PHAROS

A beacon of hope in the darkness

Newsletter of the Reading Prostate Cancer Support Group (RPCSG)

Issue 144: March/April/May 2025 *Website: www.rpcsg.org.uk*

THE MARCH MEETING

The speaker at the March meeting was Steph Potter, who is an Associate Directorate Manager - Abdominal Surgery. Steph has been involved in the new building of a urology unit at the RBH (Royal Berkshire Hospital). She has been continually involved in this project for the last three years. Steph gave an interesting account of the project, with some accompanying slides.

The design stage of the project has completed after three years and construction is under way, and the facility is expected to open around June or July this year. The space being vacated by the current Urology Procedures may be utilised by the A&E unit.

The new urology unit is being built at the southern end of RBH and thus is bounded by Craven Road, Addington Road, and Redlands road. Unfortunately some car parking spaces have been lost by the construction.

Steph described the new facility and said that it is a great improvement on the old premises. She showed an artist's impression which can be seen below.

It is a single-story building funded from central funds. She said that it will be tremendous improvement on the old location, and showed the following table of comparisons between the old and the new. You can see that there are more rooms available for all of the functional areas and more space. All rooms will have a window to the outside.

	Today	New MTX design
Reception	• Main 38 seats • Subwait 12	• Main 24 seats • Subwait 27 seats
Consultation rooms	• 5 rooms	• 7 rooms
Treatment room	• 3 Treatment • 1 Ultrasound • 1 Lithotripter	• 4 Treatment • 1 Ultrasound room • 1 Lithotripter room
Recovery room		• New 2 bed patient recovery room • Nurses station
Video clinic & office		• 2 video room
Staff	• No rest room • Procedures and Admin teams separated	• Small rest room and kitchenette • Admin, consultant and Procedures in one building

The new unit will have a reception in two parts – one will be in control of a patient information that will give real time information by television to patients including the expected waiting time, whilst the other part of the reception will deal with the making of appointments. It is proposed that an accelerated path to treatment will be in place, whereby following a consultation, a patient can instantly move to making a treatment appointment, which may possibly be on the same day or shortly thereafter.

The building will be known as the Potts centre. The name is in deference to Frederick Potts who was a hero in World War One.

Frederick was brought up in the Katesgrove area of Reading and was famed for his actions in World War One. He received the Victoria Cross in 1915. He died on the 2 November 1943 at the age of 50 and his funeral was held at Reading Crematorium on the 6th November.

Steph was thanked for her very interesting talk.

THE APRIL MEETING

The April meeting was one of our Open Meetings, at which there is no guest speaker and a great opportunity for members to talk among themselves about anything. These Open Meetings are very popular, and we aim to have a few of them every year.

THE MAY MEETING

The speaker at the May meeting was Mr Bob Yang, Urology Consultant at Royal Berkshire Hospital. Bob specialises in complex and recurrent urinary tract infections, male and female incontinence, sacral neuromodulation and functional urology. Bob also serves as an Associate Lecturer at Oxford University and holds the key position of Director for the American Urological Association Male Incontinence course.

Bob said his aim was to show us the latest devices used to treat incontinence in a relaxed talk.

There are three types of incontinence device: artificial sphincters, slings, and penile clamps.

Bob described pure incontinence and social incontinence. His treatment often focuses on social incontinence where the aim is to provide sufficient control to help a patient in a social context. The aim is not to attempt to achieve complete control of continence.

Bob described the artificial sphincter.

The artificial sphincter comprises three components:

- A cuff, a circular device that fits around the urethra, acting as a valve to control urine flow.
- A pump, which is a small device, typically placed in the scrotum (or labia), that allows the patient to inflate or deflate the cuff.
- A balloon, filled with fluid and located in the abdominal wall and connects to the pump. This balloon is the fluid reservoir for the pump.

How it works:

- When the cuff is deflated, urine can flow normally.
- When the pump is activated, the cuff inflates, closing off the urethra and preventing urine leakage.
- When the patient needs to urinate, they release the pump, deflating the cuff and allowing urine to flow.

