P1-1 Not Presenting

P1-2 Safety and Efficacy of Robotic-assisted Radical Cystectomy in previous Pelvic External Beam Radiation Therapy Patients: Contemporary Trends on Practice Patterns and Complications

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Poster Presentations 2, October 3, 2025, 12:30 - 13:10

Introduction: Robotic-assisted Radical Cystectomy (RARC) is increasingly utilized for more complex scenarios including salvage procedures. We explored outcomes for RARC with Intracorporeal Ileal Conduit (ICI) after External Beam Radiation Therapy (EBRT) for various indications to assess perioperative safety and long-term outcomes.

Patients and Methods: RARC and ICI cases following EBRT from 2010 to 2024 were reviewed. Preoperative staging modalities, demographic, tumour and patient characteristics were assessed. Desciptive statistics were applied to explore early (<90 days) and late (>90 days) complications.

Results: Between 2009-2024, 67/ 80 cystectomies following EBRT were performed robotically. Mean age and BMI were 69.7 years old (Range: 37- 89), and 27.3 (range: 15- 43) respectively. Main indications were bladder cancer (n=43, 53.8%) and radiation-induced toxicity (n=37, 46.2%). Operating time was 363 min (Range: 200- 840), mean blood-loss 350ml (range: 50-1500ml). Rectal injury occurred in n=2 cases (3%). Mean post-operative length of stay (LOS) was 11.3days (Range: 6-30) with 25.3% 90-day readmission rate. Early post-operatively (<90 days), there was no death, and 47.7% complication rate. Early complications were mostly Clavien-Dindo (CD) <2; predominantly ileus in 20 cases (30.7%). CD > 3 complications occured in 19 cases (13.4%); mostly sepsis 10.7%. Mean follow-up was 43 months (range 7- 180); Late complication rate was 10.7%, including uretero-ileal stricture in n=2 (3%), and recurrent UTIs n=2 (3%).

Conclusions: RARC following EBRT is safe and viable option in high-volume centers for carefully selected patients.

P1-3 Incidence of Venous Thromboembolic Events (VTE) after Penile Cancer Surgery in England: Analysis of Secondary Uses Service (SUS) Data from 2015 to 2024

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Introduction
The treatment of penile cancer (PC) in England is centralised into Specialised Supra-Networks. The Secondary Uses Service
(SUS) is a national healthcare data repository in England that supports NHS planning and development of national policy. VTE is one of the "four harms" in the NHS safety thermometer selected by theDepartment of Health's Quality Innovation Productivity and Prevention (QIPP) Safe Care Programme.

Materials & Methods
SUS data was extracted for all PC surgeries that were performed between March 2015 to March 2024 in England. Key variables included the date of surgery, hospital location, relevant diagnosis codes for cancer and VTE (based on ICD-10 5th edition), VTE admission dates, and procedure codes (OPCS-4.10). Data were completely anonymised using pseudo-NHS numbers and recorded/analysed using Microsoft Excel. Analysis included patients who developed VTE within 180 days of surgery, only.

Results
4310 patients underwent 5903 procedures in the 9-year period. A total of 143 episodes of VTE were recorded with 64 occurring within 180 days of surgery. Of the patients, 17 had undergone more than two procedures within this timeframe.

Primary Tumour Surgery:
• Total Penectomy: 14 (2.5%) of 539 cases developed VTE, including 6 pulmonary embolisms (PE).
• Partial Penectomy/Glansectomy: 37 (1.3%) of 2,777 cases developed VTE, with 18 identified as PE.
• Circumcision: 11 (1.5%) of 732 cases developed VTE, including 4 PE.
Lymph Node Surgery:
• Inguinal Lymph Node Dissection (ILND): 11 (4.1%) of 266 patients developed VTE, with 7 cases of PE.
• Pelvic Lymph Node Dissection (PLND): 2 (2.8%) of 71 patients developed VTE.
• Sentinel Lymph Node Biopsy: 7 (0.8%) of 898 cases developed VTE with 4 PE.

Conclusions
This data represents a significant incidence of VTE despite the apparent peri-operative use of thromboprophylaxis. This highlights the importance of establishing uniform protocols and better VTE risk assessment.

P1-4 From R0 to Reconstruction. Urology's Role in Pelvic Exenteration Surgery for Locally Advanced and Recurrent Colorectal Cancer

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Introduction:
Attaining R0 resection in pelvic exenteration (PE) for locally advanced and recurrent colorectal cancer (CRC) is critical to improving long-term survival. This often necessitates resection and reconstruction of urological organs. We present a single-unit analysis of urological outcomes following PE.

Methods:
Of 100 PE procedures performed between October 2017 and April 2025, 37 involved urological input and were included in this analysis. Demographic data, tumour characteristics, procedural details, and short- and long-term outcomes were collected retrospectively.

