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TURP

Transurethral Resection of the Prostate

RENAL / UROLOGICAL | PERIOPERATIVE CARE | HIGH-YIELD NCLEX | ADULT HEALTH

1 Definition / Overview WHAT & WHY

- **TURP** is the surgical removal (resection) of obstructive prostate tissue through the urethra using a **resectoscope** — *no external incision is made.*
- **Gold-standard surgical treatment** for symptomatic **BPH** (benign prostatic hyperplasia) not responding to medication.
- Post-op management centers on a **3-way Foley catheter with Continuous Bladder Irrigation (CBI)** using **sterile 0.9% NS** to prevent clot obstruction and hemorrhage.

> **Why it matters:** The #1 post-op priorities are *bleeding control* and *catheter patency*. The NCLEX loves to test "first action" when urine turns bright red or output drops.

2 Pathophysiology WHY TURP IS DONE

STEP 1
Aging + DHT effects → prostate enlargement (BPH)

→

STEP 2
Enlarged prostate compresses the prostatic urethra

→

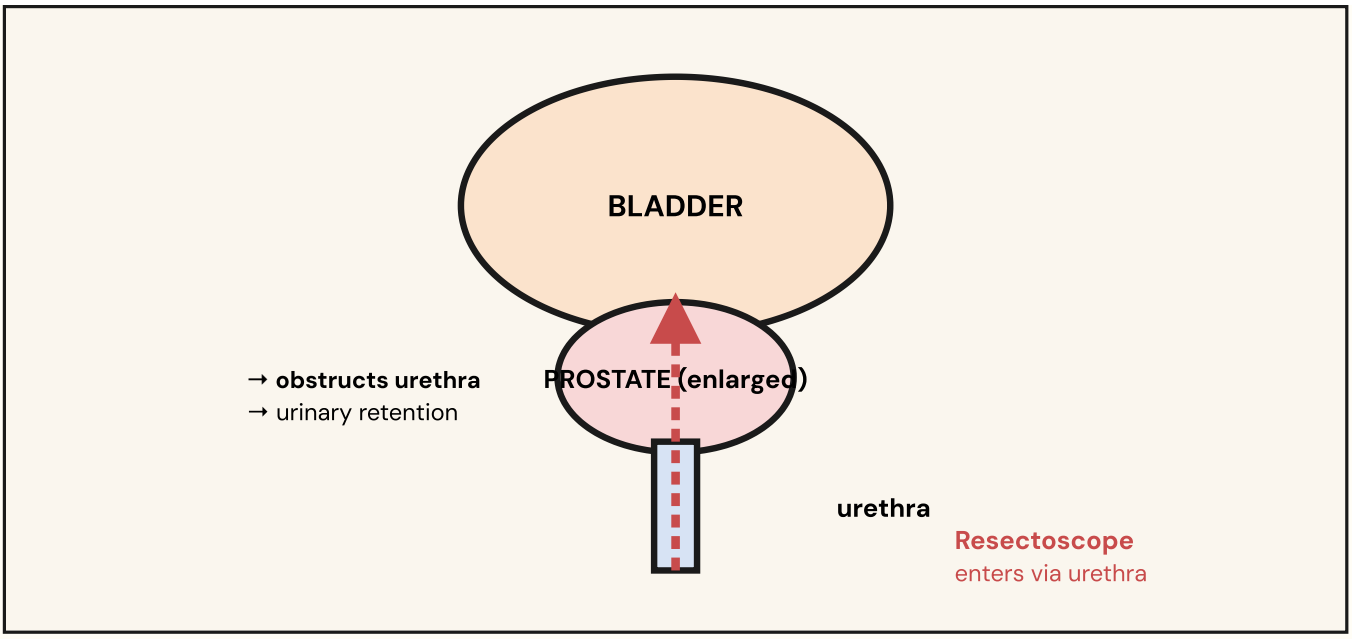
STEP 3
Bladder outlet obstruction: weak stream, hesitancy, frequency, nocturia, retention

→

STEP 4
Resectoscope passed through urethra; prostate tissue shaved away

→

STEP 5
Urethra reopens → urine flows; raw prostatic bed must be flushed clear of clots



3 Post-Op Findings & Complications

EXPECTED VS RED FLAG

✅ EXPECTED (Normal Post-Op)

- **Pink-tinged urine** — light pink to amber via CBI
- Mild **bladder spasms** ("urge to void" with catheter in place)
- Small clots clearing through catheter
- Mild lower abdominal discomfort
- Catheter traction taped to inner thigh (for hemostasis)

