ASIA-PACIFIC JOURNAL
OF CLINICAL ONCOLOGY
Volume 19, Issue S2

ANZUP®
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ANNUAL SCIENTIFIC MEETING

'BOUNCING BACK'

9-11 JULY 2023
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Program and Abstracts

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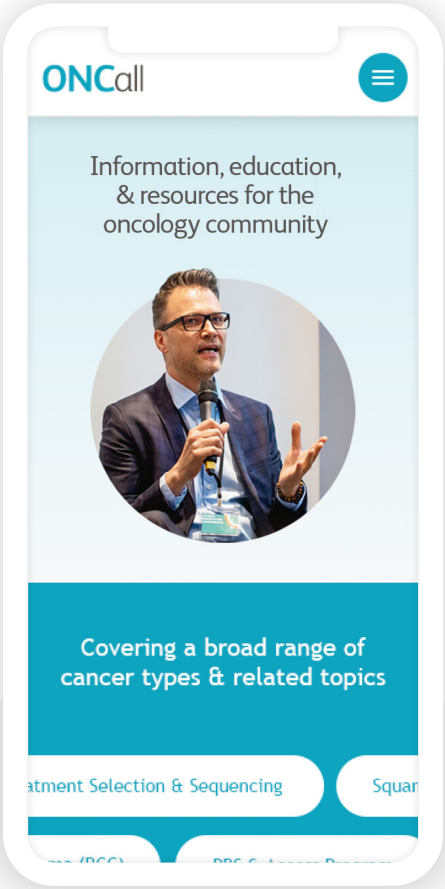

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References: 1. ZYTIGA® (abiraterone acetate) Approved Product Information, available at http://www.janssen.com.au/Zytiga_PI. 2. ERLYAND® (apalutamide) Approved Product Information, available at http://www.janssen.com.au/Erlyand_PI. 3. Australian Public Assessment Report for abiraterone acetate. Australian Govt. Department of Health and Ageing. TGA. October 2012. Available at https://www.tga.gov.au/sites/default/files/auspar-abiraterone-acetate-121004-1.pdf. Janssen-Cilag Pty Ltd, ABN 47 000 129 975, 1-5 Khartoum Road, Macquarie Park NSW 2113. Telephone: 1800 226 334. CP-307926 EMVZYT2094 Date prepared: April 2022.

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2023 ANZUP ANNUAL SCIENTIFIC MEETING

'BOUNCING BACK'

9-11 JULY 2023

Melbourne Convention Centre, Victoria, Australia

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Volume 19, Issue S2.

2023 ANZUP ANNUAL SCIENTIFIC MEETING

'BOUNCING BACK'

Contents


Ian Davis

ANZUP Chair Welcome

Welcome to the 2023 Annual Scientific Meeting (ASM) of ANZUP, the Australian and New Zealand Urogenital and Prostate Cancer Trials Group! The 2022 ASM finally brought us all back together in person after a far-too-long forced break, and we are excited and delighted to be able to meet together in person in Melbourne this year.

ANZUP exists to improve the lives of everyone affected by bladder, kidney, testicular, penile, and prostate cancers. That of course means the people who have these cancers, but it also includes their families and friends, and everyone involved in providing healthcare for them as well. We all need to understand these cancers better, and the impacts these cancers have on everyone involved. We need high quality evidence to help guide all of us in decision making. We need new ideas to help us work together to generate new treatments and better ways to support people. We need to hear from and be guided by the people directly affected by these cancers. And we need to build and support a clinical and research workforce dedicated to meeting these needs and continuing to do so into the future.

ANZUP does all of this by bringing people together. We want as much diversity of input and opinion as we can get, to make sure that everyone's views are considered and that we do not work in an echo chamber. We need to break out of our cosy boxes and hear what other people are doing and experiencing. We need to learn about advances in science and new treatments. We need to have opportunities to bounce ideas off each other and to grow small seeds into large trees. And we also need to set aside opportunities to get together as a community of people with shared goals and dreams.

The ANZUP ASM has evolved to become the peak regional multidisciplinary meeting for genitourinary cancers in this part of the world. Somehow we pull together a packed agenda for a meeting extending over only a few days that lets us achieve all those things listed above. The really unique thing about an ANZUP ASM is the atmosphere of collaboration and collegiality: people of all backgrounds and disciplines come together not only to learn and grow together, but also to enjoy each other's company. If you have not experienced this before then I hope you get to do so over the course of this meeting.

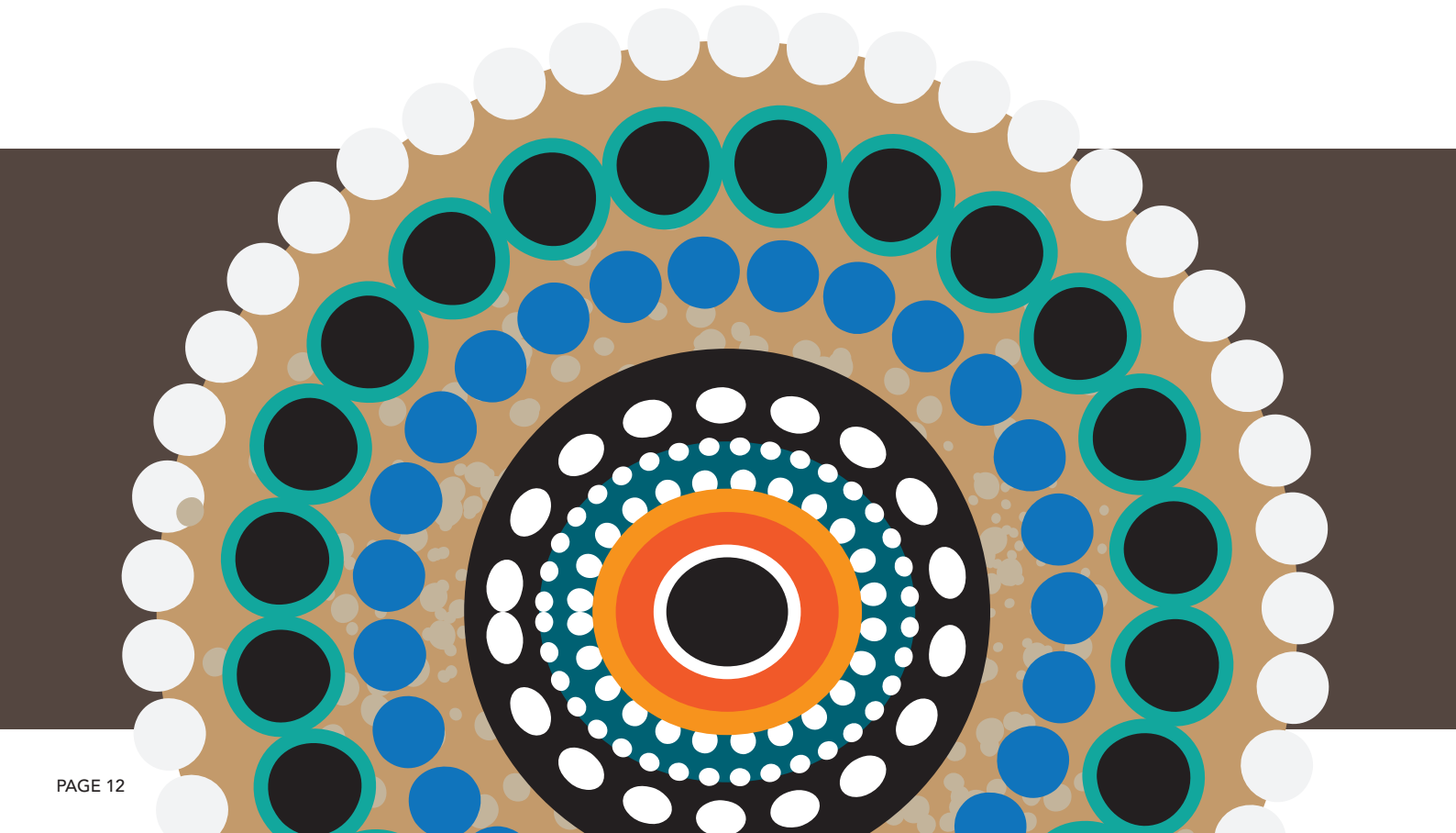
The 2023 ASM theme is *'Bouncing Back.'* We think this is particularly apt coming out of the harsh conditions we all experienced during COVID. We will talk about how people and systems have adjusted and changed in response to the pressures of the pandemic, and also in relation to the impacts of these cancers. We will celebrate catching up on lost ground and missed time, as well as thinking about how directions or priorities may have changed for some. The theme also lets us indulge our inner ten-year-olds with jokes about balls. See, we have something for everyone!

