P1-1 Day-Case Robotic Adrenalectomy Under ERAS Protocol: Early Outcomes from a Single-Centre Experience

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Introduction
Day-case robotic procedures are increasingly used to manage a variety of surgical conditions. The implementation of Enhanced Recovery After Surgery (ERAS) protocols aims to optimise perioperative care, reduce complications, and minimise healthcare costs. This study evaluates patient characteristics and short-term outcomes following robotic adrenalectomy performed within an ERAS framework.
Methods
A retrospective review was conducted of all patients who underwent day-case robotic adrenalectomy between November 2023 and March 2025. All procedures followed a standardised ERAS protocol, which included multimodal analgesia, early mobilisation, oral intake, and avoidance of bladder catheterisation. Surgical technique involved a transperitoneal approach in a flank position using four robotic trocars. Transversus abdominis plane blocks were administered intraoperatively. All patients followed the ERAS protocol, which included a 5-day course of ibuprofen, paracetamol with additional codeine and endocrine medications prescribed as needed. Each patient received an endocrinology review prior to discharge and within the first postoperative week.
Results
Eleven patients were included. The median age was 49.0 years (46.0–62.0), and the median BMI was 30.0 kg/m² (28.0–35.0). Most patients were male (72.7%, n=8), all were ASA grade 2, and 72.7% (n=8) had an ECOG performance status of 0. Tumours were located on the right in 63.6% (n=7) of cases. The median tumour size on CT was 15.0 mm (13.0–22.0), and the median estimated blood loss was 10.0 mL (5.0–10.0) and the median operative time was 54.0 minutes (27.0–74.0 minutes). A history of prior abdominal surgery was present in 27.3% of patients (n=3). Median surgical time was 54.0 minutes (27.0–74.0). Indications included primary hyperaldosteronism (72.7%, n=8), androgen-producing tumour (9.1%, n=1), RCC metastasis (9.1%, n=1), and adrenocortical carcinoma (9.1%, n=1). No intraoperative or postoperative complications occurred, and no patients required readmission.
Conclusion
Day-case robotic adrenalectomy performed under an ERAS protocol is safe and well-tolerated in selected patients.

P1-2 Impact of Pelvic Lymph-node Dissection on Oncological Outcomes in Patients with Non-muscle-invasive Bladder Cancer undergoing Radical Cystectomy

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Introduction: In the majority of very high-risk and selected high-risk cases of non muscle-invasive bladder cancer (NMIBC), radical cystectomy (RC) may be performed. However, the necessity of pelvic lymph node dissection (PLND) in this clinical scenario is still debated. This review aimed to evaluate whether performing PLND and the extent of dissection can affect survival outcomes in patients with NMIBC.

Materials and Methods: A systematic literature search was performed on July 6th, 2025, without language or time restrictions. Studies were considered eligible if they compared oncological outcomes between various extents of PLND during RC for NMIBC. The primary endpoint was overall survival (OS); secondary endpoints included cancer-specific survival (CSS) and recurrence-free survival (RFS).

Results: Nine retrospective studies comprising 20,806 patients were included. Seven studies evaluated OS, three CSS, and four RFS. Most studies demonstrated an OS benefit associated with PLND, particularly in patients with T1 tumors. Greater lymph node yield - especially the removal of ≥10 or >20 nodes - was consistently associated with improved OS. Similarly, extended PLND was linked to better CSS and RFS in several studies. However, findings for recurrence-related outcomes were heterogeneous, and endpoint definitions varied.

Conclusions: PLND during RC for NMIBC may be associated with improved survival outcomes, especially in patients with T1 HG disease. Higher lymph node yield may further enhance oncologic benefit. These findings support the consideration of at least limited PLND during RC for high-risk NMIBC. Nevertheless, prospective randomized studies are needed to establish definitive recommendations

P1-3 The Significance of Body Mass Index in the Outcomes of Bacillus Calmette-Guérin Treatment in High-Risk Non-Muscle Invasive Bladder Cancer during the Covid-19 Period: a Single Centre Experience

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Introduction
Intravesical Bacillus Calmette-Guérin (BCG) remains the gold-standard treatment for high-risk non-muscle-invasive bladder cancer (NMIBC), reducing recurrence and progression rates. Body mass index (BMI) has been associated with immune modulation which may influence the efficacy and tolerability of BCG. The aim of this analysis is to evaluate how BMI influences BCG treatment outcomes, providing insight into risk factors for treatment intolerance, success or failure.