Bob explained that if the cuff is too tight it can cut off the blood supply to the tissue of the urethra and so can cause erosion. Bob noted the cuff does take a little time to close down the urine flow. This is normal and is easy accommodated. Bob added that it is important that men do not lose their manual urinary dexterity in order to operate the pump.

The NHS fit the Boston Scientific AMS 800 artificial urinary sphincter (abbreviated to AUS). The 50 plus years of use-case data makes this the gold standard device. An alternative device is the Zelta artificial urinary sphincter, ZSI 375 manufactured by Zephyr Surgical Implants. There is less use-case data for this device.

If you have an AUS, it is crucial that any catheter insertion is performed exclusively by a urologist who is familiar with navigating the AUS. This precaution will help prevent potential damage caused by the catheter. Non-urologists are unlikely to know how to do this.

IMRT treatment of prostate cancer can affect the nerve tissue around the radiation site. This can take a while to appear, and so incontinence can get worse with time. It is possible to have an AUS, but not immediately after treatment. Brachytherapy involves less radiation to the region around the prostate than IMRT and so less impact to nerve tissue.

Bob also explained the success rates of the devices, noting that while absolute dryness is achieved in 15% of cases, social continence is achieved in 80%. He noted that the devices are typically effective for 10 years or more. The AMS 800 is now out of patent, with newer devices £1000 cheaper, however the long successful history of using the AMS 800 means it is still the preferred device.

It is possible to have both an artificial sphincter (AMS 800) and penile implant (AMS 700). There is a 5% infection rate following the AMS surgery. Having both devices increases the risk of infection.

Bob explained he employs transperineal surgery and is minimally invasive. The bulb is placed in the scrotum and the reservoir in the abdomen. This surgery is available on the NHS and typically can take place after any previous treatment for prostate cancer has had a chance to heal. This can be about 9 months allowing for nerve function to recover.

The second type of device is the sling. This is a passive device comprising piece of mesh with a small reservoir of fluid which places a small amount of pressure on the urethra to aid the patient manage their incontinence. This is a good option for patients with mild to medium incontinence. The urologist can add or remove fluid to/from the reservoir in a simple procedure to adjust the pressure.

Bob Yang discussed the differences between mesh complications in men and women, explaining that mesh complications in women are caused by the mesh being placed near the G-spot, while in men, the mesh is used to anchor the silicon bit against the urethra.

The issue of discomfort was discussed, for example when riding a bike. Bob tries to place the body’s fat between the components of the device.

The third option is the penile clamp. The penis has two blood supplies with the urethra running underneath the penis. The clamp is an adjustable Velcro cuff, designed to put pressure on the urethra to hold the urine flow but not the blood flow. A correctly sized cuff will ensure the blood flow is not impeded. Some men find it uncomfortable. A cuff can be used all day, but it is better if it is worn for 3 hours for example. It can lead to a massive reduction in urine loss and is often used by men waiting for AUS surgery. An example is the Pacey Cuff. This is not available on the NHS and costs about £80.

Some men do wear it overnight. If incontinence overnight is an issue, then a super pubic catheter can be an option for a few patients.

Bob mentioned that sacral neuromodulation is electrical stimulation of the pelvic floor muscles to help improve continence.

Bob discussed at what point a patient might consider using one of devices described this evening. Sometimes pads maybe a good option, if only using one or two per day. Bob, as a urologist, must understand the patient's urodynamics. A simple method is to weigh the used pads and then subtract the dry pad weight to get the daily urine load. For example, if the issue is an overactive bladder, a Botox injection can help the bladder to retain more and so improve continence. Many patients can be happy with using a single pad a day.

Bob said his focus as a urologist was to help both men and women manage their incontinence and so improve their quality of life.

RPCSG WALKS AND COFFEE MEETS

The walk in March started in Pangbourne and walked to Goring, where there were refreshments stops in a pub and at a café. The weather was very good and the walk picturesque.

The April walk started at the Barley Mow Slipway car park with a circular walk, finishing with refreshments at the Barley Mow pub. It was an enjoyable occasion.

The May walk was in the park at Aston near Henley, followed by lunch at the Flower Pot.

The group approaching Goring

Crossing the Pangbourne toll bridge

Park at Aston, with the white deer

The Flower Pot at Aston

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