2023 USANZ VICTORIAN SECTION MEETING

Friday 6 October 2023

The Events Centre, Collins Square
Melbourne, Victoria

Urology... Not Urology

FINAL PROGRAM

Diphereline®

triptorelin embonate

Treatment that works with life*

*** Diphereline® offers flexible dosing with 6-, 3- and 1-monthly formulations.[1]**

Diphereline is indicated for the treatment of hormone-dependent locally advanced or metastatic prostate cancer (PCa)[1]

Reference: 1. Diphereline® Approved Product Information.

Before prescribing please refer to full Product Information which is available from Ipsen Medical Information.
Ph: 1800 317 033 or from www.guildlink.com.au/gc/ws/ipsen/pi.cfm?product=ispdi

PBS Information: Restricted Benefit. Locally advanced (stage C) or metastatic (stage D) carcinoma of the prostate.

Diphereline® in Prostate Cancer: Triptorelin embonate 3.75 mg (1-month formulation) and 11.25 mg (3-month formulation) and 22.5 mg (6-month formulation). **Indications:** Treatment of hormone-dependent locally advanced or metastatic prostate cancer. See PI for all indications. **Contraindications:** Known hypersensitivity to triptorelin or product excipients, GnRH or other GnRH agonist analogues; spinal cord compression secondary to prostate cancer metastases. **Precautions:** Initial transient increase in serum testosterone levels with potential transient worsening of symptoms of prostate cancer (tumour flare) and cancer related pain (metastatic pain) – consider administration of anti-androgen to counteract initial rise in serum testosterone levels and worsening of clinical symptoms; isolated cases of spinal cord compression or urethral obstruction; androgen deprivation therapy may prolong the QT interval; increased risk of cardiovascular disease; increased risk of myocardial infarction, sudden cardiac death and stroke; potential bone mineral density loss; increased risk of mood changes and incident depression (which may be severe); hyperglycaemia and increased risk of diabetes mellitus; unmasking of previously unknown gonadotroph cell pituitary adenoma which may present as pituitary apoplexy; adjustment of antihypertensive therapy may be required; haematoma risk in patients treated with anticoagulants; suppression of the pituitary gonadal system. **Drug Interactions:** Use with caution when administered with medicines known to prolong the QT interval or induce torsade de pointes; or with other medicines affecting pituitary secretion of gonadotrophins; hyperprolactinaemic agents should not be prescribed concomitantly. **Effect on driving / using machinery:** Ability to drive and use machines may be impaired because of side effects of treatment or as a result of underlying disease. **Adverse Events:** Very common (≥10%): asthenia, back pain, paraesthesia lower limbs, libido decreased, erectile dysfunction, hyperhidrosis, hot flush. Common (≥1%, <10%): nausea, dry mouth, injection site erythema, inflammation, pain, reaction, oedema, hypersensitivity, weight increased, musculoskeletal pain, pain in extremity, headache, dizziness, loss of libido, depression, mood changes, pelvic pain, hypertension- see full PI. **Dose:** Diphereline 3.75 mg once a month or 11.25 mg once every three months or 22.5 mg once every six months. **Administration:** Intramuscular injection; injection site should be varied periodically; inadvertent intravascular injection must be strictly avoided- see full PI for administration details. **Storage:** Store below 25°C. Please refer to PI for preparation instructions. Date of Preparation: 4th August 2022

Diphereline® is a registered trademark. For further information about Diphereline®, contact Ipsen Pty Ltd: T (03) 8544 8100 F (03) 9562 5152 E info@ipsen.com.au www.ipsen.com.au, Level 5, 627 Chapel Street, South Yarra, Victoria 3141, Australia. Ipsen Pty Ltd, ABN 47 095 036 909. Date of preperation: October 2022 TRI-AU-000956

IPSEN
Innovation for patient care
UROLOGY-ONCOLOGY

Conveners' Welcome

Dear Colleagues,

As our calendars fill quickly for 2023, we look forward to welcoming you to the Victorian Section Meeting of the Urological Society of Australia and New Zealand.

Following a very successful event last year, we welcome you back to The Events Centre, Collins Square, for a day of education, presentations and interaction. Monash Health are excited to host the meeting and whilst numerous high quality scientific conferences are available, this year we are focusing on fresh and lesser explored topics of non-core urology, hence our theme; "Urology... not Urology".

We are thrilled to bring you a variety of colourful and intriguing sessions which are guaranteed to encourage thought, discussion and interest. Please note, this year we will start with the Annual General Meeting, before moving into the scientific sessions. Topics include; dealing with our complications, a forum on transgender issues, as well as, the role of physiotherapy in urology. We will include a wholesome nursing program, a registrar education session, as well as submitted research presentations.

This year we have a novel stand-out Q&A roundtable session, which we are fortunate to have attracted several distinguished panelists who will explore the future challenges of urological care in Victoria. This promises to be an event of interest, so secure your seats early!

Immediately following the program, all attendees and industry representatives are invited to enjoy themselves and catch up amongst some live music at the closing drinks.

We warmly welcome you to our Victorian Section Meeting.

Gideon Blecher FRACS
Urology Convener

Sarah Ransley
Nursing Program Convener

Sponsors and Exhibitors

Sponsors/exhibitors do not have influence or control over the program content and activities occurring at this meeting.

Major Sponsors

IPSEN Innovation for patient care

mundipharma

Exhibitors

Abbvie Pty Ltd
Astellas Pharma Australia
AstraZeneca
Avant
Bayer
Boston Scientific
Cook Medical
INTERPHARMA
Ipsen
Karl Storz Endoscopy Australia Pty Ltd
LifeHealthcare
Mayne Pharma
Medical Developments International (MDI)
Mundipharma
Novoglan Phimosis Treatments
Olympus
Pacific Edge Pty Ltd
Palette Life Sciences
Teleflex Medical

Keynote Speaker

Kieran Hart

Kieran is a urologist from Canberra who performs genital affirmation surgery for trans-gender and gender diverse assigned male at birth patients. To date he has done over 200 of these procedures.

Invited Speakers

Patrick Johnson

Patrick is a Psychiatrist, Psychotherapist, and Educator. He has worked with medical students, trainees, and medical colleagues across public and private practice.

Patrick started his medical career working predominantly in Emergency Medicine. He then changed direction, training in Psychiatry and following this, Child Psychiatry. Patrick's work has included being the CAMHS Clinical Director for a major regional Victorian service for just on ten years, which involved collaboration with Paediatricians, General Practitioners, and other Specialists.

A particular focus has been on Consultation-Liaison Psychiatry, which he continues as the Psychiatrist in the Anaesthetic Department at the RCH in the Pain Management Service. In private practice Patrick has specialised in psychoanalytical psychotherapy for adults, supervision, and secondary consultation.

Patrick has experience in medical education and student welfare. He has been an Honorary Senior Lecturer at Monash University for over thirteen years and was a visiting Honorary Associate Professor at University College Dublin. Patrick has been involved in teaching and lecturing medical students, and in college training and exams of local and overseas Trainees.

Adam Lynch

Adam Lynch is President of BEAT Bladder Cancer Australia - Australia's leading bladder cancer patient advocacy charity.

Adam founded BEAT in 2018 following the tragic loss of his wife due to bladder cancer. As carer, Adam had to navigate a world where there was a real lack of patient-centric information and support available for bladder cancer patients & carers.

BEAT's philosophy is to think and act with the PATIENT front-of-mind, making information & support accessible, understandable and actionable.