Once again, the ASM program has been developed by an outstanding convening committee, comprising our co-convenors Ben Tran and Renu Eapen, ably supported by Kath Schubach, Lisa Butler, Renea Taylor, Andrew Weickhardt, Ciara Conduit, Carole Harris, Steve McCombie, Henry Woo, Rob Newton, Melissa Le Mesurier, Amy Hayden, Lewis Au and Anis Hamid; our wonderful ANZUP team of Margaret McJannett, Lucy Byers, Nicole Tankard, Alice Clark and Min Liu; and Sarah Dixon representing our conference organisers Catalyst Events. Make sure you look into the various special sessions: the nurses' education session, MDT Masterclass, translational symposium, evening symposium, poster sessions, and of course all the great content in the main program. We are very fortunate to have a host of outstanding local speakers and chairs, and a stellar international faculty of Andrea Apolo, Darren Feldman, Alex Wyatt, Sima Porten, Ananya Choudhury, Rebecca Martin, Laurien Buffart and Bertrand Tombal. Not to be missed!

We are very grateful to our sponsors and corporate supporters, without whom this meeting could not take place. I encourage you to go and meet with them and engage productively as partners as we think about how we can continue to work together to improve our existing practices but also recognise new concepts and opportunities for research. Thanks also go to Cancer Australia for its ongoing support of ANZUP.

I hope you have a wonderful time at the 2023 ANZUP ASM and I look forward to catching up with you over the course of the meeting.

Ian Davis
Chair, ANZUP



Co-Convenor Welcome


Renu Eapen


Ben Tran

On behalf of the organising committee, it is our great pleasure to welcome you to ANZUP's 2023 ASM, the 2023 GU cancer meeting of the region with the theme of 'Bouncing Back'.

The ANZUP ASM will provide a platform to discuss and present the latest updates in GU cancer treatment, research and supportive care and to learn more about existing and planned ANZUP trials.

This event will host several engaging sessions that are sure to captivate your interest. New to the 2023 ASM, The Perfect Pitch will focus on the art of pitching ideas and fostering their development, potentially leading to fully fledged clinical trials. This would be valuable to all clinicians, but perhaps most valuable to budding investigators – so if you're a medical oncology, radiation oncology or urology trainee, make sure you come!!!

The ANZUP Nurses Symposium will bring together nurses and allied health professionals to talk, share ideas and get updates on projects happening within the ANZUP community. Our MDT Masterclass features a distinguished panel of experts who will address real-life clinical challenges. Again, a perfect session for trainees to come.

Lastly, ANZUP's Community Engagement Forum, The Ball's in Your Court, is a thought-provoking session that will explore why ANZUP exists, the importance of clinical trial research, finding information, asking the right questions, being on the same page as your treatment team, and what life looks like after cancer.

We are privileged to have an exceptional international faculty, including Andrea Apolo, Darren Feldman, Alex Wyatt, Sima Porten, Ananya Choudhury, Rebecca Martin, Laurien Buffart and Bertrand Tombal.

Furthermore, our national experts will provide updates on GU cancer management, priority areas for research, ANZUP trials, and the challenges and opportunities we face in improving access to clinical trials.

We would like to express our gratitude for your attendance, as well as for your ongoing support of ANZUP. This meeting is made possible by the dedication of our entire ANZUP community. The convening committee has displayed extraordinary commitment in developing another world-class educational and inspirational program. We also extend our thanks to the ANZUP subcommittee chairs for their diligent review of abstracts and concepts. Special appreciation goes to the ANZUP management team, particularly Margaret McJannett and Ian Davis. Finally, this meeting is only possible thanks to the support of our sponsors including Cancer Australia, who provide key infrastructure funding to ANZUP.

ANZUP continues to go from strength to strength and we strongly urge all members to actively engage, whether it is through attendance at the ASMs, proposal and development of new trials, recruitment for current trials, or involvement in the subcommittees. People continue to be diagnosed with genitourinary cancers, so even though we are making a difference there is more work to be done. With your help, ANZUP has the opportunity to place Australia and New Zealand at the forefront of the world of GU Oncology.

We hope you enjoy the 2023 ANZUP ASM.

Renu Eapen and Ben Tran
Co-Convenors, ANZUP Annual Scientific Meeting 2023

ANZUP MDT Masterclass Convenor Welcome


Carole Harris


Steve McCrombie

Sponsored by

The MDT Masterclass promises to be a highlight of the program that you won't want to miss.

Join convenors Carole Harris and Steve McCrombie as we delve into relevant and controversial topics in urological cancer management. Brace yourself for an engaging and interactive experience as we pass the ball to the audience, ensuring you'll be captivated until the very end.

This year's MDT Masterclass will feature five distinct sections, each led by an expert in the field:

- Bladder - Niara Oliveira
- Kidney - Andrew Tan
- Early Prostate - Weranja Ranasinghe
- Advanced Prostate - Megan Crumbaker
- Germ Cell - Anna Kuchel

The goal of the ANZUP MDT Masterclass is to appeal to uro-oncology trainees, consultants, nurses, and allied health professionals. These workshops promise to be challenging and informative while also tackling relevant topics in the management of urological cancers.

The focus for the prostate, bladder, penile, germ cell and renal cancer panels will be on multi-disciplinary care using a core-based teaching format.

All panels will address both common and controversial management issues spanning the spectrum of localised and metastatic disease. Each session will include participation from the audience.

Be ready to play ball by using the polling function and contributing.

On behalf of ANZUP, we warmly welcome you to the 2023 ASM. Be ready to immerse yourself in the thrilling experience and be part of the action in GU cancer!

Carole Harris and Steve McCrombie
Convenors, MDT Masterclass

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MDT MASTERCLASS

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Natasha Roberts

Alexandra Roy Onattu

Daniel Shokouhi

May Siew

Siang Tan

Jemeni Thomas

Carla Wallace

Cara Webb

Kristina Zlatic

2023 ANZUP Best of the Best Awards sponsored by Astellas

ANZUP would like to thank Astellas for sponsoring the Best of the Best Awards. The awards are open to ANZUP members who have successfully submitted an abstract and have been selected to present an oral or poster at the ASM.

Awards will be given based on the content, degree of innovation, significance and quality of the presentation, and will be judged by an independent panel.

There are five awards:

- Best of the Best Oral
- Best of the Best Poster
- Best of the Best Trainee / Fellow
- Best of the Best Nursing / Allied Health
- Best of Translational

Sponsor Acknowledgements

The Australian and New Zealand Urogenital and Prostate Cancer Trials Group gratefully acknowledge the generous support of our 2023 ASM sponsors.

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Andrea Apolo

Andrea B. Apolo, M.D. is a nationally and internationally recognised expert in bladder cancer research with a Bachelor of Science degree in chemistry and biochemistry and a medical degree from Albert Einstein College of Medicine in New York City. In 2010 she was recruited to the National Cancer Institute's Physician-Scientist Early Investigator Program to build a translational bladder cancer program. In 2014 Dr. Apolo received the Lasker Clinical Research Scholars Award and in 2021 was granted tenure at the National Institutes of Health. Dr. Apolo is dedicated to improving the treatment and survival of patients with bladder cancer and other genitourinary tumors. Her research involves developing and designing clinical trials to test novel therapies for bladder, kidney, and rare genitourinary cancers.

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Laurien Buffart

Laurien Buffart is a group leader of the Exercise Oncology research group at Radboudumc, Nijmegen, the Netherlands. She is a human movement scientist and epidemiologist by training. After obtaining her PhD, she started with exercise oncology research. With her research group, she aims to unravel which exercise program is most effective to improve quality of life and treatment outcome, for which patients with cancer, and to understand the underlying mechanism of action. With this knowledge, she aim to develop, evaluate and implement personalized exercise medicine for patients with cancer in order to optimize treatment outcome and quality of life. Her work is supported by several personal grants including an EMGO+ fellowship from Amsterdam UMC, Young Investigator "Bas Mulder Award' grant from the Dutch Cancer Society, VIDI grant from the Dutch Science Organization (NWO/ZonMW), and a Hypatia tenure track grant from Radboudumc. She has a visiting associate professor position at the Exercise Medicine Research Institute of the Edith Cowan University in Joondalup.

Ananya Choudhury

Professor Choudhury is Chair and Honorary Consultant in Clinical Oncology. She joined The Christie in 2008 specialising in urology and sarcoma and has a strong interest in translational research. In 2013, she decided to focus on radiotherapy-related research in prostate and bladder cancers. She is clinical lead for advanced radiotherapy including the MRLinac project and is co-Group Leader of The Translational Radiobiology Group within the Division of Cancer Sciences. Professor Choudhury currently undertakes research which aims to optimise and personalise radiotherapy using new techniques or imaging technology to deliver high doses of radiotherapy while minimising side effects and predictive biomarkers to determine which patients benefit from different treatments.

