health experts are available in our Department to assist you both before surgery and after surgery.

Preoperative Tips to Optimize Nutritional Status

It is important to optimize your nutritional status as much as you can before having surgery in order to help with recovery. Here are some general tips from our UCLA Dieticians:

- Increase your daily calorie intake by 500 calories by adding healthy snacks and/or eating high calorie foods.
- Eat more often. Try eating six small meals throughout the day or three snacks between three meals.
- Limit the amount of fluid you have with meals. Fluids taken with meals may make you too full and limit how much you can eat.
- If you are able, exercise lightly or take a walk before meals to increase your appetite.
- Ask your doctor about a daily multivitamin/mineral supplement or nutritional shakes.

Importance of Support

You may need additional support to get you through this journey so please identify a family member or friend who can act as your coach or advocate.

Additionally, a social worker is part of the care team in the hospital. If you are concerned that you do not have appropriate support, please speak with the inpatient Urology team about a social work consult so they can help identify a solution.

It may also be helpful to speak to a past radical cystectomy patient to learn from his/her journey. Please ask your surgeon for more information about our peer-to-peer program.

Day before your Surgery

- If your surgery is at the Ronald Reagan Medical Center, you must call the Procedure and Treatment Unit (PTU) at (424) 259-8070 between the hours of 2:00 PM and 4:00 PM on the day before your surgery. If your surgery is on a Monday, you should call the preceding Friday afternoon.
- The PTU staff will tell you the time to report to the Admissions Office on the day of your surgery. The Admissions Office is located on the first floor of Ronald Reagan UCLA Medical Center. You will have the opportunity to meet your anesthesiologist and have all your questions answered on the morning of your surgery. In some cases, the anesthesiologist may also call you the night before your surgery.

Bowel Preparation

Your surgeon may have you limit your food intake to clear liquids on the day prior to surgery. Some surgeons will also have you take a medication to clean out the intestines on the day before surgery. Talk to your surgeon about the type of bowel prep required prior to surgery and use the box on the right to help remember your instructions.

My Bowel Prep Instructions:

UCLA Anesthesia Guidelines

Some surgeons will allow certain foods up to 6 hours before your surgery and clear liquids up to 2 hours before your surgery. Please talk to your surgeon about their preferences for food before surgery. If you are at all concerned or unclear about your instructions, please contact your surgeon’s office immediately. If you are confused about your instructions and unable to contact us the night before your surgery, do not eat anything after midnight.

Carbohydrate Loading

Increasing your carbohydrate intake the day before surgery may improve how you feel after surgery. If you would like to consider this option, consider buying a 4-pack of *Clear Ensure Active* (10 ounce bottles). If you do not have diabetes, drink 2 bottles the night before surgery and 2 bottles 2 hours before arriving at the hospital (only if your instructions allow clears before surgery).

Day of Surgery

You will be admitted to the hospital on the day of your operation. At both the Ronald Reagan UCLA Medical Center in Westwood and at Santa Monica UCLA Hospital, you will take the elevators to the second floor and check in at the Surgery front desk. Your family may wait with you in the pre-operative area before your surgery. A team of nurses will check you in, have you change into a hospital gown, and start an IV. The urology, anesthesiology, and nursing teams will review their portion of the surgery with you. You will sign both Anesthesia and Surgery consents. For some patients, an epidural may be offered to improve pain control. This involves placing a very thin tube into the back to deliver pain medication. This is placed in the preoperative area before surgery.

Family Waiting Area (Maddie’s Room)

Your family will then be directed to the surgical waiting area (called “Maddie’s Room”) on the first floor of the Ronald Reagan UCLA Medical Center. At Santa Monica UCLA Hospital the surgical waiting area is on the third floor. Your family will check-in at the waiting room and obtain a pager to be called if your surgeon needs to talk to the family.

Duration of Surgery

It usually takes several hours to complete this operation. Your surgeon will give you an estimate of the operative time based on the type of diversion and any other factors that may prolong surgery, such as a history of prior surgeries. Most surgeons will have the nursing staff update the family routinely. After the operation, the surgeon will contact your family or representative. The nurses in the recovery room will contact them again when you are ready to have visitors.

Hospital Course

After the Operation

Once your room is prepared, you will be transferred to your bed on our Urology ward. Sometimes you may spend a night or two in our surgery recovery unit. Very few patients will require closer monitoring in an ICU setting.

