NAC in LR patients was significantly associated with greater odds of finding ≤pT1 disease at RC (OR 2.62; p<0.001) as well as pT0 status (OR 2.62; p<0.001); however, receipt of NAC in LR patients was not associated with a significant difference in 5-year cancer-specific survival (65% vs 68%; p=0.31).

CONCLUSIONS: Our results validate the proposed risk groups for patients with MIBC and support the use of NAC for HR patients. Moreover, we noted that, while NAC in LR patients was associated with a higher likelihood of favorable pathologic outcomes, only a minority (4.7%) of LR patients treated with up front RC were upstaged but unable to receive adjuvant chemotherapy due to postoperative complications, and receipt of NAC in LR patients was not associated with improved survival.

Source of Funding: None

PD41-08
DOES REGIONALIZATION OF RADICAL CYSTECTOMY IMPACT THE 30 AND 90-DAY MORTALITY IN PATIENTS WITH MUSCLE INVASIVE BLADDER CANCER?
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INTRODUCTION AND OBJECTIVES: Regionalization of bladder cancer treatment to high-volume facilities, with multidisciplinary care, is suggested to improve survival outcomes. The purpose of this study is to evaluate the effect of surgical volume on peri-operative mortality in patients undergoing radical cystectomy (RC) for the management of muscle-invasive bladder cancer (MIBC).

METHODS: We investigated the National Cancer Database (NCDB) to identify patients with clinically localized MIBC (cT2a-T4, M0) who underwent RC from 2004 to 2014. Demographic factors as well as 30 and 90-day mortality were analyzed. Hospitals were divided according to the median number of RC performed per year into low, medium, and high-volume centers. Multivariate logistic regression model was fitted to identify independent predictors of mortality.

RESULTS: We identified 24,763 patients with localized, non-metastatic MIBC who underwent RC from 2004 to 2014. The median number of RCs performed per year in low, medium and high-volume hospitals were 1.64, 14.4 and 26.5 respectively. The majority of RCs were performed at low-volume hospitals (70.86%) whereas only 15.83% were performed at high-volume hospitals. The overall 30 and 90-day mortality rates were 2.62% and 7.7% respectively. When stratified by surgical volume, 30-day mortality rates were 2.87%, 2.19%, and 1.83% (p<0.01); and 90-day mortality rates were 8.25%, 6.9% and 5.9% (p<0.01) at low, medium and high-volume hospitals respectively. On multivariate analyses, higher RC volume per year was identified as an independent predictor of 30 and 90-day mortality. RC in high-volume hospitals was associated with a 31% risk reduction in 30-day mortality (CI 0.48-0.82, p<0.01) and a 37% risk reduction in 90-day mortality (CI 0.31).

CONCLUSIONS: Performing RC at high-volume hospitals reduces the risk of 30 and 90-day mortality. However, in the US only 16% of RC are performed in high-volume hospitals. Further studies are required to evaluate the impact of regionalization.

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PD41-09
COMPARING INTRACORPOREAL URINARY DIVERSION AFTER ROBOT-ASSISTED RADICAL CYSTECTOMY: RESULTS FROM THE INTERNATIONAL ROBOTIC CYSTECTOMY CONSORTIUM: A MATCHED ANALYSIS
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INTRODUCTION AND OBJECTIVES: We aims to utilize propensity score matching to compare perioperative outcomes of intra-corpooreal urinary diversion (ICUD) and extra-corpooreal urinary diversion (ECUD) following robot-assisted cystectomy (RARC) from a multi-national, multi-institutional database, the International Robotic Cystectomy Consortium (IRCC).

METHODS: A retrospective review of patients in the IRCC was performed. To adjust for the selection bias, we used propensity scores matching based on gender, neoadjuvant chemotherapy, clinical T-stage and American Society of Anesthesiologists (ASA) score, with caliper width of 0.005. ICUD was compared to ECUD in terms of perioperative characteristics and complications. Multivariate logistic regression models were fit to evaluate high-grade complication (Clavien ≥3) and 90-days readmissions after RARC. Linear regression model was used to evaluate predictors of operative time.

RESULTS: 1806 patients were matched with 903 patients in each group. Patients with ICUD had lower blood loss (300ml vs 400ml, p<0.001), less blood transfusions (8% vs 20%, p<0.001), shorter operative time (360 vs 377 min., p<0.001), and higher rates of high-grade complications (19% vs 12%, p<0.001). Predictors of high-grade complications were length of stay (OR=1.07 95% CI=1.05-1.09, p<0.001) and history of abdominal surgery (OR=1.48, 95% CI=1.07-2.06, p=0.02). The diversion approach was not a predictor of high-grade complications. The odds for 90 days readmission were male gender (OR=0.58, 95% CI 0.37-0.93, p=0.03), BMI (OR=1.03 95% CI=0.01), and ICUD (OR=1.72, 95% CI 1.14-2.61, p=0.01). Predictors of operative time included young age (<1 minute/year, p<0.002), lower BMI (-3.7 min/unit, p<0.001), high volume centers (1 minute/procedure, p=0.004) and diversion approach (64 minutes shorter for neobladder, p<0.001). Procedures performed in 2013-2017 were 47 minutes faster than the 2005-2008 procedures (p<0.001).

CONCLUSIONS: ICUD is now widely accepted as a minimally invasive approach to urinary diversion. Wider adaption of this approach, steep learning curve, and evolution of technique have resulted in higher complications.

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PD41-10
ROBOTIC RADICAL CYSTECTOMY IS ASSOCIATED WITH SHORTER LENGTH OF STAY AND LESS BLOOD LOSS THAN OPEN RADICAL CYSTECTOMY: RESULTS FROM A LARGE MULTICENTER RETROSPECTIVE COHORT
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INTRODUCTION AND OBJECTIVES: Utilization of robotic assisted radical cystectomy (RARC) is rapidly increasing. However, to date, open radical cystectomy (ORC) eventually preceded by neoadjuvant chemotherapy, still represents the standard for the treatment of muscle-invasive and high-risk non-muscle invasive bladder cancer. A