Darren Feldman

Dr. Feldman is an Associate Attending Physician on the Genitourinary Oncology Service and Bone Marrow Transplant (BMT) Service within the Department of Medicine at Memorial Sloan Kettering Cancer Center (MSKCC) and Associate Professor of Medicine at Weill Medical College of Cornell University, both in New York City, NY. Dr. Feldman's research focuses on understanding the biology and improving the treatment for patients with germ cell tumors (GCT) and kidney tumors, and the mechanism and management of late toxicities resulting from GCT treatment, particularly effects on the cardiovascular system. At MSKCC, he is the Section head for GCT within the Genitourinary Oncology Service, overseeing the GCT medical oncology research program and he is also the director of the BMT Solid Tumor program. He has led and is currently leading national and international trials in the treatment of GCT and kidney cancer and has presented his research at meetings around the world. He is also the Chair of Quality Assurance for the Department of Medicine at MSKCC.

Rebecca Martin

Rebecca is a skilled, patient-focussed and innovative Advanced Nurse Practitioner working in Uro-Oncology and leads a team of specialist nurses. Her key area of work is bladder cancer with a specialist interest in the female experience of cancer and treatments. Rebecca's clinical work crosses the bladder cancer spectrum from non-muscle invasive disease to long term follow up after cystectomy. Rebecca recently completed a Pre-Doctoral Fellowship and is at the start of her PhD journey; undertaking research on female sexual recovery in bladder cancer and using qualitative methods alongside intervention development and implementation science. Key interests include: Bladder cancer, female sexual function, intravesical therapy, cystectomy, continent diversions, enhanced recovery, nephrostomy care, advanced nursing practice, patient education, patient experience, qualitative research.

Sima Porten

MD, MPH, FACS Associate Professor in Residence Sima Porten received her undergraduate, doctoral and public health degrees from Northwestern University completing her education in June 2006. She was inducted into the Alpha Omega Alpha Honor Society during medical school and also completed a Howard Hughes Medical Institute-NIH Research Scholars fellowship during that time. She then completed her urology residency training at University of California, San Francisco and her Urologic Oncology Fellowship at The University of Texas, MD Anderson Cancer Center. Currently, she is part of the multidisciplinary urologic oncology team of the UCSF Helen Diller Family Comprehensive Cancer Center where she continues to pursue her clinical and research interests in bladder cancer and upper tract urothelial cancer.

Bertrand Tombal

Professor Bertrand Tombal is Chairman of the Department of Surgery and Professor of Urology at the Université catholique de Louvain (UCL), Cliniques universitaires Saint-Luc, Brussels, Belgium. Professor Tombal is a member of the Royal Academy of Medicine of Belgium. He is the Past President of the European Organization for Research and Treatment of Cancer (EORTC), the leading European academic research organization in the field of cancer. He has both a basic science and a clinical interest in urological oncology, particularly in the field of prostate and bladder cancer. Professor Tombal obtained his MD in 1990 and his PhD in 2003, both from the Université catholique de Louvain. During his PhD, he studied the mechanisms involved in apoptosis of prostate cancer cells and the modulation of apoptosis by growth factors. He completed part of his basic sciences training at Johns Hopkins University, Baltimore, MD, USA. Professor Tombal's primary clinical interest is the treatment of advanced stages of prostate cancer, and particularly hormonal treatment and development of new biological agents. He is heading the uro-oncology division at the Université catholique de Louvain where he is coordinating several trials in this research area. In addition, Professor Tombal has authored many published papers, books, and book chapters. He has presented at numerous national and international conferences and has been the recipient of various awards for his research in the field of urology, including the European Association of Urology thesis award, which he received in 2003. Professor Tombal is also a member of the Skeletal Care Academy, and member of the Scientific Office of European Association of Urology.

Alex Wyatt

Dr. Wyatt is an associate professor in Urologic Sciences at the University of BritishColumbia, Canada. He is alsocross-appointed at the Vancouver Prostate Centre and BCCancer. Dr. Wyatt has a DPhil in genetics from the University of Oxford. His research goalsare to identify associations between genomic alterations and patient outcomes inmetastatic prostate and bladder cancer, and to translate these findings into clinicalbiomarkers. Dr. Wyatt has developed novel laboratory and computational techniques to study plasmacirculating tumour DNA (ctDNA). Through application of these methods to clinical trial cohorts, histeam hasdemonstrated that ctDNA is highly representative of metastatic lesions, and that somatic alterations detected inctDNA can help predict prostate cancer therapy resistance or response. Dr. Wyatt is the chair of correlativesciences for genitourinary cancer trials run through the Canadian Cancer Trial Group (CCTG). He also serves as amember of the investigational new drug program executive committee. Dr. Wyatt directs the ctDNA screeningstrategy and the molecular tumor board for the first multi-center phase 2 umbrella trial in metastatic castration-resistant prostate cancer (NCT03385655, NCT02905318).

National Speakers

Arun Azad is a medical oncologist and translational researcher based at Peter MacCallum Cancer Centre. With an active focus on genitourinary cancers, he has leadership roles in multiple industry- and investigator-sponsored clinical trials and in circulating biomarker research.

Tim Baker is an award-winning author, journalist, and storyteller specialising in surfing history and culture, working across a wide variety of media from books and magazines to film, video, and theatre. Some of his most notable books include "Occy", a national bestseller and chosen by the Australia Council as one of "50 Books You can't Put Down" in 2008, and "The Rip Curl Story" which documents the rise of the iconic Australian surf brand to mark its 50th anniversary in 2019. Tim is a former editor of Tracks and Surfing Life magazines. He has twice won the Surfing Australia Hall of Fame Culture Award.

Tim was diagnosed with stage 4, metastatic prostate cancer in 2015 with a Gleason score of 9. He was told he had just five years of reasonable health left, but eight years on, at 58, he's still surfing, writing, and enjoying being a dad. His latest book, Patting the Shark, also documents his cancer journey.

Joe Bakhmoutski In 2016, Joe Bakhmoutski was diagnosed with testicular cancer. Since then, he has set up Simplify Cancer, a site that includes a podcast, videos and a book about finding better ways of dealing with cancer. He is passionate about helping people who have been diagnosed with cancer to stay on top of their worries during treatment and beyond. He tells his story here.

Patti Bastick is a Medical Oncologist with a special interest in the treatment of patients with breast and genitourinary cancers, including testis, prostate, bladder and kidney cancers. She is a senior staff specialist at St George and Sutherland Hospitals in Sydney, and medical director of Cancer Care Nominees, Cancer Care Foundation and St George Oncology Associates. She was awarded a fellowship of the Royal Australasian College of Physicians in 2008, having completed her undergraduate training at the University of Tasmania in 1999. She is heavily involved in clinical trials having been an investigator for over 60 international phase II and phase III trials over the past 15 years and is integral in establishing the new private trials centre at Southside Cancer Care Centre. Patti is passionate about patient advocacy and sits on the medical advisory board for BEAT Bladder Cancer Australia. She is currently supervisor of advanced training in Medical Oncology and has always been involved in training and education of junior doctors and worked for 4 years as the Director of Prevocational Education and training. She is the deputy chair of the Germ Cell Subcommittee for ANZUP.

Jasmine Brady is a Senior Clinical Trial Coordinator Team Leader within the Medical Oncology Clinical Trials Unit in Cancer Care Services at the Royal Brisbane and Women's Hospital.

She has an interest in genito-urinary cancers and theranostics in both treatment and imaging, including site coordination of ANZUP studies such as UNISoN, UNICAB, TheraP, ENZA-p and EVOLUTION. Jasmine has been in nursing since 2005, having completed her diploma of nursing and following on to the completion of her bachelors in 2012. With post graduate studies in cancer care completed in 2014, she is an experienced oncology nurse. She has pioneered the implementation of collaborative theranostics care-planning which has seen greater efficiency and fiscal improvements across

recent years in the space of clinical trials. Jasmine has been working in clinical trials since 2018 and currently is involved in the Imaging and Theranostics subcommittee within ANZUP.

Russell Briggs is a registered nurse with 25 years' experience. He is the General Manager of PCFA's Specialist Nursing national program of 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.

Lisa Butler is a Cancer Council Principal Research Fellow and Prostate Cancer Group Leader in the South Australian Immunogenomics Cancer Institute (SAiGENCI), at the University of Adelaide. She is also Director of the Solid Tumour Program at the South Australian Health and Medical Research Institute (SAHMRI). She holds a Ph.D. in cancer biology from the University of Adelaide with postdoctoral training in preclinical drug development at Memorial Sloan-Kettering Cancer Centre in New York. Prof Butler's research focuses on androgen signalling and lipid metabolism in prostate cancer, and on biomarker discovery coupled to drug development. She has established translational research programs that leverage her unique preclinical models involving primary clinical samples, prostate biobanking and proof-of-concept clinical trials.