Interdisciplinary Care Team

While the attending surgeon will make the ultimate decisions in your care, an interdisciplinary care team will work with you to optimize your stay. While in the hospital, you will see:

- Urology inpatient team which may include:
 - Fellows (a physician who has completed urology residency and is specializing in oncology)
 - Urology chief resident (a physician in the final year of Urologic surgery training)
 - Junior residents
 - Nurse practitioners
 - Medical students
- Unit Nurses
- Social Worker and Case Manager to coordinate discharge needs
- Hospitalist or Internist for those with multiple health problems
- Anesthesiology pain team if you have a spinal epidural for pain control
- A stoma nurse if you have an ileal conduit
- A physical and/or occupational therapist if you require assistance with mobility
- Nutritionist if there are any issues with diet and adequate intake

Hospital Course

Your hospital recovery can be highly variable and depends on many factors, including your baseline health, type of surgery (open vs. robotic), and type of diversion (conduit vs. pouch vs. neobladder).

Your hospital recovery can be grouped by the following milestones:

Day 1: Pain Control. Throughout your hospital stay, you may experience different levels of pain.

You will set a pain goal with your healthcare team. Once you've met it, they will work with you to sit up in bed or a chair and to walk with assistance.

Day 1: Ambulation. Your healthcare team will work with you to walk with assistance. **This is the most important activity you can do to support your recovery**

Day 2–4: Return of Diet. Starting with small amounts of water, your diet will be advanced from liquid to solid food. Some patients will develop a condition called *ileus*, which is when your bowels fall asleep. This varies from patient to patient and may delay your ability to eat. At this point, walking and thoughtful use of pain medication will help reduce this risk. To boost your nutrition, you may receive nutritional supplements (e.g., Clear Ensure Active) during your hospital recovery.

Day 4 and Onward. Preparing for discharge. At this time, we focus on giving you the tools you need to support yourself at home. For those with an ileal conduit, you will receive teaching from a stoma nurse during your hospital stay. By this time, you should be working with the stoma nurse to change your own appliance. For those with a neobladder, you will be taught bladder irrigation and drain care. Additionally, we will work with you to ease your transition to oral pain medications and ensure you are taking in adequate amounts of liquids and food.

Hospital Tips

- Deep breathing and pulmonary exercise are good ways to prevent pneumonia. The nurses will teach you how to use a device called an Incentive Spirometer that will help you with deep breathing (please see handout for more information).
- Good sleep is also important for recovery. You may be eligible for our Rest & Recovery Program, which helps has been shown to improve patients' quality of sleep in the hospital. Please ask your nurse for more information.

Drains

To help with your healing, you may have tubes that will be visible on the outside of your body:

- **Abdominal drains.** You may have 1–2 tubes that drain excess fluid in your abdominal region. These are typically removed before discharge. If you have a **neobladder** or **continent catheterizable pouch**, you may be sent home with a drain, which will be removed in clinic at your post-operative visit.
- **Ureteral stents.** These are thin tubes that are on the inside of the body and stent open the ureter and kidney. These are typically removed 1–3 weeks after surgery in the office.
- **Stoma Appliance.** This is a plastic pouch overlying the stoma that collects the urine.
- **Foley catheter.** **When you receive a neobladder**, you will have a catheter that passes through your urethra to drain the bladder until it heals. The catheter is usually removed in several weeks during a post-operative visit in clinic.

- **Suprapubic Tube.** This is a tube that goes into your neobladder or continent diversion through the abdomen to ensure adequate drainage of your new diversion until it heals.
- **Nephrostomy tubes.** These are tubes that drain the kidney through the back. In very rare circumstances these are needed prior to surgery. Occasionally, these may need to be placed if the kidney is not drained by the ureteral stent.

Potential Complications from Surgery

Radical cystectomy is a major operation. Your UCLA surgeon’s results may be quite different from national averages, so please discuss with him or her if you have questions. We are dedicated to preventing these complications and treating them quickly and efficiently should they occur.

Potential complications include:

- Ileus/Bowel Obstruction – Bowels falling asleep or blocked, resulting in nausea/vomiting.
- Infections – Often due to bacteria that naturally exist in your body that can affect your incision, urine, bowel, or lungs.
- Altered Mental Status– Confusion or change in attention due to interruptions in sleep and medication side effects.
- Kidney Injury – Because of the surgery, your kidneys may not work properly. This is often temporary and resolves on its own. Rarely, patients may require dialysis.
- Blood Clots – 5–10% of patients have a clot in the deep veins of the leg. This can cause swelling and pain of the legs. Occasionally, these can travel to the lung causing breathing difficulties. Your doctor may place you on blood thinners to prevent clotting in the deep veins. If you do develop a clot in the leg, you may need to be placed on blood thinners for a period of time.
- Other Medical Problems - As with any surgery, patients are at risk for heart attack, respiratory distress, or worsening of other preexisting health problems. It is important to talk to your PCP or a medical physician to help minimize these risks.