Patients and Methods
A retrospective analysis of the BMI of patients with high-risk NMIBC treated with BCG during the COVID-19 pandemic, from 11/03/2020 to 05/05/2023, as defined by the World Health Organisation. Patients were excluded if they received prior BCG or mitomycin therapy, if they were medically unsuitable or declined treatment. Clinical outcomes assessed included success (disease absence on cystoscopy), intolerance and failure. BMI was categorised using NICE guidelines.

Results
Out of 115 patients offered BCG, 95 met inclusion criteria with BMI data available for a total of 89 patients (mean age 74 years, range 41–92; 85% male, 15% female). The overall mean BMI and the mean BMI across all outcomes was 28. Overall, 52.8% (n-47) patients were intolerant, 36% (n-32) showed BCG success and 11.2% (n-10) showed failure. In overweight patients, the majority (62.5%) were intolerant, 25% had BCG success and 12.5% had BCG failure. In obese class I, an equal number achieved success or intolerance (43.5% each), with a 13% failure rate. In obese class II and III, most patients demonstrated BCG success (66.7% and 100%), with 0% failure rate.

Conclusion
Most patients with high-risk NMIBC undergoing BCG treatment were overweight, reflecting bladder cancer epidemiology. Overall, intolerance was highest in overweight and obese class I patients, with failure rates also highest in overweight patients. Further evaluation of BMI significance is required in a larger sample cohort.

P1-4 Not presenting

P1-5 A UK national survey; NICE vs EAU guidelines' adoption, consistency and usability in NMIBC risk stratification and surveillance protocols.

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Introduction
Surveillance recommendations for non–muscle-invasive bladder cancer (NMIBC) differ substantially between the European Association of Urology (EAU) and National Institute for Health and Care Excellence (NICE) guidelines. These inconsistencies risk creating disparity in patient care depending on the guideline adopted. Conflicting advice may also generate uncertainty impacting patients' confidence and their outcomes.

Methods
A national survey was distributed via email and professional networks to UK urologists. Data were collected on departmental guideline endorsement, individual practice preference, and the ability to implement the referenced guideline in real-world clinical scenarios.

Results
A total of 174 respondents were analysed, geographically distributed across England, Scotland, Wales, and Northern Ireland. Respondents comprised 100 consultants (57%), 70 trainees (41%), and 4 clinical nurse specialists (2%). Departmental recommendations most frequently cited NICE (38%, n=66), followed by EAU (24%, n=41), local protocols (24%, n=41), and no agreed protocol (15%, n=26).

Individually, 39% (n=67) followed EAU guidelines and 37% (n=64) NICE guidelines, with the remainder adhering to local protocols (16%) or tailoring follow-up to individual patients (9%). Across 324 clinical scenario responses (192 from NICE-followers, 132 from EAU-followers), correct risk stratification according to the referenced guideline was achieved in 77.1% (n=148) of NICE-guided responses versus 34.1% (n=45) of EAU-guided responses ($p<0.001$).

In 60 occasions, the EAU guidelines generated two possible risk categories for the same patient depending on the histopathological grading system referenced; respondents' answers were in keeping with WHO-2004 and WHO-1973 in 57% (n= 34) and 43% (n= 26) of responses respectively.

Conclusion
Guideline adoption for NMIBC surveillance in the UK is variable. NICE was more consistent and accurately usable compared to EAU. Unified guidance is required for consistent care.

P1-6 UK-PeCaN Survey: Current Practices for Venous Thromboembolism (VTE) Prophylaxis in Penile Cancer Surgery Across the UK