Maggie Centenera, from the University of Adelaide, is the Senior Research Fellow in the Prostate Cancer Research Group at SAHMRI. Her research focus is to improve the clinical management of prostate cancer, through understanding and targeting the androgen receptor in prostate cancer cells, testing novel prostate cancer drugs, and developing biomarkers of patient response to current and emerging treatments. Dr Centenera conceptualised and developed a Patient-Derived prostate cancer Explant (PDE) model as a more clinically-relevant and translational approach to her research. She is the leading expert on the PDE technique internationally, which has been adopted by prostate cancer research groups worldwide.

Ciara Conduit is a Medical Oncologist working within the genitourinary and melanoma services at Peter MacCallum Cancer Centre in Melbourne. She completed her physician training in both Tasmania and Victoria, including a Fellowship within the Early Drug Development Unit at Peter MacCallum Cancer Centre in 2020. Alongside her clinical role, Ciara is engaged in genitourinary research at the Walter and Eliza Hall Institute of Medical Research and previously also at the Australian and New Zealand Urogenital and Prostate (ANZUP) Cancer Trials Group.

Megan Crumbaker is a medical oncologist specialising in genitourinary cancers at St. Vincent's Sydney and Macquarie University Hospitals. She completed a PhD in prostate cancer genomics at the Garvan Institute and has a special interest in translational research on genomic and molecular imaging biomarkers as predictors of response in GU cancers.

Ian Davis is a medical oncologist and is Professor of Medicine and Head of the Eastern Health Clinical School, Monash University and Eastern Health, in Melbourne, Australia. He also honorary appointments as an Affiliate Professor of Deakin University, adjunct Associate Professor of the University of Melbourne, an Associate of the University of Sydney, and Honorary Professorial Fellow with The George Institute. His primary clinical interests are in urologic cancers, and his primary research interests are in cancer immunology and the biology of urologic cancers. Prof Davis is founder of the Australian and New Zealand Urogenital and Prostate Cancer Trials Group Ltd (ANZUP). He is chair of the ANZUP Board and of its Scientific Advisory Committee.

In 2019, **Juliet De Nittis** was diagnosed at 50 with rare and aggressive kidney cancer. Following surgery to remove her left kidney (along with the tumour that covered it) was the revelation that the cancer had spread to her lungs, then the enormity of her situation struck. Without any treatment available, palliative care became the stark reality.

Luckily, hope arrived in the form of an ANZUP Clinical Trial led by Associate Professor David Pook for rare kidney cancers. Incredibly, after two years of immunotherapy treatment and another year treatment free, her cancer is now in remission, stable, with scans revealing "lungs clear."

Juliet knows she would not still be here without the immunotherapy treatment she received from an ANZUP Clinical Trial. Juliet is a success story and is now grateful to have the opportunity to pay it forward. Utilising her working background, predominately in education, well-being, neurodiversity, and the disability sector, Juliet considers it a privilege to be able to be a part of a team working to demystify the sometimes complex process of entering a clinical trial.

Haryana Dhillon (BSc MA PhD) is a Senior Research Fellow, who co-leads the Survivorship Research Group and is a Director of the Centre for Medical Psychology and Evidence-based Decision making, School of Psychology, USYD. Her research interests are broad encompassing cancer survivorship, health literacy, and interventions for survivorship, symptom management, and psycho-oncology. Haryana is active in several of the Australasian Cancer Cooperative Trials Groups, and is committed to the collaborative research process. She tweets for herself and a number of organisations. She is known for live tweeting conferences and events.

Renu Eapen is a Consultant Urologist in the Genitourinary Oncology service at the Peter MacCallum Cancer Centre and at the Austin Hospital and Olivia Newton-John Cancer Centre.

Dr Eapen completed her urology training in 2014. She undertook her robotics and uro-oncology fellowship at University of California, San Francisco. Prior to this she undertook a fellowship in urodynamics, incontinence, voiding dysfunction and pelvic reconstruction at the University of Toronto, Canada.

She is currently completing her PhD at the University of Melbourne in high risk prostate cancer in collaboration with the Prostate Cancer Theranostics and Imaging Centre of Excellence at Peter MacCallum Cancer Centre.

Dr Eapen is the recipient of the 2022 Michael and Lori Milken Prostate Cancer Foundation (PCF) Young Investigator Award.

She is co-host of GU Cast, a regular podcast series, focusing on all things related to the world of Genito-Urinary oncology. Renu is also Co-Convenor (along with Ben Tran) of the 2023 ANZUP ASM.

Daniel Galvão is Director of the Exercise Medicine Research Institute and Professor in the School of Medical and Health Sciences at Edith Cowan University, and Fellow of the American College of Sports Medicine and Exercise and Sports Science Australia. His research interests are in the applications of exercise as medicine for the management of prostate cancer treatment side effects and survival. Professor Galvão has served on numerous national research committees including NHMRC Grant review panels, Prostate Cancer Foundation of Australia Research Advisory Committee, and Cancer Council of Western Australia for over a decade.

Chun Gan is a GU Medical Oncologist at the Royal Brisbane and Women's Hospital. He completed his physician and oncology training in Melbourne in 2018, and a two-year fellowship in GU oncology at the Tom Baker Cancer Centre in Calgary in 2021, under the supervision of Prof. Daniel Heng. As the IMDC fellow, Dr. Gan led multiple international collaborative research studies in advanced renal cell carcinoma and immunotherapy. He presented at international and national meetings and received several awards, including two prestigious Merit Awards from the American Society of Clinical Oncology and the Novartis Oncology Young Canadian Investigator Award. He is an active member of the ANZUP kidney cancer subcommittee.

Craig Gedye is a medical oncologist and cancer researcher. He works for people with melanoma, brain, prostate, bladder and kidney cancers.

His research focuses on complexity and heterogeneity in cancer – why are cancers different between different people; why are cancers cells different to each other; what does this mean for each person's treatment? This challenging problem spans projects across the research spectrum, from patient experience, through clinical trials and translational science.

Craig is privileged to lead clinical trials and research projects for Calvary Mater Newcastle, ANZUP and COGNO, chairs the ANZUP Kidney Cancer Subcommittee, and sits on the Mark Hughes Scientific Advisory Committee, HNEHLD Clinical Trials Ethics Subcommittee, Brain Cancer Biobanking Australia Steering Committee, COGNO Scientific Advisory Committee and ANZUP Cancer Trials Scientific Advisory Committee.

Jennifer Gunter completed her PhD in metabolic medicine at Oxford University examining lipid metabolism in type-2 diabetes before returning to Australia to investigate the intersection between chronic metabolic disorders and their emerging relationship to cancer. She is a member of the Australian Prostate Cancer Research Centre – Queensland (APCRC-Q), an integrated, trans-disciplinary research centre, based at the Translational Research Institute, Brisbane. Here, she leads a research team examining the metabolic plasticity of cancer cells with the aim of identifying and testing therapeutic targeting strategies that extend patient survival.

Howard Gurney is the Director of Clinical Trials and Head of the Cancer Program for the Faculty of Medicine and Health Sciences at Macquarie University and Senior Staff Specialist in Medical Oncology at Westmead Hospital.

Dr Gurney has a firm background in clinical research and has subspecialty interests in urogenital cancers including prostate, bladder, testis and kidney cancer.

He has been the principal investigator for over 150 clinical trials and has over 150 per-reviewed publications in genitourinary cancers and pharmacogenomics, including recent papers in the New Engl J Med, Lancet and Lancet Oncology. Current research interests also include the pharmacogenomics and therapeutic monitoring of chemotherapy and targeted therapies and he has published widely in this area. He is regarded as an authority on mechanisms for safe dosing of anticancer agents and has held research grants and has written a number of invited editorials on these topics.

Anis Hamid is a Medical Oncologist and cancer researcher at Eastern Health and the University of Melbourne with a focus on prostate cancer biology and biomarker development. Dr Hamid completed his Medical Oncology training in Melbourne, with subsequent fellowship and PhD studies at Dana-Farber Cancer Institute (Boston) and the University of Melbourne. He co-leads a growing phase I clinical trial program at Cabrini Research and continues to collaborate nationally and internationally on translational studies in early and advanced prostate cancer.