🚨 RED FLAGS — Report / Act NOW

- **Bright red urine** with large clots or "ketchup" appearance → hemorrhage
- **Decreased / absent output** with distended bladder → catheter obstruction
- **TUR Syndrome:** confusion, restlessness, nausea, bradycardia, HTN, seizures
- Hyponatremia (Na^+ < 135), pulmonary edema, ↓ Hgb/Hct
- Fever, chills, cloudy/foul urine → infection / urosepsis
- Calf pain, swelling, sudden SOB → DVT / PE

🚨 **TUR Syndrome:** Caused by absorption of large volumes of hypotonic irrigation fluid during the procedure → **dilutional hyponatremia + fluid overload** . Hallmark = *neuro changes + bradycardia + HTN.* Modern use of isotonic NS irrigation has dramatically reduced incidence but the NCLEX still tests it.

4 Priority Nursing Interventions

ABC · SAFETY · PRIORITIZATION

PRIORITY	INTERVENTION	RATIONALE
#1 Bleeding	**Monitor urine color** in CBI tubing — goal = *pink to light red*. Bright red / clots → **increase CBI rate** to flush.	Clots obstruct catheter → bladder distension → ↑ bleeding.
#2 Patency	**Maintain 3-way Foley patency**. Check tubing for kinks/clots. If obstructed → **manual irrigation with sterile NS** (per order).	A clogged catheter is the most common cause of bladder spasms and hemorrhage post-TURP.
I & O	**Subtract** the volume of CBI infused from the total catheter output to determine *true urine output*.	Otherwise output looks falsely high (you can't tell urine from irrigant).
Vital Signs	Q15 min × 1 hr, then Q1 hr × 4–8 hr per protocol; trend BP, HR, Hgb/Hct, Na^+.	Early detection of hemorrhage and TUR syndrome.
Pain / Spasms	Administer **antispasmodics** (Belladonna & Opium suppositories, oxybutynin). **Avoid rectal temps, enemas, suppositories per surgeon** — may stimulate bleeding.	Bladder spasms ≠ pain at incision; treat with smooth-muscle relaxants, not just opioids.
Bowel	**Stool softeners** (docusate). No straining. No enemas/rectal tubes.	Straining (Valsalva) increases pressure on prostatic bed → re-bleeding.
Traction	If catheter taped to thigh for traction, **do NOT release without an order**.	Traction provides direct pressure on the prostatic fossa to control bleeding.
VTE Prevention	SCDs, early ambulation, leg exercises in bed.	Pelvic surgery + lithotomy positioning = high DVT risk.
Fluids	Encourage **2–3 L/day PO** once tolerating fluids (unless contraindicated).	Dilutes urine, flushes bladder, prevents clot formation and UTI.
If hemorrhage:	↑ CBI rate, notify surgeon, check Hgb/Hct, prepare for possible return to OR or bladder irrigation/clot evacuation.	This is a *nursing first action* NCLEX favorite.

5 Pharmacology KEY DRUGS AROUND TURP

DRUG / CLASS	USE	KEY SIDE EFFECTS	NURSING PEARLS
Belladonna & Opium (B&O) suppositories *Antispasmodic / opioid*	Bladder spasms post-TURP	Drowsiness, constipation, urinary retention (not an issue while catheter in)	Rectal route. **Confirm with surgeon** rectal route is permitted post-op.

DRUG / CLASS	USE	KEY SIDE EFFECTS	NURSING PEARLS
Oxybutynin / Tolterodine *Anticholinergic / antispasmodic*	Bladder spasms, urge incontinence	Dry mouth, constipation, blurred vision, urinary retention	Avoid in narrow-angle glaucoma. Watch elderly for confusion.
Docusate sodium (Colace) *Stool softener*	Prevent constipation/straining	Mild abdominal cramping	Take with full glass of water. **Standard post-TURP order.**
Cephalosporin / fluoroquinolone *Prophylactic antibiotic*	Prevent UTI / urosepsis	GI upset, C. difficile, allergic rxn	Verify allergies before administration.
Acetaminophen / opioids (PRN)	Incisional / general pain	Sedation, constipation (opioids)	**Avoid NSAIDs/aspirin × 7–10 days** — increase bleeding risk.
Finasteride / Dutasteride (pre-op) *5-α reductase inhibitor*	Shrink prostate before surgery; long-term BPH tx	↓ libido, ED, gynecomastia. *Pregnancy Category X* — pregnant women must not handle crushed/broken tablets.	Takes 6 mo for full effect. Lowers PSA by ~50% — adjust interpretation.
Tamsulosin (Flomax) *α-1 blocker*	Relaxes prostate smooth muscle (BPH)	**Orthostatic hypotension**, dizziness, retrograde ejaculation, "floppy iris" during cataract surgery	First-dose syncope — take at bedtime. Rise slowly. **Hold morning of surgery.**
Anticoagulants & antiplatelets (Warfarin, ASA, Clopidogrel, NSAIDs)	—	Bleeding	**HOLD pre-op** per surgeon (typically 5–7 days). Re-confirm pre-induction.