BEAT's mission is to –

- Raise bladder cancer awareness amongst the community
- Provide information & support for patients & carers
- Raise our profile into medical professionals, GPs and nurses
- Influence research, diagnosis & treatment options

Russell Briggs

Russell Briggs is a registered nurse with 25 years' experience. He is the General Manager of PCFA's Specialist Nursing National Program which includes over 100 nurses providing over 100,000 patient contacts annually. Russell is currently undertaking postgraduate research, exploring the unmet needs of men with prostate cancer on active surveillance.

Dwayne Pearce

Arrernte man from Mparntwe (Alice Springs). Registered Aboriginal Health Practitioner having worked in ICU, Cardiology and Mental Health while living in Alice Springs.

Dwayne moved from Alice Springs to Melbourne in 2019 for a change of career yet still working in Aboriginal Health. Dwayne is currently the Manager of Aboriginal Health Service's with Monash Health.

Invited Speakers (cont)

Monash Urology Nursing Team

Carolyn, Kate and Jincy are part of Urology team at Monash health covering Casey and Moorabbin campuses. Between them, they have years of urological nursing experience and found their passion whilst all working across diverse areas of Urology.

Iffy Middleton

Iffy commenced her role as a Specialist Nurse for patients with gender incongruence in London in 2003.

Iffy has presented locally and internationally and, moved to Australia in 2018 to continue her work and research within this field.

Outside of work Iffy relaxes by going to Rugby and now doing LEGO!

Sarah Ransley

Sarah has worked at Monash Health for over 25 years and has specialised in Urological Nursing for most of that time. Sarah has been a Urology Nurse Cystoscopist for 14 years assisting in the coordination of the Nurse Led Bladder Cancer surveillance program servicing over 700 patients across Monash Health. She also has a keen interest in development of nursing roles within the Urology field.

Michelle Dutton

Michelle is a GP who has worked in trans healthcare since 2014. Like many health professionals, she had a lot to learn, and now seeks to share that knowledge with others. She has worked at Northside Clinic, Equinox and Orygen Youth Health. Her vision is for trans people to feel safe and affirmed wherever they seek healthcare

Dixon Woon

Dixon has a special interest in robotic and complex open surgery for urological cancers. He completed his Society of Uro-oncology Fellowship at the University of Toronto and Princess Margaret Cancer Centre, Canada in 2019. He currently works at Austin, Eastern and Epworth Health.

Gideon Blecher

Gideon Blecher is a Urologist who specialises in Men's health issues, ED, Peyronie's disease, male fertility and genital reconstruction.

Hayley Irving

Hayley is a passionate Pelvic Health Physiotherapist. She is the Pelvic Health Team Lead at Monash Health as well as a member of the Pelvic Health teaching team at Melbourne University. She is the outgoing President of the CFA Physio Group and sits on the NCOI scientific committee for 2023. She is an invited assessor for both titling and specialisation for the APA.

Invited Speakers (cont)

Mark Frydenberg AM

Mark Frydenberg AM, is the Academic Director of Urology Cabrini Health and Professor, Department of Surgery, Faculty of Medicine, Nursing and Health Sciences, Monash University.

Ben Harris

Ben Harris is Director Policy and Research, Private Healthcare Australia. An economist by training, Ben has worked for many years in health and social policy roles for government and the not for profit sector. He is also the author of a number of policy papers, including *Is Medicare Fair?* And *Australia's Mental and Physical Health Tracker*.

David Koczkar

David was appointed Chief Executive Officer of Medibank in May 2021. He commenced at Medibank in 2014, holding the roles of Chief Operating Officer and then Group Executive – Chief Customer Officer where he was responsible for the Health Insurance and Diversified Financial portfolios, Live Better and the AHM business.

Luis Prado

Dr Luis Prado was appointed as the Director of Medical Services and Clinical Governance at St John of God Health Care in July 2023. Dr Prado is a highly experienced senior health care executive and medical leader. His previous senior leadership roles include Chief Medical Officer and Executive Director Academic and Medical Services at Epworth HealthCare and Chief Medical Officer at UnitingCare Health.

He is a Professor at Deakin University and has an affiliate academic appointment, Doctor of Medicine Clinical School.

Dr Prado is skilled in clinical governance, health systems innovation, change management, and strategic planning.

Lydia Johns Putra

Lydia is a general urologist in Ballarat. She sits on the RACS Board of Urology, is a RACS ASSET instructor and has previously been Chair of the Urology Specialty Specific Examination Subcommittee, the urology representative on the RACS Surgical Sciences Examination Committee and chair of the Victorian Section of USANZ.

Felicity Topp

Felicity is the Chief Executive of Peninsula Health, leading 7,000 people across multiple services throughout the Frankston/Mornington Peninsula area. She is an experienced healthcare executive and has worked in public health for over 35 years. She has previously held executive roles at Peter MacCallum Cancer Centre, Barwon Health and the Royal Melbourne Hospital.

Felicity has a Master of Public Health, a Bachelor of Nursing and postgraduate qualifications in intensive care nursing and health counselling. Felicity is a graduate of the Australian Institute of Company Directors, is a Fellow of the Fairfax Ethical Leadership Centre and a Board Director of HealthShare Victoria.

Program at a Glance

Program correct at the time of distribution (September 2023). Please refer to the next page for the full final program

Friday 6 October 2023

7:00am - 8:00am	Registration and Arrival Tea and Coffee Anteroom	
8:00am — 9:00am	Concurrent Session 1A: Trainee Education Assembly I&II	Concurrent Session 1B: USANZ Annual General Meeting *including the President's Address by Helen O'Connell* Assembly III, IV, V
9:00am — 9:50am	Session 2: Don't take this personally - Dealing with your complications Assembly I&II	
9:50am — 10:10am	USANZ Aotearoa New Zealand Autonomy Project Assembly I&II	
10:10am — 10:40am	Morning tea with the Industry Anteroom	
10:40am — 12:40pm	Concurrent Session 3A: Research Presentations Assembly I&II	Concurrent Session 3B: Nursing Session Assembly III, IV, V
12:40pm — 1:30pm	Lunch with the Industry Anteroom	
1:30pm — 3:00pm	Session 4: Gender Forum - Implications for Urology Assembly I&II	
3:00pm — 3:30pm	Session 5: Physiotherapy in Urology - What's on Offer Assembly I&II	
3:30pm — 4:00pm	Afternoon tea with the Industry Anteroom	
4:00pm — 5:30pm	Session 6: Sustainability of Healthcare - A Q&A Roundtable Assembly I&II	
5:30pm	Closing Drinks Anteroom "Schmooze" - a time for casual social catch up with colleagues. Enjoy amongst drinks and live music.	

ELIGARD®

leuprorelin acetate

The only subcutaneous ADT injection available in 4 dosing options[1]

1 month | 7.5mg
5 repeats
12 injections per year

3 month | 22.5mg
1 repeat
4 injections per year

4 month | 30mg
1 repeat
3 injections per year

6 month | 45mg
0 repeats
2 injections per year

Nadir T*

EFFICACY[1]
97% of patients achieved nadir serum T ≤0.35 nmol/L*

SUBCUTANEOUS ADMINISTRATION[2]
Short needle length (1.59 cm) and small injection volume (<0.5 mL)

FLEXIBLE DOSING OPTIONS[2]
1, 3, 4 and 6 months

Abbreviation: ADT = androgen deprivation therapy.
*Nadir serum T: lowest value of testosterone observed during treatment.

PBS Information: Restricted Benefit. Locally advanced (stage C) or metastatic (stage D) carcinoma of the prostate.

