

History & Physical  
08/03/2007

Chief Complaint: Prostate cancer

History of Present Illness: This is a 58-year-old gentleman who is diagnosed with prostate cancer, Gleason score 8, clinical stage T2 with a prostatic specific antigen of 8.26. He underwent biopsy at local urologist's office about an hour away from here on 05/15/2007. Metastatic work-up including CT pelvis and bone scan was negative. He wanted to proceed with laparoscopic robotic surgery. He understands that he is not being given neuro sparing due to the high-grade stage of his cancer. He did have previous umbilical hernia repair and potentially he could have issues with scar tissue needing to open as well.

Allergies: None

Medications:

1. Lotrel 5/20 daily
2. Paroxetine 20 mg 1/2 tablet daily

Past Medical History:

1. Depression/anxiety
2. Hypertension

Past Surgical History:

1. Umbilical hernia repair
2. Left inguinal hernia repair

Social History: He smoked in the past. He quit in 1968. He drinks beers socially.

Family History: Hypertension

Review of Systems: Per history of the present illness

Physical Examination:

In General: WM in no acute distress

HEENT: Normocephalic and atraumatic. The neck is supple.

Chest: Unlabored breathing

Abdomen: Soft

Rectal: Shows a hard nodular prostate, more so on the right side

Extremities: No cyanosis

Assessment: Prostate cancer

Plan: Laparoscopic and robotic prostatectomy with laparoscopic bilateral lymph node dissection

Signed: Urologist #1

Operative Report  
08/03/2007

Preoperative Diagnosis: Prostate cancer

Postoperative Diagnosis: Prostate cancer

Procedure: Laparoscopic robotic prostatectomy

Anesthesia: General

Indications: This is a 58-year-old gentleman who was diagnosed with prostate cancer. He has a Gleason score of 8, with palpable disease. He wanted to proceed with laparoscopic robotic prostatectomy. He did have a previous umbilical hernia repair as well as a left inguinal hernia repair. He understood the risks for scar tissue and need for conversion. Also, with his palpable disease, I told him he was at risk for possible rectal injury as well. He did want to proceed with surgery knowing that we would not do a nerve-sparing procedure.

Procedure: After informed consent was obtained, the patient was taken to the operative suite where he was placed in the dorsal lithotomy position under general anesthetic. The area of his genitalia and abdomen were prepped and draped in a standard fashion. A 20-French Foley catheter was placed in the field sterilely. The patient had a previous umbilical hernia surgery. Therefore, the left upper quadrant had a small incision made. Through there a 5-mm trocar with visual obturator was used with a camera and inserted into the peritoneal cavity under direct visualization. Once we were in the peritoneal cavity, insufflation was commenced. Laparoscopy revealed no signs of any adhesions in the area. There were no adhesions even under the umbilicus as was the initial concern.

A U incision was therefore made at the umbilicus. A 12-mm trocar was placed under direct visualization into the peritoneal cavity. We placed our two Da Vinci 8-mm ports in the right and left lower quadrants, and a 12-mm port in the right upper quadrant. Once the trocars were in place, the patient was placed in steep Trendelenburg and the robot was docked. The bladder was then taken down with cautery, dropping the bladder in toward the space of Retzius, going out laterally encountering the vas deferens, dividing it, and opening it at the lateral pelvic sidewall space areas. The endopelvic fascia was exposed, and the prostate was de-fatted. The superficial dorsal vein was cauterized.

The endopelvic fascia was entered. Levator muscles were slipped off the left side without much difficulty going distally to the apex. On the right side as we incised the endopelvic fascia, the levator muscles were a little bit more stuck toward the prostate. The tissue plane would not open up as freely as it typically would do. It took a little bit more dissection to get it freed off. I used both sharp and cautery dissection to get things freed up. Once we were able to do this, we went distally to the apex of the prostate. The puboprostatics were partially divided on both sides as well. A 0-Vicryl suture was then placed over the prostate ligating the dorsal vein complex as it runs over the prostate and securing it. The bladder neck was then taken down. The prostate was noted to be quite large and had quite a large wide bladder neck.