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Introduction
The treatment of penile cancer (PC) in the UK was centralised into specialised supranetworks in 2002. Currently, no specific guidelines for VTE prophylaxis in penile cancer surgery
exist. This survey aims to collect data on intraoperative and postoperative practices for VTE prophylaxis across Specialist UK
centres.
Materials & Methods
A survey was sent to 37 Specialist Penile Cancer Surgeons at all UK Specialist Centres, using Microsoft Forms. The survey focused on VTE
prophylaxis for primary tumour and lymph node procedures, intraoperatively (IO) and postoperatively (PO). Surgeons were asked
about the type of prophylaxis (mechanical, pharmacological, or both) and its duration (none, inpatient only, or extended >28days).
Results
24 surgeons across 10 specialist centres responded. 71% of respondents did not use thrombosis risk
prediction models.
Primary tumour procedures:
Circumcision: IO 62.5% used only thromboembolic deterrent stockings (TEDS), while 25% added intermittent pneumatic
compression devices (IPCD). PO, 37.5% used no prophylaxis, while others relied on inpatient-only strategies with TEDS and low molecular weight heparin (LMWH).
Glansectomy/Partial Penectomy: IO 66.7% utilized both TEDS and IPCDs. PO, 83.3% used LMWH and TEDS till discharge from
hospital.
Subtotal/Total Penectomy: IO TEDS and IPCDs were used by 75% of surgeons. PO, 79.2% continued LMWH and TEDS only during hospital stay.
Lymph node surgery:
IO: TEDS were used in all nodal surgery while 60% used them with IPCDs for sentinel lymph node biopsies. 83% used TEDS and IPCDs for the inguinal or pelvic dissections.
PO: Extended prophylaxis with LMWH and TEDS, was used in more than 60% of Inguinal and 75% of pelvic lymph node
dissections. The remaining used the combination only till discharge.
Conclusions
There are significant variations in practices for VTE prophylaxis among Penile Cancer Surgeons in the UK. Disparities exist not only between centres but also among surgeons within the same institution.

P1-7 Updated Analysis: Blue light transurethral resection and biopsy of bladder cancer with hexaminolevulinate: Histopathological characteristics and recurrence rates in a single UK centre study

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Objective
To evaluate the diagnostic yield of blue-light cystoscopy (BLC) compared with white-light cystoscopy (WLC) in detecting carcinoma in situ (CIS) and muscle-invasive bladder cancer (MIBC), and to assess outcomes of re-resection following initial WLC.

Patients and Methods
We retrospectively analysed 238 patients undergoing BLC-hexaminolevulinate (HAL) (July 2017–July 2024): 72 had primary BLC at initial resection, and 166 underwent BLC re-resection following WLC. We assessed CIS detection, tumour upstaging, and 12-/24-month recurrence to evaluate the impact of BLC-HAL on detection and mid-term oncological outcomes.

Results
Overall, malignancy was confirmed in 113/238 patients (47%). Detection was higher in the secondary arm (55%) compared to the primary arm (29%). CIS was found in 19% of the primary arm and increased from 18% on WLC to 38% with BLC in the secondary arm ($p=0.00053$), with over one-quarter visible only under blue light. MIBC was detected in 23.8% of the primary arm and 10% of the secondary arm ($p=0.0215$). More than one-third of patients were upstaged into higher EAU risk groups. Recurrence remained high: 29% and 33% at 12 and 24 months in the primary arm, and 38% at both 12 and 24 months in the secondary arm.

Conclusions
Blue-light cystoscopy significantly enhances CIS detection and upstages risk in over one-third of patients, directly influencing management. Recurrence remains high, consistent with high-risk NMIBC, reinforcing guideline recommendations for routine use at TURBT, especially in suspected CIS and high-grade disease.

P1-8 Negative Biopsies in the Presence of PI-RADS 4/5 Lesions – Do We Need a National Standardised Protocol?

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Introduction

The Rapid Diagnostic Service (RDS) streamlines prostate cancer diagnosis by assessing patients with elevated PSA, concerning history, physical examination, or suspicious MRI findings. This audit examines the management and outcomes of RDS patients with positive multi-parametric MRI results but negative biopsy results, assessing alignment with clinical standards.

Method

We retrospectively reviewed 343 patients seen in the RDS clinic over seven months (November 2023 to May 2024), with up to 12 months of follow-up. Positive MRI findings were defined as Prostate Imaging and Reporting and Data System (PI-RADS) 3-5 (positive MRI would be 4-5). Positive MRI but benign biopsy results were assessed for biopsy adequacy and MDT discussion, including any change to the initial PI-RADS score and final recommendations.

Results

Of the 343 patients, 16.6% (n=57) had benign biopsy results. Among these, 31 had PI-RADS 4-5 lesions, all with adequate biopsies and MDT discussion. Thirteen had their PI-RADS score changed, with 12 downgraded and 1 upgraded. The remaining 26 with PI-RADS 1-3 had varied management: 10 were discussed in MDT, 11 seen by urology consultants, 3 by urology registrars, and 2 by clinical nurse specialists. MDT and clinic plans ranged from repeat MRI and biopsy, PSA surveillance, or discharge.