Please review the Product Information before prescribing. Product Information can be accessed via www.mundipharma.com.au/products or via the QR code.

Adverse events should be reported. Reporting forms and information can be found at https://aems.tga.gov.au/.
Adverse events should also be reported to drugsafety@mundipharma.com.au

Reference: 1. Pieczonka CM, et al. REv Urol. 2018;20(2):63-68. **2.** ELIGARD® Approved Product Information, July 2022.

Mundipharma Pty Limited ABN 87 081 322 509. Sydney NSW 2000. Tel: 1800 188 009.

Final Program

Friday 6 October 2023

Program correct at time of distribution (September 2023).

7:00am — 8:00am	Registration and Arrival Tea and Coffee
8:00am — 9:00am	**Concurrent 1A: Trainee Education** Patients that present with problems you don't see in public outpatients *Paul Manohar and Amit Ganguly*
8:00am — 9:00am	**Concurrent 1B: USANZ Annual General Meeting**
8:00am	President's Address *Helen O'Connell*
9:00am —9:50am	**Session 2: Don't take this personally - Dealing with your complications**
9:00am	Acknowledgement of Country and introduction *Sarah Ransley*
9:05am	Dealing with your complications *Led by Patrick Johnson*
9:50am —10:10am	**USANZ Aotearoa New Zealand Autonomy Project**
10:10am — 10:40am	Morning tea with the Industry
10:40am — 12:40pm	**Concurrent 3A: Research Presentations**
10:40am	Cardiovascular events remain the leading cause of death following endoscopic prostate surgery – An analysis of the Australia and New Zealand Audits of Surgical Mortality Data *Elena Galiabovitch*
10:49am	Biomechanical and immunobiological properties of human fascia lata (HFL) vs mesh: implications for pelvic reconstructive surgery *David Hennes*
10:58am	Prospective assessment in bladder cancer surveillance of DNA mutation analysis in liquid biopsies by Droplet Digital PCR *Antara Karmakar*
11:07am	A prospective observational study assessing CxBladder compared to conventional haematuria workup for detection of urothelial carcinoma *Samantha Koschel*
11:16am	Can incorporating PSMA PET into prostate cancer risk calculators better risk stratify patients compared to traditional models? *Gideon Ptasznik*
11:25am	Patient-centred pathology reporting improves patient experience, and understanding of disease in prostate cancer care *Jordan Santucci*
11:34am	Development and implementation of an online learning curriculum for foundations in robotic surgery *Daniel Costello*
11:39am	Comparison of ureteric stent complications in an Australian public hospital *John El-Khoury*
11:44am	What is the best way to manage Ureteric Calculi in the time of COVID-19? A comparison of Extracorporeal Shockwave Lithotripsy (SWL) and Ureteroscopy (URS) in an Australian healthcare setting *Matthew Farag*
11:49am	Trial of Void at Home post GLL PVP *Arjun Guduguntla*
11:54am	Heated intravesical chemotherapy with mitomycin for high-risk non-muscle invasive bladder cancer: a single Australian centre experience *David Hopkins*
11:59am	Comparison of intravesical gemcitabine-docetaxel and re-induction BCG as salvage therapy for bladder cancer *Kylie Yen-Yi Lim*
12:04pm	Outcomes of cystectomy patients admitted to intensive care by hospital type: a national cohort study *Jessica Paynter*

Final Program (con't)

12:09pm	Maintaining balance, wellness and happiness as a busy Urologist *Ranjit Rao*
12:14pm	The diagnostic accuracy of Renal MRI in a tertiary Melbourne hospital: a 10-year review *Jordan Santucci*
12:19pm	Cost-effectiveness of single-dose intravesical therapy after TURBT in Australian healthcare system *Niranjan Sathianathen*
12:24pm	A multispectral immunohistochemistry panel to investigate T cells in the tumour microenvironment of penile squamous cell carcinoma *Jiasian Teh*
12:29pm	Percentage of free PSA as a biomarker for survival in metastatic castration-resistant prostate cancer *Andrew Silagy*
10:40am — 12:40pm	**Concurrent 3B: Nursing Session**
10:40am	Welcome *Sarah Ransley*
10:43am	Available resources for urology nurses: Bladder cancer resources for patients *Adam Lynch (virtual)*
10:50am	Available resources for urology nurses: prostate cancer resources for patients *Russell Briggs*
10:55am	Available resources for urology nurses: Aboriginal and Torres Strait Island liaison *Dwayne Pearce*
11:05am	Functional urological nursing care: Care of the Nephrostomy – Nursing Edition *Monash Urology Nursing Team (Kate Green, Carolyn Jackson and Jincy Kuriakose)*
11:25am	Gender incongruence - Care of the gender diverse patient *Iffy Middleton*
11:55am	Gender reassignment surgery *Kieran Hart*
12:25pm	Introduction to the gender forum – Why it's important to me *Sarah Ransley*
12:40pm — 1:30pm	Lunch with the Industry
1:30pm — 3:00pm	**Session 4: The Gender Forum - Implications for Urology**
1:30pm	What is gender dysphoria, what do urologists and their nurses need to know *Dixon Woon*
1:35pm	The trans patient consultation – To-dooos and taboos with an overview of gender affirming hormonal care *Michelle Dutton*
2:05pm	Vaginoplasty and urological implications of gender surgeries *Kieran Hart*
2:35pm	Phalloplasty *Gideon Blecher*
2:55pm	Discussion
3:00pm — 3:30pm	**Session 5: Physiotherapy in Urology - What's on Offer**
3:00pm	Monash Physiotherapy Department *Hayley Irving*
3:30pm — 4:00pm	Afternoon tea with the Industry
4:00pm — 5:30pm	**Session 6: Sustainability of Healthcare - A Q&A Roundtable** *Mark Frydenberg* – Moderator *Ben Harris* – Director, Policy and Research, Private Healthcare Australia *David Koczkar* – CEO, Medibank Private *Luis Prado* – Group Director Medical Services and Clinical Governance, St John of God Health Care *Lydia Johns Putra* – Deputy Chairperson, RACS Board of Urology *Felicity Topp* – CE, PeninsulaHealth
5:30pm - 7:30pm	Closing Drinks "Schmooze" - a time for a casual, social catch up with colleagues. Enjoy amongst drinks and live music.

General Information

Registration Desk and Venue

The registration desk will be located in Tower 2, Level 5, The Events Centre, Collins Square, Melbourne, Victoria.

Opening hours: Friday 6 October 2023: 7:00am – 5:00pm. For more information about the venue please visit: https://www.collinssquare.com.au/events-meetings/

Industry Exhibition

Morning tea, lunch and afternoon tea will be served in the industry exhibition in the Anteroom.

Closing Drinks

"Schmooze" - a time for a casual, social catch up with colleagues. Enjoy amongst drinks and live music.
Friday 6 October 2023 | 5:30pm - 7:30pm
Venue: Anteroom, Level 5, The Events Centre, Collins Square, Melbourne, Victoria
Dress code: Business attire/smart casual
All meeting registrations include a ticket to the closing drinks.

Continuing Professional Development (CPD) Program

This educational activity has been approved in the RACS CPD Program. RACS Fellows, Specialist International Medical Graduates (SIMGs) and surgeons participating in the RACS CPD Program can claim one point per hour in Educational Activities.

RACS Fellows who have included their RACS ID at the time of registration will have their RACS CPD automatically updated in their ehub.