In our experience, many of these events can be avoided by quality patient instruction, frequent walking, adequate fluid intake, strong social support, and a positive spirit.

Planning for Home

Medications

When you go home, most patients will be prescribed medication for pain and medication to prevent constipation, a common side effect from pain medication. You may also be started on a new medication. If you were taking medications prior to surgery, these may be adjusted. All medications should be taken as directed.

If you were taking any blood thinners prior to surgery, such as Aspirin, Plavix, or Coumadin, speak with your doctor before you leave the hospital about when you may resume taking them.

Diet

Most patients will be able to eat a regular diet at the time of discharge. However, it is common for your intestines to slow down after this type of surgery, so we recommend eating smaller, more frequent meals, and drinking plenty of liquids until your initial follow-up appointment. One of the most common reasons for readmission to the hospital is dehydration, so be sure to drink plenty of fluids to stay hydrated.

Pathology

It takes about 7 working days for your pathology results to return. If you were already discharged by this time, we will call you with the results. Based on the pathology, we will develop a plan of care that may include further treatments such as chemotherapy or radiation therapy if necessary.

Incision Care

You can shower with the steri-strips or staples in place. While in the shower, you can gently clean your incision with soap and water. Watch for any signs of infection such as redness, tenderness, foul drainage, or a break in your incision line. If you detect any of these, contact your urology team. Please let your steri-strips fall off on their own. For patients with staples on the incision, these will need to be removed 1–2 weeks after surgery.

Follow-Up Appointments

Call the urology office to make an appointment for your post-operative check. Please call the office of your surgeon between Monday and Friday during business hours. The follow-up will usually occur 1–3 weeks after hospital discharge.

At Home

It may take some time before you will return to your baseline level of health. This differs for each patient but often ranges from a few weeks to several months.

Signs to watch out for at home:

- Persistent nausea and vomiting
- Inability to tolerate food
- Inability to expel gas or have a bowel movement
- Dusky, brown or black stoma
- No urine output from stoma or stent
- Persistent lower back pain or flank pain
- Fever over 102 degrees Fahrenheit
- Foul smelling and/or bloody urine
- Problems with your catheter, including leaking, unintended removal, blood in the urine, foul odor or drainage, blockage
- Bulge underlying or next to the stoma with or without associated pain

If you develop any of the above, please call your surgeon’s office (see UCLA Urology Bladder Cancer Surgery Team). After hours your call will be redirected to the urologist on call at UCLA.

Guidelines to resume common activities:

DRIVING. You are typically ready to drive when you are no longer taking pain medication and your Foley catheter is removed (if one was in place). Secure your seat belt low on your abdomen and beneath your stoma site, if present. If necessary, you may wish to pad the portion of the belt that rests near your stoma.

WORKING. Your return to work depends on how well you heal and your job responsibilities. If this involves physical labor, this may take 6 weeks or more.

LIFTING. Avoid lifting heavy objects (over 20 lbs.), straining and strenuous exercise for at least 6 weeks after surgery

WALKING. You are encouraged to advance your activity to your tolerance level. We encourage you to take walks with periods of rest as described in the Preparing for Surgery section. Inactivity can increase your risk for the complications described above.

SHOWERING. You can shower once you are home with your ostomy pouch or drainage tubes in place. Do not bathe until the incisions are completely healed and all tubes are removed.

SEXUAL ACTIVITY. Sexual activity can be resumed when you are ready. You and your partner will need to discuss what positions may be more acceptable and comfortable for you. Remember to empty your stoma appliance, neobladder, or pouch before sexual activity so it does not interfere with intimacy.

Caring for your Urinary Diversion

For many, an ileal conduit can be a life-changing event. While most patients are very satisfied, there is often period of adjustment. To help you through this process, we recommend the following:

- Outpatient stoma marking and teaching **before surgery.**
- **Active participation** during teaching in the hospital.
- **Outpatient ostomy teaching** after discharge for further support and customization.

Here are some helpful tips for your stoma. For additional help, please refer to your teaching packet from the ostomy team.