Discussion

Adherence to MDT review for PI-RADS 4–5 lesions despite negative biopsy ensures diagnostic accuracy and adherence to best practice. The MRI PI-RADS score changes following MDT discussions highlight the value of urology-specialised radiologists. The role of MDT discussions for PI-RADS 3 lesions warrants further evaluation. Limitations include the short follow-up period (6–12 months), underscoring the need for longer-term studies to assess outcomes in conservatively managed patients.

P1-9 Optimising an expedited TURBT pathway for MIBC and high risk NMIBC

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Introduction: National Cancer Waiting Time (CWT) guidelines state a maximum 31 days from decision to treat to first definitive treatment (FDT). Updated guidelines in September 2020 state TURBT only counts as FDT when tumour is completely removed, and patient is placed on a surveillance pathway.
We aimed to prioritise patients with MIBC and high risk NMIBC for TURBT within 2 weeks to ensure high-risk patients receive definitive treatment in a timely manner, as per GIRFT recommendations.

Methods: At the time of haematuria clinic patients were moved to an expedited pathway if they met the following criteria: tumour >3cm and/or multifocal, solid looking lesion, suspicion of muscle invasive disease and/or hydronephrosis on imaging, previous upper tract TCC or high-grade bladder cancer.
To optimise this pathway, facilities were created for same day pre-operative assessment, imaging was booked from triage and clinicians were given access to the booking calendar so that patients could be given an expedited date for TURBT on the day of haematuria clinic.

Results: We performed retrospective analysis of patients undergoing TURBT between 10/10/2024 and 20/06/2025. 72 patients had a TURBT, 19 were stratified as high risk and moved to an expedited pathway. 15 patients were male and 4 female. Mean age was 75.1 (SD=11).
Median time from recognition of high-risk disease to TURBT was 12 days (IQR=6). Pre-operative assessment on the same day as haematuria clinic/patient review took place for 10 (53%) patients. Of 16 patient who had a flexible cystoscopy, 11 (68.8%) had imaging prior to this.

Conclusion: Risk stratification of patients allows for expedited TURBT for high-risk patients and reduced time to definitive treatment, in keeping with national CWT guidelines and GIRFT recommendations. Facilitating same day pre-operative assessments, imaging prior to haematuria clinic and clinician access to the booking calendar enables this expedited pathway to function effectively.

P1-10 Survival in variant histology bladder cancer after robot-assisted cystectomy: The role of stage and neoadjuvant chemotherapy.

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Introduction

Variant histology (VH) in urothelial bladder cancer is associated with poorer outcomes than pure urothelial carcinoma. We observed an increasing incidence of VH in our robot-assisted radical cystectomy (RARC) series and assessed whether neoadjuvant chemotherapy (NAC) improves survival in this subgroup.

Patients & Methods

We retrospectively analysed 66 patients with variant histology urothelial cancer on transurethral resection of bladder tumour (TURBT) histology who underwent RARC between 2020 and 2024; 20 received NAC and 46 did not. Overall survival (OS) was estimated by Kaplan–Meier curves (log-rank test) and multivariable Cox regression incorporating age, NAC, pathological stage (pT1–4) and ASA score.

Results

Mean OS was 35.0 months (95% CI: 27.6–42.5) with NAC vs. 36.9 months (95% CI: 29.4–44.4) without. Kaplan-Meier curves showed a trend favouring NAC, but no significant difference was found ($p = 0.604$).
Cox regression confirmed pathological stage as the dominant predictor: pT3 tumours had a 14.6-fold higher hazard of death vs. pT1 (95% CI: 1.62–131.75, $p = 0.017$); overall stage effect was borderline significant ($p=0.057$). NAC reduced hazard by 55% (HR = 0.449), though not significantly ($p = 0.237$).
Age and ASA were not independently associated with OS. The sample included multiple VH subtypes (e.g., squamous, micropapillary, sarcomatoid), but numbers were insufficient for reliable survival comparisons.

Conclusions

Pathological stage predominantly determines survival in VH RARC patients. NAC demonstrates a non-significant protective trend in this small series. Prospective, larger-scale studies are warranted to clarify NAC's role and to characterise outcomes by histological subtype.