Carole Harris is medical oncologist with a special interest in breast and genitourinary cancers (kidney, bladder, prostate and testicular cancer). In 2002 Dr Harris graduated from medicine from the University of Sydney with honours and received her fellowship in Medical Oncology from the Royal Australian College of Physicians in 2009. She went on to complete a Masters of Medicine by Research at UNSW. This research focused on targeted cancer therapies in breast cancer where her work has been published and presented locally and internationally and she still has an interest in pharmacoepidemiology of cancer treatments.

Dr Harris is a staff specialist at St George Public Hospital and Sutherland Hospital and a VMO at St George Private Hospital and Southside Cancer Care Centre, Miranda. She is principle investigator on a number of clinical trials and chair of the St George Breast Cancer Multidisciplinary Team. In addition, Dr Harris is a clinical academic at the University of New South Wales, based at the St George and Sutherland Clinical School where she oversees the oncology teaching programme to undergraduate students. She is a clinical examiner with both UNSW and the Royal Australian College of Physicians and is a member of a number of professional bodies including the Medical Oncology group of Australia, American Society of Clinical Oncology, ANZ Breast Cancer Trials Group and ANZ Urological and Prostate Trials Group.

Amy Hayden specialises in the management of urological cancers (including prostate, bladder & kidney cancers) & sarcomas.

A/Prof. Hayden completed her medical degree at UNSW in 2000, and subsequently undertook radiation oncology training at Westmead Hospital. She completed a prostate cancer research fellowship at the British Columbia Cancer Agency in Canada, focusing on the use of radiation therapy and brachytherapy in specific cancers.

A/Prof. Hayden works as a specialist radiation oncologist with Genesiscare, as well as at Westmead & Blacktown Hospitals, and is a member of the uro-oncology and sarcoma multidisciplinary teams.

She is the past-Chair of the Australian & New Zealand Radiation Uro-oncology Group (FROGG), and was appointed as a national board member of the Prostate Cancer Foundation of Australia. She has published several national guidelines for radiation therapy in prostate cancer and has contributed to the Cancer Institute NSW EVIQ prostate cancer radiotherapy guidelines. A/Prof. Hayden is actively involved in teaching, research and clinical trials through TROG and ANZUP.

A/Prof. Hayden is dedicated to offering the highest quality treatment and in providing compassionate care for patients.

Dickon Hayne is a urologic surgeon who leads urological research and undergraduate education in urology, at the University of Western Australia and is Head of Urology for the Fiona Stanley and Fremantle Hospital Group. Dickon chairs the Bladder Urothelial and Penile (BUP) Cancer Sub-committee of ANZUP, is an SAC member, leads the BCGMM trial and is widely engaged in ANZUPs other sub-committees, trials and activities. His major clinical and research interests are urological cancer, in particular bladder cancer.

Martin Hong is a Clinical Trials Fellow working at Liverpool Hospital in Sydney with a focus on early phase trials. Martin has recently received his fellowship in Medical Oncology from the Royal Australasian College of Physicians and has tumour stream interests in genitourinary and lung cancers. Martin is passionate about reducing inequities in healthcare access in culturally and linguistically diverse communities, particularly in clinical trials.

Lisa Horvath MBBS(hons1) FRACP PhD is the Director of Research at the Chris O'Brien Lifehouse, Professor of Medical Oncology (Genitourinary cancer) at the University of Sydney and Head of Advanced Prostate Cancer Research/Faculty member at the Garvan Institute for Medical Research. She is a clinician scientist, has an active clinical practice and is involved with a large number of clinical trials in prostate cancer in addition to phase I trial work. She has published >150 original research papers published in peer-reviewed journals in the last 20+ years across the fields of cancer biology, biomarkers and clinical trials.

Andrisha Inderjeeth is an early career medical oncologist currently working at Peter MacCallum. She is also the clinical research fellow at both ANZUP and the Walter and Eliza Hall Institute of Medical Research. Having trained in Western Australia before completing a fellowship at Peter MacCallum in both melanoma and genitourinary cancers, she has an interest in clinical trials including protocol design and development.

Belinda Jago is Chair of the ANZUP Consumer Advisory Panel (CAP) since 2013. Belinda professionally has worked in human resources in a variety of operational and strategic roles after completing a Bachelor of Business in 1981. Belinda's interest in ANZUP stems from her role as a carer for her daughter who was diagnosed with kidney cancer in 2006 at the early age of 13. Volunteering with ANZUP has provided an opportunity for Belinda to share the knowledge and skills acquired as a carer with a particular interest in kidney and Adolescent and Young Adults (AYA) cancers and clinical trial research.

Anthony Joshua completed his medical oncology training at the Royal Prince Alfred hospital in Sydney, Australia before moving to Toronto, Canada to complete a PhD under the supervision of Dr Jeremy Squire in prostatic carcinogenesis, and a clinical Fellowship under Dr Ian Tannock.

He joined the Department of Medical Oncology at Princess Margaret Cancer Centre in Toronto as a staff oncologist in late 2008, specialising in genito-urinary malignancy with research interests in circulating tumour DNA, tumour heterogeneity, mechanisms of enzalutamide resistance and autophagy.

He returned to Australia, joining the Kinghorn Cancer Centre and the Garvan Institute of Medical Research in late 2015. He is currently a conjoint Professor with the University of New South Wales.

Aaron Kent is a Specialist Radiation Oncologist at Alfred Health and Gippsland Radiation Oncology with a focus on Genitourinary Oncology and special interest in optimising management for men with prostate cancer in both metropolitan and regional Victoria. Aaron completed specialist training at Alfred Health and Peter MacCallum Cancer Centre with a research focus on clinical outcomes for men with high risk prostate cancer treated with high dose rate brachytherapy. Active interests include the implementation of stereotactic radiotherapy for various subsites including use for non-operable renal cell carcinoma with participation in the International Radiosurgery Oncology Consortium for Kidney (IROCK).

Kim Kerin-Ayres is the Cancer Survivorship Nurse Practitioner at the Sydney Cancer Survivorship Centre at Concord Cancer Centre in Sydney. She has worked in cancer nursing since 1989 in a wide range of ranges encompassing inpatient, ambulatory care and nursing education. She currently runs a nurse-led follow up clinic for patients who have completed their cancer treatment and is interested in the provision of survivorship care to those living with advanced disease.

Anna Kuchel is a medical oncologist at the Royal Brisbane and Women's Hospital where she specialises in GU and gynae cancers. Other interests include cancer of unknown primary and junior doctor support and education.

Edmond Kwan is a genitourinary oncology fellow and postdoctoral researcher at the Vancouver Prostate Centre, University of British Columbia in the lab of Dr. Alex Wyatt. After completing his Oncology training in Melbourne in 2017, he undertook a PhD with A/Prof Arun Azad at Monash University identifying candidate plasma circulating DNA/RNA biomarkers in metastatic prostate cancer. By combining expertise in cancer genomics, clinical oncology, and computational biology, Dr Kwan's current research strives to understand how genomic alterations identified in tumour tissue and blood can better guide therapeutic decision-making in patients with genitourinary cancers.

Les Land worked originally in the public service before joining the motor industry and was employed in management positions. He is now fully retired. In about January 2010 Les went to his GP with a sore left shoulder blade. Tests revealed something in the kidney area. He was referred to a urologist, had a biopsy and the same procedure carried out some 5 months later. Dr Coombes, the surgeon, then removed his left kidney as the biopsy had shown growth and was deemed cancerous. Dr Coombes referred Les to Martin Stockler who put him into the Sorefanib trial program. He stayed with the medication for the full 3 years with a few ups and downs with side effects. Les attended every 6 months for blood tests, chest x rays or whatever the protocol dictated until the trial closed. He started the trial from a selfish point of view knowing they'd look after me extremely well. The more he got involved the more he thought about other people who might be diagnosed just like himself, perhaps someone 30 years of age with a couple of children. He is glad that he might have now helped them.

Brandon Lau Clinical Senior Lecturer, UWA Medical School, Internal Medicine

Mitchell Lawrence is a Laboratory Head in the Department of Anatomy and Developmental Biology and Biomedicine Discovery Institute, Monash University. He also has appointments at the Peter MacCallum Cancer Centre and Cabrini Health. Dr Lawrence's research on prostate cancer involves multidisciplinary studies into tumour biology, pathology, and novel therapies. In collaboration with the Melbourne Urological Research Alliance, Dr Lawrence is using patient-derived models to uncover why some patients' tumours are more aggressive than others and to identify how to treat these tumours more effectively. This is leading to changes in international clinical practice, concurrent clinical trials, and partnerships with industry.

Melissa Le Mesurier, originally trained as a journalist, has 25 years' experience as a senior corporate affairs executive with blue-chip organisations such as Medibank, Kraft/Cadbury, Foster's Group and Australian Airlines. She is currently the Principal of MLM Consulting which advises executives and boards on strategy, reputation, cultural change and communications.

