



MP13-14 USE OF NEOADJUVANT CHEMOTHERAPY IN ELDERLY PATIENTS WITH MUSCLE INVASIVE BLADDER CANCER: A POPULATION-BASED STUDY, 2006-2017

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INTRODUCTION AND OBJECTIVE: Current guidelines recommend neoadjuvant chemotherapy (NAC) prior to radical cystectomy (RC) for muscle invasive bladder cancer (MIBC). NAC has been shown to confer a survival benefit across all ages. Yet, many elderly patients are not offered NAC due to concern regarding physiologic reserve and postoperative complications. Our objective was to evaluate age-based disparity in treatment and outcomes of MIBC.

METHODS: Using the National Cancer Database, we identified patients with MIBC from 2006-2017. First, use of different treatments including RC, RC and adjuvant chemotherapy, RC with NAC ("optimal treatment"), chemo-radiation, and no treatment, was compared between age groups. A second analysis was performed in the cohort of elderly patients, ≥70, undergoing cystectomy. Propensity weighting was used to compare peri-operative and mortality outcomes in those who received NAC vs. no NAC.

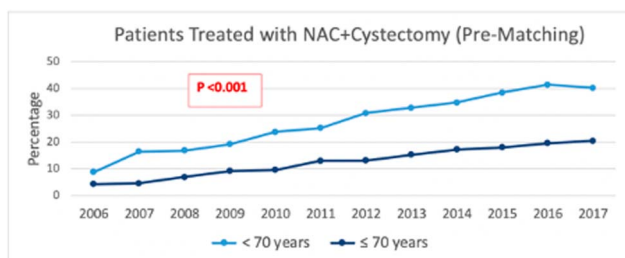
RESULTS: In 70,911 patients with non-metastatic MIBC, use of RC with NAC was lower in patients ≥70, 7.2 vs. 20.9%, p<0.001 (Table 1, Figure 1). Patients receiving RC with NAC were younger, had private insurance, higher high school completion rate and median income, shorter distance to hospital, lower CCI, diagnosis in recent years, and higher stage disease. NAC use was also associated with pelvic lymph node dissection (OR 4.55, p<0.001). In patients ≥70 undergoing RC, NAC was associated with shorter length of stay (LOS) (8.5 vs 9.6 days, p<0.001), decreased 30-day readmission (8.6 vs 10.6%, p=0.003), lower 30- and 90-day mortality (1.9 vs 3.6%, p=0.01 and 4.9 vs 7.7%, p=0.004, respectively), and better overall survival (OS) (43.8% vs. 37.5%, p<0.001). Multivariate logistic regression found NAC as an independent predictor of shorter LOS, lower 30- and 90-day mortality, and improved OS.

CONCLUSIONS: Despite increased omission of NAC in patients ≥70, NAC is not associated with worse peri-operative outcomes or mortality in elderly patients. Advanced age in properly selected patients should not preclude offering NAC prior to radical cystectomy.

Table 1. Treatment differences between age groups. *

Treatment	Pre-Weights			Post-Weights		
	< 70 (n=27,228)	70+ (n=43,683)	p	< 70 (n=15,143)	70+ (n=24,442)	p
RC, no. (%)	5627 (20.7)	7858 (18.0)	<0.001	2959 (19.5)	4483 (18.3)	<0.001
RC + AC, no. (%)	3818 (14.0)	2316 (5.3)		2250 (14.9)	1401 (5.7)	
Chemo-Radiation, no. (%)	1830 (6.7)	5620 (12.9)		857 (5.7)	2785 (11.4)	
NAC + RC, no. (%)	4872 (17.9)	2643 (6.1)		3163 (20.9)	1760 (7.2)	
No Treatment, no. (%)	197 (0.7)	593 (1.4)		0 (0)	0 (0)	
Missing, no. (%)	10884 (40.0)	24653 (56.4)		5914 (39.1)	14013 (57.3)	

*Propensity score weighted adjustment for age, race, year of diagnosis, insurance status, percentage of non-high school completion, area of residence, proximity to hospital, Charlson score, histology, clinical T stage, LN dissection, and surgery type.



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MP13-15 THE ROLE OF PERITONEAL CAVITY SPARING IN THE REDUCTION OF RADICAL CYSTOPROSTATECTOMY (RCP) POSTOPERATIVE COMPLICATION RATES

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INTRODUCTION AND OBJECTIVE: Radical cystectomy remains the gold standard for the management of invasive bladder cancer. However, postoperative complications of this complex surgery still remain the major problem, which ranges between 30-64%. Neobladder extra-peritonization as a method for reduction of postoperative complications was discussed by few authors, showing that it has the potential to reduce the complication rate. In 2018 a video-description of the new technique of peritoneal cavity sparing (Karazanashvili, G. (2018)) was presented at AUA annual congress. We aimed to investigate the role of this new technique in the reduction of the RCP postoperative complications.

METHODS: In 2011-2016 years 98 RCP were performed using the standard transperitoneal descending approach, leaving just a partially extra-peritonized neobladder in the peritoneal cavity. In 2016-2020 years 60 patients underwent RCP using the new technique - peritoneal cavity sparing extraperitoneal RCP with extraperitoneal orthotopic neobladder formation: RCP was performed in a retrograde manner, from apex prostate to the bladder pedicles and the dome; peritoneum was detached from bladder wall and peritoneal cavity hermeticism was kept until complete removal of the specimen and until completion of extended lymphadenectomy. So the peritoneal cavity remained untouched for the most part of the operation. After the creation of the neobladder, it was completely extra-peritonized; the peritoneal cavity was closed almost hermetically (hiatus was left only for neobladder mesentery) without drains. Complication rates after the operations were calculated according to the Clavien-Dindo scale.

RESULTS: The retrospective analysis of complication rates has revealed that Clavien-Dindo Grade 1 to 3 intestinal complications significantly decreased using the new RCP technique compared to the old - standard one: Postoperative ileus medical treatment rate decreased from 3% to 0%; Intra-abdominal urine leakage - from 2.2% to 1.69%; Ileus surgical intervention - from 10.8% to 5.08%; Ileal anastomosis leakage from 5.7 to 0%; Evisceration - from 2.7% to 0%. Thus Intestinal Grade 1 complications decreased from 5.2% to 1.69 and Grade 3 complications - from 18.7% to 5.08%; totally the intestinal complication rate decreased by 17.22% (from 23.9% to 6.77%), however prolonged lymphorrhea rate increased by 12.54% (from 7.8 % to 20.34%).

CONCLUSIONS: Peritoneum cavity sparing extraperitoneal RCP and extraperitoneal orthotopic neobladder formation can lead to notable reduction of RCP postoperative intestinal complication rate in price of prolonged lymphorrhea.

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MP13-16 TRENDS OF LYMPH NODE OUTCOMES IN PARTIAL CYSTECTOMY FOR MUSCLE INVASIVE BLADDER CANCER

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INTRODUCTION AND OBJECTIVE: Local tumor invasion depth has been associated with increased risk of lymphovascular invasion in urothelial carcinoma. Theoretically, MIBC patients undergoing partial cystectomy (PC) or radical cystectomy (RC) with curative intent should be treated equally aggressively with pelvic lymphadenectomy due to the indiscriminate risk of spread. Although utilized for a minority of cases, PC is an important bladder preserving surgery reserved for patients with certain favorable prognostic indicators. There is poor evidence surrounding the utility of pelvic lymph node dissection (PLND) in