6 NCLEX Test Traps ⚠ WRONG VS RIGHT

❌ WRONG
Urine turns bright red with clots → **Stop the CBI** to "let it settle."

✅ RIGHT
INCREASE the CBI rate to flush out clots and maintain patency. Notify surgeon. Stopping CBI lets clots form and obstruct the catheter.

❌ WRONG
Total catheter output 4 hours after surgery = 1800 mL → document as urine output.

✅ RIGHT
Subtract CBI infused volume from total drainage. True urine output = total out − irrigant in. Otherwise polyuria is fictitious.

❌ WRONG

✅ RIGHT

Catheter taped to thigh for traction looks too tight → release the tape to make patient comfortable.

Do NOT release catheter traction without an order. Traction provides hemostatic pressure on the prostatic bed.

✕ WRONG

Patient asks about "milky urine after sex" weeks later → call HCP, sounds like an infection.

✅ RIGHT

Retrograde ejaculation is expected after TURP (semen flows into bladder). Harmless. Teach patient: not infection, not infertility-emergency.

✕ WRONG

Confused, restless post-op patient with HTN and bradycardia → assume narcotic effect.

✅ RIGHT

Think **TUR Syndrome** (hyponatremia, fluid overload). Notify HCP, check Na^+, anticipate hypertonic saline & diuretics.

✕ WRONG

Bladder spasm → "I'll give more morphine."

✅ RIGHT

First — **check catheter patency for clots/kinks**. Then administer the prescribed **antispasmodic** (B&O suppository, oxybutynin). Opioids don't fix smooth-muscle spasms.

✕ WRONG

Patient wants to give himself an enema for constipation post-op.

✅ RIGHT

NO enemas, no rectal tubes, no rectal thermometers post-TURP. Use stool softeners and increase fluids/fiber. Rectal stimulation can disrupt the prostatic surgical site.

7 Patient & Family Education DISCHARGE TEACHING

🏠 Activity

- ✓ **No heavy lifting > 10 lb** for 4–6 weeks
- ✓ No driving for ~2 weeks
- ✓ No prolonged sitting (pressure on prostatic bed)
- ✓ Avoid Valsalva — no straining at stool
- ✓ **No sexual activity** for 2–6 weeks (per surgeon)
- ✓ Gentle walking encouraged

💧 Hydration & Diet

- ✓ Drink **2–3 L water/day** (unless restricted)
- ✓ Avoid **caffeine, alcohol, spicy foods** — bladder irritants
- ✓ High-fiber diet to prevent constipation
- ✓ Continue stool softener as ordered

🚻 What's Normal vs Not

☎️ Call Provider Immediately

- ✓ **Pink-tinged urine** for several days is OK
- ✓ **Burning/frequency** may persist 4–6 wk
- ✓ **Some incontinence** early → improves with Kegels
- ✓ **Retrograde ejaculation** is permanent & harmless ("dry orgasm")
- ✓ Erectile function usually preserved; ED is uncommon but possible

- **Bright red urine, large clots, or inability to void**
- Fever > 101°F (38.3°C), chills, foul-smelling urine
- Severe lower abdominal pain or distension
- Calf swelling/pain, sudden chest pain or SOB
- Persistent incontinence past several months

Kegels: Tighten pelvic floor muscles 10 sec × 10 reps × 4–5 times/day to speed urinary continence recovery.