Parents' Room and Childminding Services

A parents' room will be available at the venue, please visit the registration desk if required. Below is a list of childcare agencies that offer inhome childcare in Melbourne.

RACS/USANZ accepts no liability for any of the below-listed childcare companies and it is up to the individual to choose and be responsible for their bookings.

Asharon Agency
www.asharonagency.com.au/home

Rockmybaby Australia
www.rockmybaby.com.au/pages/home

Abracadabra Childcare Services
www.abrachild.com.au/

Special Dietary Requirements

Please note that the venue is responsible for all catering at the meeting and RACS Conferences and Events Management and USANZ does not inspect or control food preparation areas or attempt to monitor ingredients used. You should contact the venue directly for all special dietary requirements during the meeting, irrespective of whether details have been provided to RACS. If RACS requests information about your dietary requirements for a specific event, RACS will endeavour to forward the information provided to the venue (time permitting). RACS will not retain information provided for future events, so you must verify your requirements for each event. Even if information is requested or provided, RACS takes no responsibility for ensuring that the venue acknowledges your dietary requirements or that these requirements can be met. In all cases you must verify for yourself that your dietary requirements have been met and RACS refutes any and all liability for any failure to adequately provide your special dietary requirements or any consequential damage resulting from such failure.

General Information

Intention to Photograph

Please be advised that photographs may be taken during the meeting and reproduced by the meeting organiser/USANZ. These photographs may be used for the following purposes:

- Projection onsite
- Reporting on the meeting in online and hard copy publications
- Marketing a future meeting, including online and hard copy publications
- Publishing in RACS/USANZ publications

If you do not wish to be included in a photograph, please advise the photographer.

Car Parking

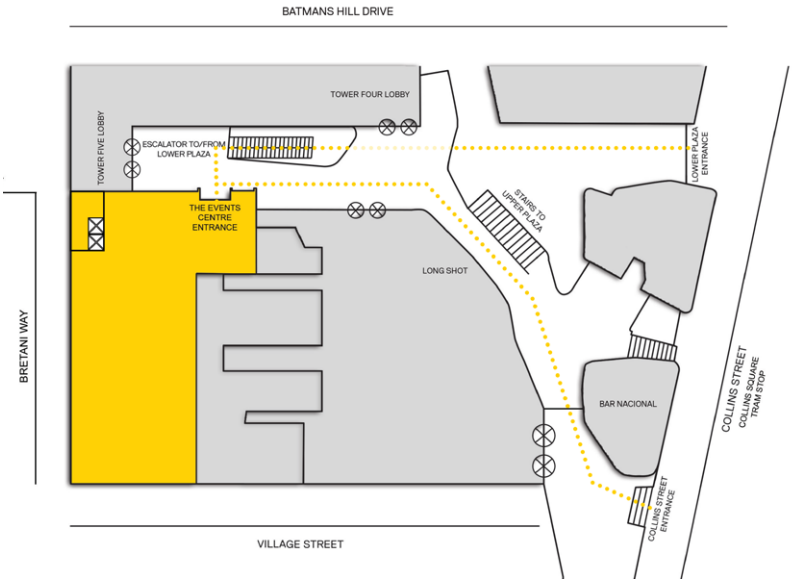
There are several public car parks within walking distance of Collins Square.

- Secure Parking – 700 Collins Street, Melbourne. Located approximately 150m from 727 Collins Street (2-minute walk)
- Watergate Care Park – 767 Bourke Street, Melbourne. Located approximately 400m from 727 Collins Street (5-minute walk)
- World Trade Centre – Siddeley Street, Docklands. Located approximately 500m from 727 Collins Street (6-minute walk)
- Inter Park – 717 Bourke Street, Docklands. Located approximately 500m from 727 Collins Street (7- minute walk)
- Wilson Parking – 800 Bourke Street, Melbourne. Located approximately 550m from 727 Collins Street (7-minute walk)

Public Transport

The Events Centre, Collins Square is positioned within the CBD and within close proximity to public transport.
If catching the train, the venue is 200m from Southern Cross Station. Alternatively, tram stop D15-Batmans Hill/Collins St (Tram 48 and 11) is located just outside the venue.

Access Map



Abstracts

Note: Abstracts are listed in alphabetical order of the presenter's surname.

DEVELOPMENT AND IMPLEMENTATION OF AN ONLINE LEARNING CURRICULUM FOR FOUNDATIONS IN ROBOTIC SURGERY

D.M. Costello, T. Fay, D. Driscoll, S. Tissot, K.Larkins, H. Mohan

International Medical Robotics Academy, Victoria, Australia

This study aimed to create an online curriculum for robotic surgery designed to prepare novice robotic surgeons for hands on experience. To do so, Kern's 6 step model for curriculum development was employed. First, a literature review highlighted a lack of standardisation and access to high quality online robotic surgery resources. In step two, a needs assessment was conducted using expert group consensus and a review of the existing robotic surgery textbooks. Structured interviews with consultant surgeons and registrars were used to assess educational needs and course experiences, this determined the goals and objectives for the curriculum in step three. Ten definitive theory modules for an online robotic surgery course were initially determined. Step four outlined the education strategy; flexible, high-quality, online robotic surgery education, developed for, and delivered by robotic surgeons. Step 5 involved beta-testing the curriculum, post-course surveys and structured interviews were used to evaluate the course, the participants rated the course highly overall. In step six the curriculum underwent two rounds of evaluation and feedback the first round of feedback was sort from participants that completed the beta-testing, the Royal Australasian College of Surgeons provided feedback for the second round. Overall, the course was seen as credible and of higher educational value than other available resources. The Royal Australasian College of Surgeons recommended increasing flexibility within the course and made suggestions for the content format. An 11th module was added to prepare participants for hands on experience. The final curriculum emerged as the Foundations in Robotic Surgery and has been formally adopted by the Royal Australasian College of Surgeons and the Irish College of Surgeons. This is the only robotic course to be credentialled by these training colleges.

WHAT IS THE BEST WAY TO MANAGE URETERIC CALCULI IN THE TIME OF COVID-19? A COMPARISON OF EXTRACORPOREAL SHOCKWAVE LITHOTRIPSY (SWL) AND URETEROSCOPY (URS) IN AN AUSTRALIAN HEALTHCARE SETTING

Dr. Matthew Farag[1], Mr. Greg Jack[1], Mr. Lih Ming Wong[2], Mr. Dan Lenaghan[2], Mr. Damien Bolton[1]

[1] Austin Health, [2] St Vincent's Hospital, Victoria, Australia

Introduction & Objectives
Many ureteric stones still require treatment during the COVID-19 pandemic. In this setting, in which resources are constrained, extracorporeal shockwave lithotripsy (SWL) has prima facie advantages over ureteroscopy (URS). It is also necessary to also consider post-treatment resource consumption in regards to complications and repeat procedures.

Methods
The ideal ureteric stone treatment during a pandemic such as COVID-19 would involve minimum resource consumption and a minimum number of patient attendances. We compared all patients initially treated with SWL to those initially treated with URS for acute ureteral colic within the state of Victoria, Australia in 2017.

Results
2724 ureteric stones were analysed, a cumulative '3-month exposure and burden on the healthcare system' was calculated for each patient by their initial procedure type. The number of hospital attendances per patient was 1.62 days for SWL versus 1.99 days for URS ($p=0.0412$). The number of procedures per patient was 1.52 for SWL versus 1.89 for URS ($p=0.0213$). In the 3 months following the procedure, re-admissions through the emergency department were 5% for URS and 10% for SWL, $p= 0.015$, with significantly more re-admissions for URS within the first 28 days ($p<0.0001$).