Both professionally and personally, Melissa is passionate about medical research, consumer engagement and patient empowerment – something sparked when her (now adult) son was diagnosed with cystic fibrosis in 1996 and strengthened when she was diagnosed with bladder cancer in 2017. She is a Graduate of the Australian Institute of Company Directors and a Director of the Lung Foundation Australia. She was previously a member of the Alfred Hospital's CF Consumer Advisory Panel and founding Chair of the Royal Children's Hospital Cystic Fibrosis Research Trust (1999-2009) which has raised more than $3m for research and funded about 20 clinical fellows.

Nicole Lewis has over 20 years of nursing experience, for the past four years working as the Prostate Cancer Clinical Specialist Nurse and ten years as the Oncology Clinical Nurse Specialist at Goulburn Valley Health. In 2019, successfully completed the DHHS funded project, Symptom and Urgent Review Clinic, better known as SURC at Goulburn Valley Health and in 2016 successfully completed the project combined with St Vincent's Hospital, Urology-Oncology Clinical Nurse Led Specialist Clinic for low risk prostate and renal cancer patients discharged from Urologists to their GP's. Nicole is highly motivated and passionate to assist and improve patients understanding and self-care strategies when dealing with chemotherapy and immunotherapy treatment side effects which has led to the next project, Medical Therapy Exercise (MET) for advanced cancer patients during anti-cancer treatment.

Roger Liang is a medical oncology advanced trainee, currently undertaking training in the South West Sydney network comprising Liverpool, Campbelltown and Bankstown hospitals. His research and clinical interests are in improving the psychological care and support of people with cancer.

Elizabeth Liow is a medical oncologist at Monash Health. She is also currently undertaking novel research in kidney cancer at the Walter and Eliza Hall Institute of Medical Research (WEHI) while undertaking her PhD. She has ongoing research collaborations with the International Metastatic Renal Cell Carcinoma Database Consortium (IMDC).

Jarad Martin practices as a Radiation Oncologist in Newcastle, where he has subspeciality interests in Genitourinary, Gastrointestinal and Benign conditions. He is active in Clinical Trial leadership, with particular interests in optimizing stereotactic radiotherapy, harnessing immune-radiotherapy and generating high level evidence for the use of radiation in benign diseases. Outside interests include running, obstacle course racing and craft beer, with a recent side-hustle in Uber driving.

Elizabeth Medhurst has been specialising in genitourinary cancers for the past six years and developed a keen interest in metastatic prostate cancer. Most recently, Elizabeth has been working as a PSMA theranostics nurse consultant as a part of the Prostate Cancer Theranostics and Imaging Centre of Excellence (ProsTIC) at Peter MacCallum Cancer centre. Elizabeth is currently undertaking a Masters of Cancer sciences at the University of Melbourne. Elizabeth is keen to continue to explore the impact of nursing interventions and care pathways to improve the quality of life of men receiving these treatments.

Sarah Moody is a postdoctoral researcher in the Testis Development and Male Germ Cell Biology lab. She completed her PhD in 2020 under the supervision of Professor Kate Loveland and A/Professor Patrick Western. Her PhD research investigated the role of the growth factor, activin A, on fetal male germ cell and testis development. Dr Moody's current research aims to understand the mechanisms underlying testicular germ cell tumour formation and progression. Working with clinical samples, Dr Moody has spearheaded an international collaboration utilising spatial transcriptomics to investigate transcript and signalling profiles of testicular germ cell tumours.

Declan Murphy is Consultant Urologist and Director of Genito-Urinary (GU) Oncology at Peter MacCallum Cancer Centre, Melbourne, and Professorial Fellow at the University of Melbourne. He is a founding Director of Cancer Specialists, a large group practice at Epworth Healthcare. Declan is an internationally-recognised key opinion leader in GU Oncology, prostate cancer in particular, and has published hundreds of peer-reviewed papers. He has been Chief Investigator on competitive GU oncology grants worth many millions of dollars and leads an active team of clinical researchers at Peter Mac. Declan's research interests focus particularly on PSMA imaging and theranostics.

He holds senior editorial positions at the BJUI, European Urology, Nature Reviews Urology, and Prostate Cancer & Prostatic Diseases, and is on the board of reviewers for many other journals. Declan is very active on social media with many thousands of followers on Twitter and a busy YouTube channel. He blogs regularly for a number of websites and hosts the popular GU Cast podcast.

Ruchira Nandurkar Ruchira is a junior doctor at Eastern Health this year, and has an interest in uro-oncology. Her latest focus has been on developing and validating a non-invasive method for detecting NMIBC and MIBC, and has recently submitted her PhD Thesis on the Local Management and Systemic Detection of Bladder Cancer to Reduce Post-Treatment Recurrence.

Paul Neeson completed a PhD in the Pathology Dept at the University of Melbourne, followed by a post-doc in the Paterson lab at the University of Pennsylvania, track record as a human translational immunologist and is an expert in exploring the immune system in human cancer. He leads the human immunology translational research lab (HITRL) in the Cancer Immunology program at the PeterMac, and is also a professor in the Sir Peter MacCallum Department of Oncology at the University of Melbourne. The Neeson Lab explores human cancer immune context, reveals immunotherapy resistance mechanisms and develops novel combination treatment strategies to address these issues. His approach includes engineering human CAR-T cells to be resistant to the immuno-suppressive tumor micro-environment to enhance CAR-T cell anti-tumor function and persistence in patients.

Colin O'Brien. First diagnosed with prostate cancer in 2005, Colin has been a member of the ANZUP CAP and Victorian Prostate Cancer Outcomes Registry Steering Committees since 2012. Prior to these he was a consumer representative on the Victorian government's Department of Health Cancer Quality Outcomes Committee, and Cancer Vic Cancer Registry. He has spent 40 years with small business as an owner, business advisor, workshop developer/ facilitator and inaugural EO of Victoria's and Australia's largest network of small business providers, Business Enterprise Centres. Becoming a member of the inaugural ANZUP CAP was an ideal opportunity to work more closely with other consumers to provide feedback re cancer trials to improve patient outcomes. A strong interest in improved benchmarking regarding the treatment, care and outcomes for cancer patients remains his core focus and interest with ANZUP. He has volunteered for many years with Australian Business Volunteers on small business volunteer assignments in Thailand, Solomon Islands, Fiji, Papua New Guinea, Vanuatu and Bali, Indonesia from one to three months. Previously a competitive distance runner and cyclist, he now contents himself with social mountain bike and road roads followed by the obligatory café "de-brief." His next travel experience, good food and wine with family and friends are always on the horizon.

Jonathan O'Brien is a urology trainee currently working in Launceston. His interest in GU oncology began as a final year medical student at the Austin Hospital. His research focuses on penile cancer and PSMA theranostics for prostate cancer. This work was performed during his time as a GU research fellow with the ProsTIC team at the Peter MacCallum Cancer Centre.

Niara Oliveira is a Senior Medical Oncologist at Mater Hospital Brisbane with a subspecialty interest in genito-urinary malignancies. She is an active member of the Australian and New Zealand Urogenital and Prostate (ANZUP) Cancer Trials Group and is the principal investigator of several clinical trials in prostate, bladder and kidney cancer at Mater Hospital Brisbane/Mater Cancer Care Centre.

Dr Oliveira serves as a Senior Lecturer at The University of Queensland (UQ) and has been involved with core teaching activities at the UQ Faculty of Medicine. She is also a local examiner for the Royal Australasian College of Physicians/Divisional Clinical Examination for Adult Medicine.

David Pook specialises in the treatment of prostate, kidney, bladder and testicular cancers. He is the principle investigator on multiple international clinical trials treating urological cancers with experimental drugs including novel combinations of immune therapy.

He is a clinical research fellow in the Prostate Cancer Research Group at Monash University where he helps develop prostate cancer models which can be used to test novel treatments. He is also the Deputy Chair of the Kidney Cancer Subcommittee of the Australia and New Zealand Urological and Prostate Cancer Trials Group.

Laura Porter is an Early Career Research Fellow at Monash University in the Prostate Cancer Research Group, which has a strong translational approach that is applicable to urology and oncology clinical practice. Dr Porter's expertise is the use of patient-derived models for studying prostate cancer pathology and preclinical drug testing, and her current research focuses on CAR T cell immunotherapy. CAR T cell therapy is a major advance in cancer treatment; however, its use in prostate cancer has had limited success thus far. Her aim is to improve the efficacy of CAR T cell therapy for prostate cancer treatment.