8 Memory Boosters

MNEMONICS & PATTERN RECOGNITION

T·U·R·P

- **T** **Three-way Foley** with CBI
- **U** **Urine pink** = good; red with clots = bad
- **R** **Resect** prostate via urethra (no incision)
- **P** **Prevent** straining: stool softeners, fluids, no Valsalva

"P·I·N·K"

- **P** **Patency** — keep catheter clear of clots
- **I** **I & O** — subtract irrigant from total
- **N** **Notify** for bright red urine / no output
- **K** **Keep** traction (don't release without order)

TUR Syndrome → "BRAIN"

- **B** **Bradycardia** (paradoxical)
- **R** **Restlessness** / confusion
- **A** **Altered** Na^+ (hyponatremia < 135)
- **I** **Increased** BP & fluid overload
- **N** **N/V,** seizures, visual changes

"NO RECTAL!"

NO rectal thermometers

NO enemas

NO rectal suppositories (except per surgeon, e.g., B&O)

NO rectal tubes

Why? All can disrupt the fresh prostatic surgical site.

Pattern shortcut: If the question shows *distended bladder + ↓ output + bladder spasms* → it's a **clogged catheter** , not bleeding. First action: assess tubing/manual irrigate per order, *not* opioid.

NCJMM Clinical Judgment Scenario

6-STEP NGN WALKTHROUGH

Case Scenario

A 68-year-old male is **4 hours post-op** from a TURP for symptomatic BPH. He has a 3-way Foley with CBI running at a moderate rate. The nurse notes the urine has turned **bright red with visible clots** over the past 30 minutes, the CBI bag is nearly full, and the catheter drainage has **slowed**. Vital signs: BP 102/64, HR 112, RR 22, SpO_2 96%. The patient reports **strong urge to void and severe lower abdominal pressure**. Bladder is firm and distended on palpation. Most recent Hgb 10.2 (down from 13.4 pre-op).

1 Recognize Cues — RECOGNIZE

Bright red urine + clots; ↓ catheter output; firm distended bladder; urge to void with catheter in; HR 112 (tachycardia); BP trending down; Hgb dropped 3.2 points; severe lower abdominal pressure.

2 Analyze Cues — ANALYZE

Two intertwined problems: (a) *Catheter obstruction from clots* — explains the slowed output, full CBI bag, bladder distension, and urge to void. (b) *Active hemorrhage from the prostatic bed* — explains the bright red urine, clot formation, tachycardia, and falling Hgb. Untreated, clot retention will worsen bleeding and may precipitate bladder rupture or hypovolemic shock.

3 Prioritize Hypothesis — PRIORITIZE

#1 hypothesis: *Catheter occlusion from clots with ongoing hemorrhage*. This is the priority because circulation (C) is threatened. Bleeding cannot be controlled until patency is restored.

4 Generate Solutions — GENERATE

- **Increase CBI rate** immediately to flush clots
- **Manually irrigate** the catheter with sterile NS per protocol if CBI fails to clear obstruction
- Verify catheter **traction** is still in place; do NOT release
- Notify the surgeon STAT; anticipate orders for clot evacuation / return to OR
- Draw CBC, type & crossmatch; anticipate transfusion if Hgb continues to fall
- Continuous VS, large-bore IV access, fluids; assess for shock
- Reassess bladder, output, and urine color every 15 minutes

5 Take Action — ACT

The nurse **increases CBI to maximum tolerated rate**, performs **manual irrigation with sterile NS** per standing order, confirms catheter **traction taped firmly to thigh**, and notifies the urologist while a second nurse draws labs and prepares for possible transfusion. Pain/spasm is reassessed once patency is restored.

6 Evaluate Outcomes — EVALUATE

Effective: Urine returns to pink-tinged, large clots cleared, bladder soft and non-distended, HR < 100, BP stable, urge-to-void resolves, follow-up Hgb stable. **Ineffective / escalate:** persistent bright red urine, output remains low after irrigation, BP continues to fall, Hgb continues to drop → patient returns to OR for cystoscopic clot evacuation and/or surgical hemostasis.

SOURCE DISCLOSURE

This topic — *Transurethral Resection of the Prostate (TURP)* — was **NOT PRESENT** in the uploaded reference notes for this library. Content was synthesized from the standard NGN NCLEX 2026 reference set: *Saunders Comprehensive Review for the NCLEX-RN* (Silvestri), *ATI RN Adult Medical-Surgical Nursing*, *Lippincott Illustrated Reviews: Pharmacology*, and the **AMERICAN UROLOGICAL ASSOCIATION (AUA) CLINICAL GUIDELINE ON MANAGEMENT OF BENIGN PROSTATIC HYPERPLASIA (BPH)**. Clinical content reviewed against current NCLEX-RN 2026 Test Plan blueprint categories (Physiological Adaptation, Reduction of Risk Potential, Pharmacological and Parenteral Therapies).