Conclusions
Patients with ureteric stones treated initially by SWL have shorter length of stay with fewer overall attendances and procedures at 3 months than those treated with URS. During a pandemic such as COVID-19, SWL may have benefits in preserving hospital resources and limiting opportunity for virus transmission, compared to URS.

Abstracts (cont'd)

TRIAL OF VOID AT HOME POST GLL PVP

Arjun Guduguntla, Dennis Gyomber

Northern Health, Victoria, Australia

Greenlight Photo-Sensitive Vaporisation of the Prostate (Greenlight PVP) is a novel alternative to conventional Transurethral Resection of Prostate (TURP) associated with decreased post-operative bleeding. At Northern Health, in standard cases, post-operative patients get two full bags of 2L saline at full rate and then have their bladder washout ceased; patients then proceed to their trial of void (TOV) day 1 post-operatively. This retrospective cohort study aims to assess the outcomes of selected patients who have undergone the TOV at home program conducted in conjunction with Hospital In The Home (HITH) between April 2023 and August 2023. In this program, patients are sent home on the day of surgery post washout, and undergo their TOV with HITH the following day. The aim of this program is to reduce the overall inpatient stay for GLL PVP patients. This not only beneficial for patients, but also has positive economical and resource implications on the healthcare system. The primary outcome was measured as the rate of success of TOV. Secondary outcomes were hospital re-admission rates and patient satisfaction. All 13 patients who have gone through the TOV at home pathway thus far have had successful TOVs. There have been no hospital re-admissions, and patient satisfaction is overall quite high. Despite being limited by small sample size so far, we have shown that in carefully selected patients post GLL PVP, trial of void at home is a safe and feasible option. This study is a proof of concept that other healthcare systems may adopt a similar program to benefit both patients and their healthcare providers.

BIOMECHANICAL AND IMMUNOBIOLOGICAL PROPERTIES OF HUMAN FASCIA LATA (HFL) VS MESH: IMPLICATIONS FOR PELVIC RECONSTRUCTIVE SURGERY.

David Hennes[1,2,3], Saeedeh Darzi[2], Kallyanashis Paul[3], Victoria Buckley[3], Michael Carey[3], J. Werkmeister[1,2], A. Rosamilia[2,3], C. Gargett[1,2], S. Mukherjee[1,2]

[1]Ritchie Centre, Hudson Institute of Medical Research, Clayton, VIC, Australia
[2] Monash University, Clayton, VIC, Australia
[3] Monash Health, Clayton, VIC, Australia

Aims:
This study aimed to evaluate the morphometric properties, biomechanical properties and in vivo foreign body response of HFL in a pre-clinical murine abdominal incision model. Furthermore, we investigated the key molecular mechanisms driving its integration in the body to inform its application in augmentative procedures for pelvic organ prolapse.

Methodology:
Human fascial lata (HFL) was harvested from consenting women undergoing autologous fascial grafting for sacrocolpopexy or pubovaginal sling insertion (n=26). HFL and polypropylene mesh were characterised using uniaxial tensiometry using cyclical loading. HFL or mesh was implanted in C57/BL6 immunocompetent mice via an abdominal skin incision (n=8 mice/gp/time-point). Histological analysis of explants at 7 and 90-day time-points included cell infiltration, elastin and collagen content. Quantitative PCR was used to assess 80 genes associated with ECM homeostasis, cell adhesion, angiogenesis and inflammation in explanted tissues as fold changes to non-operative controls.

Results:
HFL tissue is primarily comprised of relatively acellular fibrous collagen, conferring superior tensile properties in comparison with synthetic mesh. At 7 days, HFL exhibited good tissue integration with histological evidence of host cell infiltration within the graft, while mesh demonstrated loose integration, increased acute inflammatory cell infiltration and foreign body giant cell formation surrounding explants. Quantitative PCR analysis revealed a significant increase in genes associated with ECM production (Tgfrb1), ECM regulation (Mmp2) and angiogenesis (Fgf1, Ang-1) in the HFL group compared with synthetic mesh at 90 days, indicating significantly improved wound healing.

Abstracts (cont'd)

Conclusion:
HFL is a highly durable alternative surgical graft with superior tissue integration when compared to polypropylene mesh Consisting of fibrous structural proteins such as collagen and elastin confers high mechanical adaptability and durability, making this an ideal surgical implant for augmentative pelvic reconstructive procedures.

HEATED INTRAVESICAL CHEMOTHERAPY WITH MITOMYCIN FOR HIGH-RISK NON-MUSCLE INVASIVE BLADDER CANCER: A SINGLE AUSTRALIAN CENTRE EXPERIENCE

Dr David Hopkins [1], Dr Sachin Perera [1], Haoyue Zhang [2], Dr Geo Zhou [1], Elizabeth Hayes [1], Mr Paul Anderson [1]

[1] Royal Melbourne Hospital, VIC, Australia
[2] University of Melbourne, VIC, Australia

Introduction
Bladder cancer is the seventh most common form of cancer in men, with non-muscle-invasive bladder cancer (NMIBC) comprising an estimated 75% of new cases. Current guidelines for the treatment of high-risk NMIBC recommend surgical resection by TURBT with adjuvant intravesical bacillus Camille Guérin (iBCG). However, effective, bladder-sparing treatments for BCG-refractory or intolerant patients remain limited. Hyperthermic intravesical chemotherapy with mitomycin C (HIVEC with MMC), an alternative adjuvant treatment for iBCG, has been employed in the Royal Melbourne Hospital since 2016. This group sought to evaluate the efficacy and safety of adjuvant HIVEC with MMR in preventing bladder cancer recurrence and progression in our centre.

Methodology
A single-centre, retrospective analysis of a prospectively gathered database concerning all HIVEC with MMC treatment in our centre from 2016 to 2022 was performed. Demographic, pathologic, treatment and adverse event data were analysed. Appropriate statistical analysis was performed using SPSS. Primary outcome was recurrence-free survival at 12-months. Secondary endpoints included disease-related mortality, adverse event incidence and severity.

Results
26 patients underwent at least one induction cycle of HIVEC with MMR. Mean age was 74.5 years. 61.5% (n=16) had previously undergone treatment with BCG. 57.7% (n=15) had carcinoma in situ disease present on histopathology. 15.3% (n=4) stopped HIVEC with MMR treatment due to adverse events (two for rash, two for LUTS). Recurrence-free survival at twelve months was 61.5%, following at least a full induction cycle (six doses) of HIVEC with MMC. There was no disease-related mortality at twelve months.

Conclusion
This small retrospective analysis found HIVEC with MMC is a well-tolerated, bladder-sparing alternative treatment where BCG is not feasible. Strong recurrence free survival at twelve months suggests strong treatment efficacy, though the sample size included is small.

PROSPECTIVE ASSESSMENT IN BLADDER CANCER SURVEILLANCE OF DNA MUTATION ANALYSIS IN LIQUID BIOPSIES BY DROPLET DIGITAL PCR

Dr Antara Karmakar, Professor Shomik Sengupta, Professor Ian Davis, Dr Pavel Sluka

Monash University/Eastern Health Clinical School, Victoria, Australia

Increasing bladder cancer detection and improved survival rates has resulted in increased healthcare burden in surveillance. High demand for surveillance flexibile cystoscopies, urine cytology and imaging, especially in NMIBC patients, has created an opportunity for more efficient, cost-effective alternatives which can deliver precision medicine for the patient.