As we divided the bladder neck across, we tried to work it down to the urethra and tube as much as possible entering into the urethra at the level of the bladder neck and then freeing up the bladder neck completely from the prostate at this level. The prostate was quite asymmetric with the right lobe deviating to midline toward the left side. The plane between the posterior bladder neck and the prostate was then freed up with cautery going down deep until we encountered some vesicals in the vas. We extended our dissection out laterally exposing the lateral pedicles. The vas was then dissected out freeing it up, dividing it, and then the seminal vesical was dissected out with cautery on that right side. In a likewise fashion on the left side, the vas was initially dissected out, divided, and the seminal vesical was then dissected out with cautery as well. Lifting up on the seminal vesicals and the vas, the rectum was then swept posteriorly off the prostate after we went through Denonvilliers' fascia. It was noted on the right side that the rectum was quite a bit more stuck on the prostate. On the right side a lateral pedicle was initially taken with a Hem-o-Lok and then divided. There was noted to be a piece of tissue that was actually extending out a little bit more laterally and posteriorly. I went around that and noted it to most likely be a piece of prostate that was growing out laterally a bit. I went around and took a little wider margin. It was planned not to do a nerve-sparing procedure from his clinical stage, but also now looking intraoperatively, again the tissue planes were quite stuck, particularly on the right side. Therefore, after the lateral pedicle was dissected down with Hem-o-Loks and cautery, we went wide and included the neurovascular bundle along with the prostate out laterally and then posteriorly. The rectum was then peeled back and off the prostate, but again it was very adherent.

We could see that the longitudinal serosal muscle fibers of the rectum were adherent onto the prostate. This was taken down sharply with just a little bit of cautery as appropriate. Once this was taken down, we were able to work the margins all the way distally to the apex of the prostate on the right side. The left side came down a bit easier with a lot better tissue planes, but it was felt best to go ahead and take a wide margin on this side as well too. The lateral pedicles were Hem-o-lok'd and divided, then going out laterally we included the neurovascular bundle with our package going out distally to the apex. The posterior attachments were also freed off as well.

A stapler was then used to divide the dorsal vein complex. However, it was too big of a bite. We were only able to ligate about half of it. Therefore, an 0 Vicryl stitch was then placed in the dorsal vein complex in a figure-of-eight fashion and then tied. The dorsal vein complex was divided exposing the apex of the prostate. Once the apex of the prostate was cleanly dissected, the urethra was then divided at that level getting a margin around the apex of the prostate, going deep, dividing the rectourethralis, and freeing up the specimen intact. There was noted to still be a little bleeding coming from the dorsal vein complex. Therefore, another 0 Vicryl stitch was placed through there gaining excellent hemostasis.

The pelvis was carefully inspected for any bleeding. Excellent hemostasis was seen. Upon inspecting the rectum, we placed a sizer through our O'Connor sheath into the rectum. Pushing upon it, we did not see any perforations of the rectum. Everything looked fine. We could identify the longitudinal serosa muscle fibers of the rectum. It was noted that there was an area where some of the longitudinal fibers looked thinner. However, the rectum was noted to be intact. It was felt best to reinforce this attenuated area. Therefore, 3-0 silk sutures were used in

interrupted fashion to help reinforce this attenuated area of the longitudinal muscles. After this was done, the area was inspected for any bleeding under low insufflation pressure. Good hemostasis was seen. Pelvic lymph node dissection was carried out by Urologist #2. She will dictate separately.

Urethrovesical anastomosis was done using 3-0 Monocryl sewing around in the 4 to 5 o'clock position, working our way clockwise and then counter clockwise, cinching the suture, and then putting a brand new catheter in place. Irrigation test showed no signs of leakage. We had a nice urethral stump to tie to. Things came together nicely under no tension. A brand new Foley catheter was placed. Fifteen mL was in the balloon. Fibrillar was then placed in the right and left pelvic sidewalls where lymph node dissection was carried out, as well as along the neurovascular bundle resected areas, as well as the dorsal vein complex. Fibrin glue was then placed over these areas as well to secure hemostasis.