- Empty your pouch when it is 1/3 to 1/2 full.
- One size does not fit all. Experiment with different types of appliances to find the best one for you.
- Drink plenty of fluids to minimize your risk of urinary tract infection.
- Monitor your supplies to avoid running out prematurely.

Ostomy Outpatient Clinic:

- The Ostomy clinic is open Monday and Wednesday mornings from 9:00 am to 12:00 pm in the Pflieger Liver Clinic, located in 200 Medical Plaza, Suite 214. Please call 310-794-7788 for an appointment with the Ostomy Nurse.

For additional resources and support:

United Ostomy Associations of America

1-800-826-0826

www.ostomy.org

Neobladder and Continent Catheterizable Pouch

For patients who receive a neobladder or continent catheterizable pouch, you will have a catheter in your urethra and/or a catheter draining the pouch that comes out of your abdominal wall. The catheter will remain in place for 21 to 28 days after your surgery and will be removed in clinic at that time.

It is important to remember that both the neobladder and continent catheterizable pouch are constructed from intestines. Therefore, mucus in the urine is normal following surgery. The mucus will decrease over time. Immediately after surgery, to prevent the catheters from becoming plugged by this mucus, it is important that you regularly irrigate it with sterile water or saline. The nurses in the hospital will teach you how to perform self-**catheterization** and **irrigation**.

While the catheter is in place, please irrigate it 3 times a day when you go home with sterile irrigation. Your nurse will teach you the proper technique while in the hospital and will review it with you until you are comfortable doing it yourself. You will have supplies to go home with from the hospital. If you have any pelvic discomfort or cramps, or if the catheter is not draining freely, you must irrigate immediately to prevent any blockage of the catheter that could be caused by the mucus that collects in your new bladder.

The following procedure should be used when irrigating the catheter:

- Wash your hands thoroughly with soap and water.
- Pour 200 cc of sterile irrigation in a clean bowl.
- Draw up 40–60 cc of sterile irrigation in the syringe provided to you.
- Hold the end of the catheter upright between the thumb and first finger. Place the tip of the syringe into the catheter.
- Gently inject the sterile solution into the catheter. Do not force the water in as this can cause discomfort.
- Gently withdraw the water from the catheter with the syringe. Watch for mucus (mucus is what you want to see). It is normal to draw back 10 to 15 cc less fluid than you put in.
- Repeat several times. Once you can no longer withdraw mucus, you may stop for that irrigation.
- After each irrigation, wash the tip of the syringe with soap and hot water. Cleanse the tip with alcohol and recap it.
- Clean your syringe after each irrigation with a small amount of the sterile irrigation and store your supplies in a clean place.
- If you have both a foley catheter (through the urethra) and a suprapubic tube, please clamp one tube while irrigating the other, as demonstrated to you while you are still in the hospital; repeat this procedure with each tube.

Catheter care

A Foley catheter, suprapubic tube, and/or nephrostomy tube may be a temporary part of life while you recover in the hospital and possibly at home. Below are instructions for catheter care at home.

Handling the Bag and Tube

- **Keep the bag below the level of your bladder.** This will keep urine from flowing back into your bladder and causing an infection.
- Arrange the tubing so it doesn't kink or loop.
- Don't let the bag rest on the floor.
- Don't puncture or cut the tube.
- Don't pull on the catheter or try to remove it.

Emptying the Bag

- Empty the bag every day, or anytime it is about half full.
- **Wash your hands** with soap and water.
- **Get an empty container** and put it within arms reach, or you can empty the bag into the toilet.
- **Remove the drainage spout** from its sleeve at the bottom of the bag. Be careful not to touch the tip of the spout.
- **Open the valve on the spout** and let the urine drain into the container or toilet.
- **Clean the end of the drain spout** with an alcohol wipe. Close the valve and put the spout back in its sleeve.
- **Wash your hands** again with soap and water.

Changing and Cleaning the Bags

If you wear a **leg bag** during the day, change to a large drainage bag when you go to bed. Follow these steps when you change bags:

- **Wash your hands** with soap and water.
- **Gather your supplies:** a clean bag, some alcohol wipes, and an irrigation syringe.
- **Disconnect the catheter tube** from the drainage tube at the connection valve.
- **Clean the end of the catheter tube** with an alcohol wipe. With another alcohol wipe, **clean the end of the drainage tube** of the clean bag.
- **Attach the catheter tube** to the drainage tube of the clean bag.
- **Using an irrigation syringe, fill the used bag** with 1 part white vinegar to 3 parts water and leave for 20 minutes.
- **Empty and rinse the bag** with water, and hang it with the valve open so it will dry.
- **Once dry, store the bag** in a clean plastic bag until you need to use it again.
- **Wash your hands** again with soap and water.