David Pryor is a radiation oncologist specialising in the management of urological cancers and is the Director of Training in Radiation Oncology at the Princess Alexandra Hospital. He is the clinical lead for the stereotactic body radiotherapy (SBRT) program at the Princess Alexandra Hospital, implementing SBRT for prostate and kidney cancers and is chair of a national study evaluating the role of SBRT in patients with limited sites of metastatic spread of their prostate cancer (termed oligometastases). He is actively involved in developing collaborative, multicentre clinical trials evaluating SBRT in the management of prostate cancer and is the current chair of the Genitourinary Committee of the Trans-Tasman Radiation Oncology collaborative trials group (TROG).

Dr Pryor is an Adjunct Associate Professor with APCRC-Q and has an active clinical research program with special interests in precision radiotherapy (including SBRT), its combination with systemic agents and the incorporation of functional imaging to guide radiation treatment and response. His collaborations with APCRC-Q focus on quality improvement through clinical outcome registries and pre-clinical models of precision radiotherapy.

Dr Pryor is the clinical lead for the Prostate Cancer Outcomes Registry (PCOR) in Queensland and member of the PCOR-ANZ national steering committee.

He is involved in developing and monitoring quality indicators to measure the quality of care provided to prostate cancer patients in Australia.

Dr Pryor is also lead clinical investigator on the Queensland node of the Prostate Cancer Outcomes – Compare & Reduce Variation study, which is a global project designed to improve quality of care and patient reported outcomes in men with localised prostate cancer.

David Quinn MBBS (Hons. I) PhD FRACP FACP undertook his early training at St. Vincent's Hospital in Sydney before completing a PhD in Cancer Biology at the Garvan Institute and moving to the United States in 2000. Quinn is currently Group Medical Director – Tumor Targeting, Oncology Early Development at Abbvie Research and Development and Clinical Professor of Medicine in Oncology at USC Norris Clinics. He joined Abbvie in December 2021 as Senior Medical Director.

Prior experience includes Directorship of the Clinical Investigation Support Office and Leadership of the Genitourinary Cancer and Developmental Therapeutics Programs for the USC Norris Comprehensive Cancer Center. He is a medical oncologist with focus in the field of clinical trials and molecular correlative studies in genitourinary cancer and early therapeutics. David Quinn has published more than 200 papers, reviews and chapters including recent publications in New England Journal of Medicine, Nature, Lancet Oncology, Lancet, Journal of the National Cancer Institute, Cell Stem Cells and Journal of Clinical Oncology. He is a reviewer for more than 50 peer-reviewed journals and has been an invited speaker in more than 30 countries.

Dr. Quinn was previously a member of the NCI Prostate Cancer Task Force the Renal Cancer Task Force after 6 years, Chair of the Department of Defense Prostate Cancer Research Program Integration Panel, Co-Chair for Genitourinary Cancer in the California Cancer Consortium and SWOG organ site chair for advanced prostate cancer (2012-21).

Arti Raghubar is a research active academic at Charles Darwin University with 20+ years of expertise as a diagnostic histology scientist. Arti is in the final stages of her PhD candidature enrolled through the University of Queensland (UQ). Arti's PhD research integrated cutting-edge spatial transcriptomics sequencing with tissue histology to profile immunological and proximal tubular epithelial cell signatures within the para-tumour, low- and high-grade clear cell renal cell carcinoma tumour microenvironment as a proof-of-concept for precision diagnostics. Arti's PhD research was completed in collaboration with the nephrologists, urologists, histologists and research scientists at Princess Alexandra Hospital, Royal Brisbane and Women's Hospital, the Institute for Molecular Bioscience UQ, the Translational Research Institute UQ and Queensland Institute of Medical Research.

Weranja Ranasinghe, MBChB, Ph.D., MRCSEd, FRACS (Urol), is Consultant Urologist and Urologic Oncology surgeon at Monash Health and Austin Health. He is the Urologic-Oncologic lead at Monash Health and the deputy leader for the Urological Society of Australia and New Zealand Genito-Urinary Oncology Special Advisory Group. A/Professor Ranasinghe graduated from the University of Bristol, UK and was awarded a Ph.D. at the University of Melbourne. He completed his urology training (FRACS Urology) and the Society of urologic-oncology fellowship at the MD Anderson Cancer Center, USA.

A/Prof. Ranasinghe is also a US DOD Early Career Research fellow at the University of Monash Biomedical discovery center and his research interest in the pathophysiological processes of lethal prostate cancers in particular, ductal prostate cancers. He serves as an oncology editor for the BJUI Compass journal, and has over 100 publications and received numerous national and international awards, including the AUA Urology Care Scholar award and ANZUP Below the Belt Award.

Andy Redfern is a Consultant Medical Oncologist at Fiona Stanley Hospital, a translational cancer researcher with the University of Western Australia and the current clinical head of the Cancer Division at Harry Perkins Institute. He is also Medical Director of Linear Clinical Research, WAs centre for early drug trials and is the State Lead Clinical for Breast Cancer overseeing services across the state.

Andy carried out his undergraduate Medical and Scientific training in Aberdeen, Scotland. He then trained in cancer treatment at the Royal Marsden Hospital in London; at the Northern Centre for Cancer Treatment in Newcastle-Upon-Tyne; at the Medical Oncology Centre in Auckland and at Saint Vincents Hospital in Melbourne before moving to Perth in 2001. His research interests centre around growth signalling and mechanisms of chemotherapy and hormone therapy resistance in cancer. He has active laboratory research projects in breast cancer, prostate cancer, melanoma and bowel cancer. He is also currently conducting a variety of human trials of chemotherapies, hormone therapies and immune therapies against a range of different cancers in the clinic.

He also does work with the Cancer Council of WA, the National Breast Cancer Foundation and The Breast Cancer Network of Australia.

Fairleigh Reeves is a urological surgeon with experience in minimally invasive surgery. She is a fellow of the Royal Australasian College of Surgeons, and has completed a subspecialty fellowship in Uro-Oncology and Robotic surgery. Fairleigh also provides general urology care for adults, including treatment of kidney stones and management of lower urinary tract symptoms. She offers a range of operations for benign prostate enlargement including Holmium laser enucleation of the prostate. Fairleigh is passionate about providing evidence-based, patient-centred care. She has a PhD in prostate cancer from The University of Melbourne, and has published widely in the field of urology.

Matthew Roberts is a urological surgeon-scientist working within Metro North Health, Queensland Health and is an Associate Professor & Group Leader at the UQ Centre for Clinical Research. His clinical interests include prostate cancer diagnosis, imaging and management (including robotic surgery) as well as for other malignancies. Matthew has over 120 peer-reviewed communications and has been an invited speaker at national and international conferences. He is an active participant within local and national research organisations, such as ANZUP as a member of the Prostate and other sub-committees and activities, as well as member of multiple clinical trial steering committees.

Natasha Roberts is a specialist nurse in prostate cancer. She is an early career clinician researcher, with roles as a Conjoint Clinical Research Fellow with the Surgical Treatment and Rehabilitation Service (STARS), Metro North Clinical Research Fellow and Implementation Scientist with the University of Queensland. She has 30 years nursing experience, including genito-urinary and prostate cancer clinical trials. Natasha attained her Bachelor of Nursing degree in 1994, her Honours degree in 2001 and her PhD in 2021. Her fellowship research programs are investigating unmet needs in prostate cancer care.

Shahneen Sandhu is a consultant medical oncologist and a leading clinician researcher with a full time appointment in the melanoma/skin and uro-oncology units at the Peter MacCallum Centre, Melbourne. Her research is currently focused on the design, conduct and analysis of early clinical trials with novel drugs that aim to co-develop predictive biomarkers in conjunction with therapeutics in order to personalise treatment and improve patient outcome. Her training and research experience have provided her with a

diverse range of skills in the conduct of clinical and translational research studies. She has led trials from phase I concept development all the way to registration of the compound and companion diagnostic for optimal patient selection. She currently leads several multicentre investigator-initiated trials and multiple collaborative biomarker translational projects evaluating the immune landscape in melanoma, merkel cell carcinoma and prostate cancer. Associate Professor Sandhu has >187 peer reviewed publications including, 39 first or last author publications in premier journals such as New England Journal of Medicine, Nature Biotech, Cancer Discovery, Lancet Oncology, Journal of Clinical Oncology, Nature Review Cancers, European Urology, Clinical Cancer Research, European Journal of Cancer, Annals of Oncology, etc. This work has largely focused on the development of Poly(ADP-ribose) polymerase (PARP) inhibitors in ovarian, breast and prostate cancer, evaluating immunotherapy combination therapies and immune related toxicities and developing prognostic and predictive circulating biomarkers (circulating tumour cells, circulating tumour DNA, mRNA) in prostate cancer and melanoma.