A drain was placed through the right lower quadrant Da Vinci port. The 12-mm port was closed with the inlet closure device. All the other port sites were inspected as they were removed under direct visualization. Excellent hemostasis was seen. The umbilical incision was extended out laterally a bit more than normal due to the size of the prostate. I was able to finally get the prostate specimen out with a bag through there. The fascia was closed with a running 0 PDS. Wounds were irrigated and injected with local anesthetic, then staples were placed over all the skin sites. The patient tolerated the procedure well. The Foley was hooked up to dependent drain. He was taken to recovery in stable condition.

Signed: Urologist #1

Patient MR# 888805  
Patient Name: Buddy Batton

Prostate Advanced Case #1  
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Operative Report  
08/03/2007

Preoperative Diagnosis: Prostate cancer

Postoperative Diagnosis: Prostate cancer

Procedure: Laparoscopic-assisted robotics lymphadenectomy, bilateral

Anesthesia: General

Procedure: After Urologist #1 had completed the prostatectomy, we turned our attention to the lymph nodes. The external iliac vein was identified and the lymph tissue between the vein and obturator nerve and artery were removed in the usual fashion. Care was taken to make sure that the nerve was preserved bilaterally. Cautery was used for hemostasis. Both lymph node packets were placed in an EndoCatch bag and were placed off to the side to be removed when the prostate was removed. After the lymph nodes had been removed, Urologist #1 then proceeded on with the vesicourethral anastomosis. The patient tolerated the procedure well.

Signed: Urologist #2

Pathology Report  
08/03/2007

Clinical Information: Prostate cancer

Specimen:

- 1 Prostate
- 2 Bilateral lymph nodes

Gross Description:

Specimen #1 consists of a radical prostatectomy specimen weighing 87 grams and measuring 6.2 x 6 x 4.8 cm. The right seminal vesicle measures 3.3 x 2 x 1 cm and the left seminal vesicle measures 4.1 x 2.2 x 0.9 cm. Sectioning through the seminal vesicles and prostate show solid nodular cut tissue. Sections are taken as follows: Cassette 1A contains a cross section of the right seminal vesicle, Cassette 1B contains a cross section of the left seminal vesicle, Cassette 1C contains the proximal prostatic urethral resection margin, Cassette 1B contains the distal prostatic urethral resection margin, Cassettes 1E through 1H contain sections of the right prostate lobe, and Cassettes 1I through 1L contain sections of the left prostate lobe.

Specimen #2 consists of two fragments of adipose tissue measuring 4.7 x 2.5 x 2 cm and 4.8 x 2.8 x 2.5 cm. Representative sections of the smaller fragment are submitted in Cassettes 2A through 2C and representative sections of the larger fragment are submitted in Cassettes 2D through 2F for microscopic examination.

Final Diagnosis:

1. Prostate, radical prostatectomy: Adenocarcinoma, see CAP checklist.
2. Lymph nodes, bilateral: Lymph nodal tissue with no evidence of metastatic tumor.

Specimen Type: Radical prostatectomy

Histologic Type: Adenocarcinoma

Histologic Grade: Total Gleason score 8, primary pattern 4, secondary pattern 4

Tumor Quantitation: Proportion of prostate involved by tumor approximately 30%

Pathologic Staging:

Primary tumor: pT3a, extraprostatic extension

Regional lymph nodes: pN0, no regional lymph nodes metastasis

Distant metastasis: pMX, cannot be assessed

Margins: Margins uninvolved by invasive carcinoma

Extraprostatic Extension: Present

Seminal Vesicle Invasion: Absent

Perineural Invasion: Present

Venous Large Vessel Invasion: Present

Lymphatic Small Vessel Invasion: Present

Patient MR# 888805  
Patient Name: Buddy Batton

Prostate Advanced Case #1  
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Office Note  
09/08/2007

Patient was seen and examined. Recovering nicely. No complaints of side effects. Recent PSA 0.02 and pelvic negative today. Discussed path report findings of extracapsular extension and ramifications. Offered observation versus radiation versus hormone therapy. Patient not wanting to just observe and chose hormone manipulation. Injected Trelstar and will see patient back in 3 months for PSA and next injection.

Signed: Urologist #1