The aim of our study was to prospectively assess our DNA mutation panel by Droplet Digital PCR (ddPCR) in patients diagnosed with NMIBC at various surveillance timepoints, and correlate with clinical status of cancer presence or absence. Sixteen patients were prospectively assessed for median of 10 months (range 3-24 months) from most-recent NMIBC tissue diagnosis at time of recruitment. Three patients had positive urine at time of tissue recurrence (HGT1, LGTa, PUNLMP), all with negative plasma. Eight patients had a

Abstracts (cont'd)

positive urine and/or plasma sample within the first 12 months, in keeping with reported recurrence rate of 50% in NMIBC. Four patients had negative liquid biopsy, concordant with clinical status. Twelve patients had atleast one positive surveillance liquid biopsy during the prospective follow-up.

Although this is a small cohort, the results of our DNA mutation panel are promising for use in NMIBC surveillance, potentially providing an alternative to cystoscopies or urine cytology at surveillance timepoints. The study is ongoing to strengthen these initial findings and provide longer follow-up data.

A PROSPECTIVE OBSERVATIONAL STUDY ASSESSING CXBLADDER COMPARED TO CONVENTIONAL HAEMATURIA WORKUP FOR DETECTION OF UROTHELIAL CARCINOMA

Samantha Koschel, Brett Anderson, Niall Corcoran, Homi Zargar

Western Health, Victoria, Australia

Introduction:
Exclusion of urothelial carcinoma (UC) is pertinent in patients presenting with haematuria. Conventional investigations include voiding urine cytology, dedicated upper tract imaging and cystoscopic assessment of the bladder. CxBladder is a urine based genomic biomarker assessing five RNA expressed genes. It uses a mathematical equation to calculate the probability of UC based on risk factors (age, smoking status, gender) and biomarker expression, with the goal being to establish those with very low probability of UC where traditional investigations are not required. Our aim was to assess the role of CxBladder in excluding UC in patients presenting with haematuria.

Method:
This is a prospective observational study that recruited patients referred to Western Health for assessment of haematuria. Enrolled patients provided a urine sample for CxBladder analysis prior to flexible cystoscopy, and also underwent routine upper tract imaging and voiding urine cytology. Ethics approval was obtained through Western Health Ethics Panel (HREC/19/WH/57718).

Results:
259 patients were enrolled between July 2020 and February 2023, with 244 eligible for analysis. CxBladder was considered positive in 96 patients (39.3%) with 12 of these positive for UC at subsequent bladder biopsy, including 7 with high grade UC, 1 with CIS, 3 with low grade UC and 1 with prostate cancer invading into bladder. Of the 148 patients with negative CxBladder, only 1 had a positive bladder biopsy for low grade UC. Negative predictive value was 99.3% in this cohort, with sensitivity 92.3%. There were a significant number of false positive CxBladder results, with specificity 63.6% and positive predictive value 12.5%.

Conclusion:
In our cohort of haematuria patients, CxBladder demonstrated excellent negative predictive value and sensitivity for detecting UC in keeping with existing literature. In low risk patients, it represents an ideal alternative to more invasive and costly workup with imaging, urine cytology and cystoscopy.

COMPARISON OF INTRAVESICAL GEMCITABINE-DOCETAXEL AND RE-INDUCTION BCG AS SALVAGE THERAPY FOR BLADDER CANCER

Kylie Yen-Yi Lim, Jincy Kuriakose, Obaid Fazli, David Pook, Sarah Ransley, Janice Downie, Matthew Harper, Scott Donnellan, Weranja Ranasinghe

Monash Health, Victoria, Australia

Aims:
Non-surgical therapeutic options for patients who fail initial BCG with non-muscle invasive bladder cancer (NMIBC) are limited. Re-induction of BCG has a 50% response while intravesical gemcitabine-docetaxel is associated with a 50-58% 2-year high-grade recurrence-free survival. We compare our institution's experience with re-induction BCG compared to intravesical gemcitabine-docetaxel therapy after failure of initial induction BCG.

Abstracts (cont'd)

Methodology:
Patients who received induction BCG therapy were retrospectively identified between 2017-2022. Inclusion criteria were patients who had initial BCG treatment with high-grade NMIBC recurrence post BCG induction and received intravesical gemcitabine-docetaxel or re-induction BCG.

Results:
From 2017-2022, 135 patients underwent induction BCG for NMIBC. Seventeen (12.6%) patients had high-grade non-muscle invasive recurrence following induction BCG. Of these, five (29.4%) were treated with re-induction BCG, six (35.3%) received intravesical gemcitabine-docetaxel, one underwent palliative radiotherapy and one had an early cystectomy. The remaining four patients had no further treatment. The median age of patients who received re-induction BCG and gemcitabine-docetaxel was 74 and 78 years old respectively. The majority (80%) of re-induction BCG patients and all who received gemcitabine-docetaxel (100%) were male. Four (80%) patients had HGTa and one (10%) HGT1 prior to re-induction BCG, while four (66.7%) patients had HGTa and two (33.3%) HGT1 prior to Gem/Doce treatment.

On post-treatment cystoscopy, one patient (20%) had high-grade recurrence (HGT1 + CIS) post BCG re-induction while no patients had high-grade recurrence post gemcitabine-docetaxel.

Both groups of patients completed all 6 doses of treatment. Four patients (80%) who underwent re-induction BCG reported urgency, frequency and dysuria. Compared to the four (66.7%) who had gemcitabine-docetaxel who experienced mild-moderate urinary frequency, dysuria and lethargy.

Conclusion:
Our initial experience with intravesical gemcitabine-docetaxel demonstrates that it appears to be safe and better tolerated in patients with BCG failure NMIBC compared to re-induction BCG. Further evaluation of longer-term outcomes is required.

OUTCOMES OF CYSTECTOMY PATIENTS ADMITTED TO INTENSIVE CARE BY HOSPITAL TYPE: A NATIONAL COHORT STUDY.

Jessica A. Paynter, Zakary Doherty, Janelle Brennan, David Pilcher,

Bendigo Health, VIC, Australia

Introduction and Aims:
Cystectomy is a complex surgical procedure with high peri-operative mortality and morbidity. There has been much advocacy for radical cystectomies to occur at high-volume, centralised institutions. Most of this literature comes from European countries which may not be applicable in Australia due to the reality of Australia's expansively distributed rural population. Some studies have shown improved outcomes at higher volume centres (not higher volume surgeons) which is thought to be due to improved perioperative care. A cornerstone of this is Intensive Care Unit (ICU) management. ICU admissions following cystectomy are common and this study aimed to compare patient outcomes for patients admitted to ICU following cystectomy between rural and non-rural hospitals in Australia .

Methodology:
This was a retrospective, national study of 3381 adult patients admitted to 178 Australian ICUs following cystectomy between January 2011 and December 2021, using the Australian and New Zealand Intensive Care Society Adult Patient Database. Comparisons between outcomes per hospital type were made using the Kruskal-Wallis rank sum test and Pearson's Chi-squared test as indicated. Rural hospitals were defined as Modified Monash Model 2 and above.

Results:
Rurally admitted patients (n=295) were more likely to live further away (63km vs 19km, $p<0.001$) and be more socially disadvantaged than metropolitan patients, who were more likely to be immunosuppressed (4.4% vs 7.6%, $p=0.0002$). Rurally admitted patients were more likely to stay longer in ICU (2.09 days vs 1.12 days, $p<0.001$) compared to metropolitan patients. There was no significant difference in in-hospital mortality (1.9% vs 2.4%, $p=0.066$).