For more information, please visit the UCLA Urology website to find an instructional video on Urinary Catheter Care: <http://urology.ucla.edu/cathetercare>.

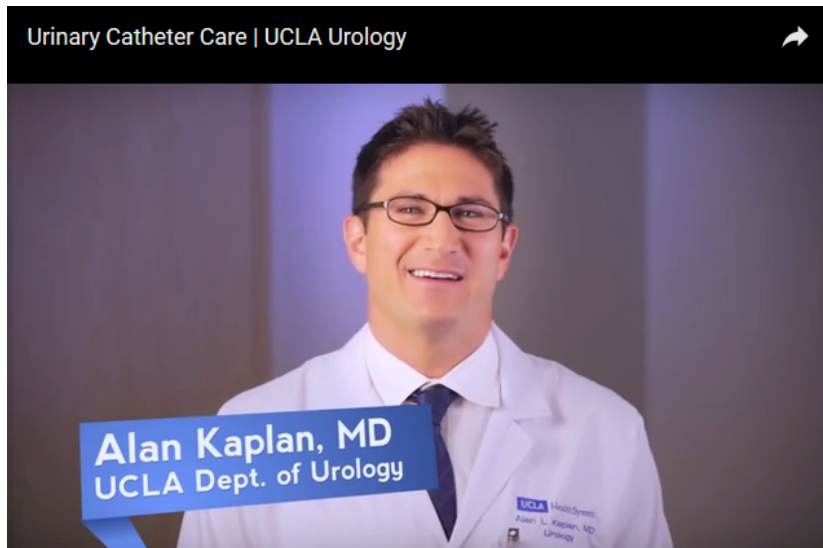


Figure 6. Urology resident Alan Kaplan, MD explains the basics of Urinary catheter care.

For those with a neobladder, when the urethral Foley catheter is removed, you will experience urinary leakage. You may need to wear a protective garment (e.g. Depends for Men) or a large absorbent pad (e.g. for women Kotex, ABD) early on. This will gradually improve, first in the daytime then at night. You may find that you have to wake up at regular intervals or use a pad control leakage at nighttime.

Pelvic Floor Exercises

You will regain control of the muscle that controls urinary leakage gradually over a period of time. There is an exercise (Kegel exercises) that you will be taught that will help to rebuild the strength in this muscle. It is a contracting/relaxing exercise. By performing this exercise consistently on a daily basis, many people notice marked improvement after 3 to 4 months.

Finding the muscle:

The muscle that you use to hold back gas is the one you want to exercise. Some people find this muscle by voluntarily stopping the stream of urine.

Doing the exercise:

- Squeeze the muscle and hold for 10 seconds.
- Relax the muscle for 10 seconds.
- It is just as important to relax as it is to contract this muscle.
- Do 15 exercises in the morning, afternoon, and at night. You can also exercise 10 minutes three times a day. Try to work up to doing 25 exercises at one time. Initially you may not be able to hold this muscle for 10 seconds. However, slowly, over several weeks, you will build up to 10 second holds.

You will build strength in this muscle slowly - do not expect results right away. In about 4 weeks of consistent exercise, you will notice less urinary leakage. In two months, you will see an even bigger difference. If leakage persists, you may benefit from seeing a pelvic floor physical therapist. Please ask your surgeon for referral.

Social Support Resources

Coping with cancer is different for each person. It will depend on many factors. Each patient comes to our team with a rich history and a sense of the life they would like to resume. Our goal is to return you to a life that is meaningful to you, despite changes in the way you will have to approach some practical matters. While you are here at UCLA, we want you to feel comfortable asking for a social work consult if you have any questions or concerns that we might be able to help you with. Clinical Social Workers assist patients and families with physical, emotional and social issues and concerns that exist during a hospital stay. Clinical Social Workers communicate knowledge about health and illness to patients and families that will promote active participation and collaboration in their treatment and care.

The following are some of the resources which many patients find helpful.

American Cancer Society

Resources and programs for patients and caregivers.

1-800-227-2345

www.cancer.org

Bladder Cancer Advocacy Network

4915 St. Elmo Avenue, Suite 202

Bethesda, MD 20814

(888) 901-BCAN/(888) 901-2226 (toll-free)