Results:
Among the 37 patients (62% male, median age 61 years), 28 had locally advanced CRC and 9 had recurrent disease. Urological procedures included cystoprostatectomy (n=11), ileal conduit/urostomy (n=11), partial cystectomy or bladder cuff excision (n=8), Boari flap reconstruction (n=8), urethrectomy with anastomosis (n=2) and ureteric reimplantation/repair (n=1). Partial prostatectomy or shave was performed in 11 cases. R0 resection was achieved in 31/37 cases (84%). Median length of stay was 17 days. Long-term urinary diversion or stoma was required in 40%, while bladder function was preserved in selected cases through reconstructive techniques. Clavien–Dindo grade III–IV complications occurred in 30%. At a median follow-up of 17.4 months, recurrence occurred in 35% of patients, with overall mortality of 22%.

Conclusion:
A high proportion of patients undergoing PE for locally advanced and recurrent CRC require urological input. Integrating urologists into the multidisciplinary PE team is vital for robust preoperative planning and optimising both oncological and functional outcomes.

P1-5 Evaluating the Role of Peritoneal Flaps in Reducing Lymphocele Formation Following Robotic-Assisted Radical Prostatectomy with Pelvic Lymph Node Dissection: A Systematic Review and Meta-analysis

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Introduction:
Lymphocele formation is a common complication following robotic-assisted radical prostatectomy (RARP) with pelvic lymph node dissection (PLND). The peritoneal flap (PF) technique has been proposed to mitigate this complication. However, existing studies have reported variable outcomes regarding its efficacy. Given the increasing volume of research investigating PF techniques in lymphocele prevention, an updated synthesis of current evidence is warranted. Therefore, this systematic review and meta-analysis aimed to critically evaluate recent studies to determine the effectiveness of PF use in reducing lymphocele formation among patients undergoing RARP with PLND.

Methods:
A thorough search was conducted in major databases (PubMed, MEDLINE, Embase, CENTRAL, Scopus, Web of Science, and Google Scholar) for randomized controlled trials (RCTs) and observational studies comparing PF techniques against standard procedures during RARP with PLND. Outcomes assessed included symptomatic, asymptomatic, total lymphoceles, lymphoceles requiring intervention, operative time, blood loss, postoperative complications, surgical margin positivity, and hospital duration. Statistical analysis was performed utilizing pooled odds ratios and mean differences.

Results:
Analysis of 14 studies (6 RCTs, 8 observational) involving 7,316 patients showed that the application of PF significantly reduced the incidence of symptomatic lymphoceles (OR: 0.36, 95% CI: 0.22-0.60, $p < 0.001$), asymptomatic lymphoceles (OR: 0.54, 95% CI: 0.34-0.85, $p = 0.008$), total lymphoceles (OR: 0.49, 95% CI: 0.34-0.71, $p < 0.001$), lymphoceles needing intervention (OR: 0.47, 95% CI: 0.27-0.84, $p = 0.009$), and postoperative complications. However, the standard approach was associated with slightly reduced intra-operative blood loss. No significant differences were found regarding operative duration, hospital stay length, or rates of positive surgical margins.

Conclusions:
Peritoneal flap utilization during RARP and PLND significantly decreases lymphocele formation and postoperative complications without negatively impacting oncological outcomes or perioperative parameters. Despite these promising findings, variations in PF techniques necessitate further standardisation efforts and multi-centric randomised trials to validate optimal practices.

P1-6 Altered Tropomyosin Isoform Expression in Bladder Cancer: A Single-centre Clinical Pilot Study

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Background: Bladder cancer is the ninth most prevalent cancer globally and carries significant morbidity and mortality. Currently, cystoscopy remains the gold standard for the diagnosis of bladder cancer, although it is an invasive procedure with notable side effects. Naturally, many attempts have been made to discover novel non-invasive biomarkers for diagnosing bladder cancer. Tropomyosin isoforms, encoded by the TPM gene, are key regulators of various cellular functions, and their disruption plays a significant role in carcinogenesis. In this pilot study, we aim to compare the expression of both high molecular weight (HMW) and low molecular weight (LMW) isoforms of all four TPM genes between bladder cancer cells and normal bladder cells.

Methods: Ethical approval was granted by the Wales Research Ethics Committee (REC reference: 18/WA/0046). Ten patients undergoing transurethral resection of bladder tumour (TURBT) were recruited, and samples of bladder tumour and normal bladder mucosa were collected. RNA extracted from the samples was converted into cDNA, and real-time polymerase chain reaction (RT-PCR) was performed to determine relative expression of HMW and LMW isoforms of all four TPM genes. Results were analysed using Livak's method and ANOVA with Tukey's post hoc test to determine the relative expression between both samples.

Results: Expression of HMW isoforms of TPM1 ($p=0.015$), TPM2 ($p=0.004$), and TPM4 ($p=0.014$) was significantly reduced in bladder cancer cells compared to controls. No statistically significant change was seen in either HMW or LMW isoforms of TPM3 ($p=0.630$, $p=0.456$, respectively).

Conclusion: The significant downregulation of HMW isoforms of TPM1, TPM2, and TPM4 in bladder cancer tissue suggests their potential as a panel of novel biomarkers. These preliminary findings warrant validation in larger, multi-centre cohorts to fully explore their diagnostic and prognostic utility.