Abstracts (cont'd)

Conclusion: There was no difference in early mortality outcomes for cystectomy patients requiring ICU admission between rural and non-rural public hospitals. These findings contribute towards the argument against centralisation of all cystectomy patients.

CAN INCORPORATING PSMA PET INTO PROSTATE CANCER RISK CALCULATORS BETTER RISK STRATIFY PATIENTS COMPARED TO TRADITIONAL MODELS?

Gideon Ptasznik, Brian Kelly, Matthew J. Roberts, Paul Doan, Phillip Stricker, James Thompson, James Buteau, Kenneth Chan, Omar Alghazo, Jonathan S. O'Brien, Michael S Hofman, Mark Frydenberg, Nathan Lawrentschuk, Dara Lundon, Declan G Murphy, Louise Emmett, Daniel Moon

Sir Peter MacCallum, Victoria, Australia

Introduction:
Numerous studies are beginning to demonstrate that a combination of PSMA PET/CT and mpMRI of the prostate are superior to MRI-only diagnostic algorithms in the primary diagnosis of PCa[1].

Aims:
To develop of novel risk calculator (RC) incorporating mpMRI and PSMA PET data from a cohort of men undergoing imaging modalities prior to TP biopsy[2].

Methodology:
291 men from the PRIMARY[2] study were included with no external validation cohort. The RC was developed using multivariable logistic regression analysis to predict overall cancer (GG $\geq$ 1) and csPCa (GG $\geq$ 2) and then compared to the ERSPC-MRI calculator. Resampling methods were used to evaluate the discrimination and calibration of the RC and to perform decision curve analysis.

Results:
The MRI only RC resulted in an AUC of 0.791 for overall PCa and 0.812 for csPCa. In comparison to the MRI/PSMA RC which produced 0.831 and 0.875 for PCa and csPCa respectively

Conclusion:
PSMA PET PCa RC's outperform tools with MRI only.

[1]Ptasznik G, Papa N, Kelly BD, Thompson J, Stricker P, Roberts MJ, et al. High PSMA PET SUVmax in PI-RADS 4 or 5 men confers a high probability of significant prostate cancer. BJU International. 2022;n/a(n/a).

[2]Emmett L, Buteau J, Papa N, Moon D, Thompson J, Roberts MJ, et al. The additive diagnostic value of prostate-specific membrane antigen positron emission tomography computed tomography to multiparametric magnetic resonance imaging triage in the diagnosis of prostate cancer (PRIMARY): a prospective multicentre study. European urology. 2021.

MAINTAINING BALANCE, WELLNESS AND HAPPINESS AS A BUSY UROLOGIST

Ranjit Rao

Epworth Hospital, Victoria, Australia

Medicine and Surgery has higher rates of mental health problems than the general community. There are a combination of factors that lead to this including personality traits; overachievement, demand for perfection; workplace stress; time scarcity; lack of relaxation outlet; relationship dysfunction; and many more.
Maintaining balance is a skill, just like any else, but it needs to be prioritised, elevated, and guarded against many competing forces for one's time. Failure to do so, risks the downward spiral into poor physical and mental health.

In this presentation, I would like to share how I strategically structure my time, schedule, and calendar in a daily, weekly, monthly and

Abstracts (cont'd)

yearly way, in order to stay in balance both on and off the urological playing field.

PATIENT-CENTRED PATHOLOGY REPORTING IMPROVES PATIENT EXPERIENCE, AND UNDERSTANDING OF DISEASE IN PROSTATE CANCER CARE

Santucci J, Al Saffar H, Tan J, Murphy D, Moon D, Birch E, Koschel S, Medhurst E, Jobson D, Lawrentschuk N

Peter MacCallum Cancer Centre, Victoria, Australia

Aim:
Patient-centred (PC) care improves patient satisfaction and health outcomes. We investigated the benefit of utilising a PC pathology report in patients undergoing radical prostatectomy (RP) for prostate cancer (PCa). Our study aimed to compare patient understanding of their PCa diagnosis after RP upon receiving either a standard pathology report or a personalised PC report.

Methods:
Patients from three metropolitan urology clinics were randomised to receive either a PC or standard pathology report. Patient satisfaction questionnaires (Perceived Efficacy in Patient-Physician Interactions (PEPPI), Consultation And Relational Empathy (CARE), Communication Assessment Tool (CAT) and a knowledge test were conducted within 72 hours of the initial appointment, and again at 4 weeks. Accurate recollection of Gleason Grade Group (GG) and extracapsular extension (ECE) were classified as 'correct'. Comparison of correctly answered 'knowledge' questions was analysed using chi-squared test. A significance level of $p \leq 0.05$ was used.

Results:
Data from 62 patients were analysed (30 standard versus 32 PC report). No significant baseline differences were found between groups. Both groups reported high levels of satisfaction with their healthcare experiences in all domains of patient-physician rapport, empathy, and communication. No significant differences were observed between groups in PEPPI (p=0.68), CAT (p=0.39) and CARE (p=0.66) scores, at 0 and 4 weeks. 93% of patients who received PC report understood the report while 90% felt the report added to their understanding of their PCa. Regarding patient knowledge, the PC report group had significantly more correct answers on GG and ECE, as compared to the standard report group, at 0 and 4 weeks (p

THE DIAGNOSTIC ACCURACY OF RENAL MRI IN A TERTIARY MELBOURNE HOSPITAL: A 10-YEAR REVIEW

Haidar Al Saffar, Jordan Santucci, Tom Sutherland, Lih-Ming Wong
St Vincent's Hospital Melbourne, Victoria, Australia

Aims:
While Ultrasound (USS) and Computed Tomography (CT) are first choice modalities for renal imaging, magnetic resonance imaging (MRI) can be used in the event of compromised renal function, contrast allergy, or avoiding radiation in pregnant women and children. Previous studies demonstrate that MRI has significantly higher specificity than CT with equivalent sensitivities in the assessment of renal masses. Moreover, MRI may alter the Bosniak classification and ultimately change management. We aim to investigate the diagnostic accuracy of renal MRIs for renal masses performed at St Vincent's Hospital Melbourne (SVHM).

Methods:
We performed a retrospective review of all renal MRI studies completed between 2012 and 2022. MRIs were correlated with USS and CT, while the diagnosis was confirmed using biopsy and tissue diagnosis.

Results:
52 renal MRIs were retrieved. The average patient age was 64 years, whilst 24 (46%) and 33 (63%) patients underwent an USS and CT, respectively, prior to MRI, while 18 (34%) patients had both.

In 15 patients with indeterminate renal lesions on CT or USS, prior imaging often showed discordance between the USS and CT or was unable to identify solid versus cystic lesions. In this subset, MRI revealed seven solid lesions, two angiomyolipomas, and six cysts. Five

Abstracts (cont'd)

biopsies were taken to investigate these lesions, which identified four malignant lesions and one benign angiomyolipoma.

Following MRI, six patients (11%) went straight to surgery and avoided a biopsy, whilst four patients underwent a radical nephrectomy and two underwent a partial nephrectomy. Surveillance without active treatment was offered to 11 patients after MRI, eight of whom remain on surveillance and two of whom have since undergone radical nephrectomy or repeat angiomyolipoma embolization.

Conclusion:
MRI was useful in selected cases where it led to biopsy or surgery. Alternatively, MRI provided a radiological diagnosis that prevented an unnecessary biopsy.

COST-EFFECTIVENESS OF SINGLE-DOSE INTRAVESICAL THERAPY AFTER TURBT IN AUSTRALIAN HEALTHCARE SYSTEM

Niranjan Sathianathen[1], Jacob Gantz [2], Nathan Lawrentschuk [1] , Edward Messing [2], Badrinath Konety [3]

[1] University of Melbourne, Victoria, Australia
[2] (University of Rochester, New York, USA)
[3] (Allina Health, Minnesota, USA)

Aims
International guidelines recommend the administration of single-dose intravesical chemotherapy after transurethral resection of low-grade bladder tumours to reduce the risk of subsequent recurrence. Both Mitomycin C and Gemcitabine have been shown to be effective in reducing recurrence risk. The cost-effectiveness of using these agents have not been established locally. We undertake a cost-effectiveness analysis of using Mitomycin C or Gemcitabine after TURBT of low-grade bladder lesions in the Australian healthcare setting.

Methodology
A state transition model was developed to simulate the management of men diagnosed with LR NMIBC. At the time of initial diagnosis, men were hypothetically treated with intravesical gemcitabine, intravesical mitomycin or no intravesical therapy. We then modelled the natural history of disease for a time horizon of five years and superimposed guideline-based surveillance and treatment strategies. Recurrence and progression rates were informed from the literature and primary data from the SWOG S0337 trial. Costs were calculated from the health sector perspective using 2023 Australian dollars and effectiveness was measured in quality-adjusted life years (QALYs).

Results
Single dose intravesical gemcitabine after TURBT was the cheapest strategy after accounting for the cost of future recurrences. Gemcitabine improved quality-adjusted survival by 2.2 months compared to no intravesical instillation after TURBT. Intravesical Mitomycin C also improved quality-adjusted survival by 0.8 months and was a lower cost strategy than no intravesical instillation. If the hazard ratio for Mitomycin C in decreasing disease recurrence compared to no instillation was less than 0.66 then it became the strategy that represented the best value for money.

Conclusion
Single dose instillation of chemotherapy after TURBT for low-risk disease can improve health outcomes and reduces costs for the Australian health sector. Using Gemcitabine represents better value than Mitomycin C in Australia.

Abstracts (cont'd)

PERCENTAGE OF FREE PSA AS A BIOMARKER FOR SURVIVAL IN METASTATIC CASTRATION-RESISTANT PROSTATE CANCER

Andrew W. Silagy, Dixon T.S. Woon, Ting W. Yiu, Marian S. Wettstein, Hanan Goldberg, Jaime O. Herrera-Cáceres, Hina Shiakh, Gregory Nason, Alexandre Zlotta, Eleftherios Diamantis, Damien Bolton, Neil Fleshner.

Austin Health, Victoria, Australia

Aims
To evaluate whether the percentage of free PSA (%fPSA) in men with metastatic castrate resistant prostate cancer (mCRPC) is associated with cancer-specific (CSS) and overall survival (OS).

Methodology
A prospective biobank of mCRPC cases was analysed for %fPSA (cut-off of 15), clinicopathologic characteristics, first-line systemic therapies and survival outcomes. Cox proportional hazard models evaluated whether %fPSA associated with CSS and OS across the cohort and by treatment.

Results
Of 254 patients with mCRPC, 121 (48%) received Docetaxel and 110 (43%) received abiraterone acetate or enzalutamide (Abi/Enza). Median follow up was 25.6 months (16.0, 37.7). 161 (63%) men had %fPSA >15. Median CSS and OS were 43.8 and 39.6 months, respectively.

Patients with %fPSA >15 had lower PSA than %fPSA <15 (31.30 vs 50.80; p=0.007) and otherwise comparable clinicopathologic and treatment profiles. There was no difference in CSS or OS by %fPSA >15 alone.

On univariable analysis, Docetaxel was associated with adverse CSS (HR 1.6, 95% CI 1–2.3; p=0.032) but not OS (HR 1.4, 95% CI 0.97–1.21; p=0.073), compared with Abi/Enza. OS and CSS among men with %fPSA <15 were similar by treatment. Among men with %fPSA >15, treatment with Abi/Enza conferred favourable OS (HR 0.54, 95% CI 0.33–0.88; p=0.013) and CSS (HR 0.47, 95% CI 0.28–0.80; p=0.005).

On multivariable analysis, treatment with docetaxel (HR 1.72, 95% CI 1.13–2.60; p=0.012), Charlson Comorbidity Index (HR 1.27, 95% CI 1.01–1.60; p=0.04), PSA (HR 1.0, 95% CI 1.0–1.0; p<0.001) and %fPSA >15 (HR 1.56, 95% CI 1.02–2.40; p=0.039) conferred adverse OS. Adverse associations of %fPSA >15 occurred in subgroup analyses of patients treated with docetaxel but not Abi/Enza.

Conclusion
In men with mCRPC, %fPSA >15 treated with Docetaxel is associated with poorer survival. Herein, %fPSA may be an inexpensive prognostic and predictive biomarker.

Abstracts (cont'd)

A MULTISPECTRAL IMMUNOHISTOCHEMISTRY PANEL TO INVESTIGATE T CELLS IN THE TUMOUR MICROENVIRONMENT OF PENILE SQUAMOUS CELL CARCINOMA

Jiasian Teh[1,2,3,5], Robert Ramsay[3,4], Alexander Heriot[3,4], Nathan Lawrentschuk[1,2,3,5,6]

[1] University of Melbourne, Department of Surgery, Austin Hospital, Melbourne Victoria Australia
[2] Young Urology Researchers Organisation (YURO), Australia
[3] Department of Surgical Oncology, Peter MacCallum Centre, Melbourne, Victoria, Australia
[4] Sir Peter MacCallum Dept. of Oncology, University of Melbourne
[5] Department of Surgery, University of Melbourne and Royal Melbourne Hospital, Department of Urology, Melbourne, Victoria, Australia
[6] EJ Whitten Prostate Cancer Research Centre at Epworth Healthcare, Melbourne, Victoria, Australia.

Introduction
Penile squamous cell carcinoma (SCC) is a rare disease with limited treatment options and poor outcomes. Tumour and immunological heterogeneity are factors which may contribute to a patient's response to therapy and is an area which is poorly understood in penile SCC. To further our understanding of the pathological processes of penile SCC, we comprehensively characterised tumours, integrating information from a cellular level with spatial distribution of key immune cell populations in the tumour microenvironment

Methods
Multiplex immunohistochemistry (IHC) was performed on formalin fixed paraffin embedded (FFPE) tissue sections. mIHC staining was performed using a novel protocol with the Opal 7-colour kit. We focused on the following subset of markers: CD8, CD4, PD-L1, FoxP3, PD-1, tumour marker AE1AE3, and nuclear marker DAPI. Cellular phenotypes, cell size and morphology were identified using spectrally unmixed images through the combination of markers listed above.

Results
A novel multiplex immune-labelling protocols were used to each evaluate 7 markers simultaneously within one single FFPE tissue section, and the 7-marker-stained tissue was imaged in multiple spectrums.

Conclusions
This is a pilot study to assess the feasibility of using mIHC in penile SCC, with successful staining of immune cell biomarkers. We demonstrated spatial relationships between individual cellular components in the tumour microenvironment, which may offer novel insights into the dynamic nature and complexity of penile SCC and allow for a more detailed understanding of their biological interactions with their surrounding environment.

Urology... Not Urology

2023 USANZ VICTORIAN SECTION MEETING

Friday 6 October 2023

The Events Centre, Collins Square
Melbourne, Victoria

#USANZVSM23