Sally Sara is the Director of Nursing for the Prostate Cancer Foundation Australia (PCFA), leading a team of over 100 specialist prostate cancer nurses across Australia. A PhD candidate, Sally also holds a Master of Clinical Nursing and has 35 years nursing experience in a broad range of specialty areas, with a strong interest in improving health care and quality of life outcomes for men diagnosed with prostate cancer. She holds an Adjunct Professor of Nursing position at the University of Southern Queensland and an Adjunct Associate Professor (Industry) position at the University of Technology Sydney. Sally is a Councillor and member representative on the Coalition of National Nursing and Midwifery Organisations and represents the Australian College of Nursing on the Cancer Australia Intercollegiate Advisory Group.

Darren Saunders is a Eureka Prize winning scientist and communicator, with over 20 years' academic and industrial experience in cancer biology and neuroscience in Australia and North America. He is currently NSW Deputy Chief Scientist & Engineer and Executive Director of the Office of the NSW Deputy Chief Scientist & Engineer, and Adjunct Associate Professor in Medical Sciences at the University of Sydney. Darren has worked with Elizabeth Broderick and Co since 2017 as a senior research advisor on numerous cultural reviews in the mining, aviation, education, arts and law enforcement sectors, and has made significant contributions to leadership, governance and engagement through peak professional bodies and policy development. Darren is a regular commentator on television and radio, and resident scientist on ABC TV's The Drum and Channel 7's Daily Edition. His written work covers everything from cancer, to science policy, masculinity and gender equity. When not in the lab, Darren loves being in the ocean or flying down a mountain.

Kath Schubach is a GU Nurse Practitioner working in private practice in metropolitan Melbourne and rural Victoria. She has had 25 years of experience and qualifications working across two-core disciplines cancer and urology. Kath has expertise in managing sexual dysfunction in oncology/urology patients. She has a master's in Nursing Science and postgraduate qualifications in oncology, urology, and continence, nursing. She is currently enrolled in her Ph.D.

Luke Selth leads the Prostate Cancer Research Group at Flinders University and is a Beat Cancer Principal Research Fellow. After a PhD at University of Adelaide, he undertook post-doctoral training at the London Research Institute (now the Francis Crick Institute), where he studied processes underlying transcriptional dysregulation in cancer. Since returning to Adelaide, he has developed an internationally-recognised prostate cancer research program. More specifically, Selth's team investigates the mechanisms underlying prostate cancer metastasis and therapy resistance, in particular the roles of transcriptional and epigenetic regulators of these processes. He has published over 85 original peer-reviewed articles, including recent papers in Cell Reports, Cancer Research, European Urology, Nature Cell Biology, eLife and Nature Medicine.

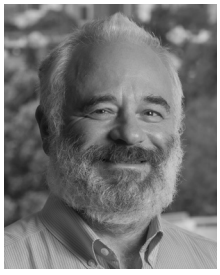
Shomik Sengupta is a consultant urologist at Eastern Health, Melbourne and Professor of Surgery at the Eastern Health Clinical School of Monash University. Shomik has a practice with a uro-oncology subspecialty interest – including open, laparoscopic and robotic cancer surgery. He completed his urological training through the Victorian Section of the Urological Society of Australia & New Zealand (USANZ) and subsequently completed a Uro-Oncology fellowship at the prestigious Mayo Clinic, USA. He has also completed a Masters in Surgery (2002) and a Doctorate in Medicine (2014) through the University of Melbourne.

Shomik is a strong contributor to academic urology, having been the Chair of the Victorian training subcommittee of USANZ from 2014 to 2016, and leader of the GU Oncology advisory group from 2013 to 2019. He has significant involvement in urologic research, including clinical trials run through the Australian and New Zealand Urogenital & Prostate (ANZUP) cancer trials group, where he is a Board member and USANZ representative on the Scientific Advisory Committee. Shomik has more than 140 original publications to date, regularly features as invited speaker at national and international conferences, and has convened numerous scientific meetings including the 2022 Annual congress of the Urological Association of Asia.

Camille Short works at the University of Melbourne and holds a joint appointment across the Melbourne School of Psychological Sciences and Melbourne School of Health Sciences (Department of physiotherapy). She is also an affiliate at the Peter MacCallum Cancer Centre. She leads a program of work focused on the use of technology for improving access to high quality, personalised, and multidisciplinary exercise support for cancer patients to prepare for and recover from treatment. As a behavioural scientist, she is passionate about ensuring exercise programs support people to make lifestyle changes by addressing the psychological, physical and social factors that impact on exercise and access to exercise services. According to expertscape she is in the top 1.5% of researchers in cancer survivorship internationally.

Oliver Schumacher, PhD is an Early Career Researcher within the Exercise Medicine Research Institute at Edith Cowan University in Perth. In 2022, he received a Prostate Cancer Foundation of Australia Priority Impact Research Award and in 2023 was awarded the Cancer Council Western Australia Postdoctoral Research Fellowship. His research focuses on exercise medicine for prostate cancer patients treated with radiotherapy, treatment-related toxicity and patient-reported outcomes, and the tumour microenvironment; in particular, how exercise during cancer treatment affects tumour perfusion, hypoxia, and vascularisation, and how these effects can be exploited to improve the delivery and effectiveness of cancer treatment.

Shankar Siva and leads the stereotactic body radiotherapy (SABR) service at the Peter MacCallum Cancer Centre. He leads 5 international multicentre trials through the TransTasman Radiation Oncology Group (TROG) with a focus in SABR. He has over 250 publications, with his current research focused on high-tech radiotherapy delivery, in the context immunotherapy combinations, oligometastatic disease, kidney cancer and prostate cancer.



Martin Stockler is Director of Oncology at the NHMRC Clinical Trials Centre, Professor of Cancer Medicine and Clinical Epidemiology at The University of Sydney, and Consultant Medical Oncologist at the Concord and Lifehouse Cancer Centres. His research focuses on improving survival, quality of life, prognostication, and communication for those affected by genitourinary, gynaecologic, thoracic, and other cancers.

Sonia Strachan graduated from La Trobe University in 1995 and has over 25 years of nursing experience. In addition to her Bachelor of Nursing Degree she also has a Graduate Diploma in Palliative Care and a certificate in Prostate Nursing Care. After more than 15 years working in Palliative care in the Goulburn Valley Sonia commenced in the role of Prostate Cancer Specialist Nurse at Goulburn Valley Health in 2014 where she set up the Prostate Cancer Nursing Service in that region. Sonia is very passionate about her role as a Prostate Cancer Specialist Nurse and providing care to men with Prostate Cancer in the Goulburn Valley catchment region. Sonia's role is funded by the Goulburn Valley community through their annual Biggest Ever Blokes Lunch.

Dennis Taaffe, PhD, DSc, MPH, is a researcher in exercise oncology in the Exercise Medicine Research Institute at Edith Cowan University in Perth. Dennis' research work examines the role of exercise before, during, and after treatment to improve patient outcomes. An overview of the results from a recently completed pre-surgical exercise and cystectomy study funded by ANZUP will be provided in the presentation.

Andrew Tan is originally from New Zealand, where he completed his Urological training in 2002. He was awarded a travelling scholarship by the Endourology Society and undertook a Fellowship in Laparoscopy and Endourology at University of Western Ontario in Canada.

Prior to Urological training, Andrew completed his Medical Degree at the University of Otago, New Zealand. His main interest is in Uro-Oncology, particularly kidney and prostate cancer, laparoscopic and robotic surgery and minimally invasive treatment of prostate enlargement with holmium laser surgery. Andrew has taught internationally on laparoscopy, robotic surgery and laser surgery and has published several research papers and book chapters. His main private practice is at Perth Urology Clinic, where he is a Director and he is a Consultant in Urology and Kidney Transplant at Fiona Stanley Hospital.

Renea Taylor is the Co-Head of the Cancer Program, Monash Biomedicine Discovery Institute. Renea is internationally recognised for her expertise in preclinical cancer research using patient-derived xenografts (PDXs), which in collaboration with her urology, pathology and oncology colleagues, provides a strong translational approach to address clinically relevant questions. The PDX platform facilitates discovery research as well as preclinical drug testing, allowing her team's laboratory-based studies to directly influence clinical practice. She is a member of the ANZUP Program Organising Committee, leading the translational science stream.

Ben Tran is a Medical Oncologist at Peter MacCallum Cancer Centre and Clinician Scientist at the Walter and Eliza Hall Institute. Clinically, his focus lies entirely within the Genitourinary (GU) Tumour stream, in particular, testicular and urothelial cancers. While also focused on GU, his research interests uniquely occupy the two ends of the spectrum in Early Drug Development, and Real World Data (RWD). Ben is actively involved within ANZUP and chairs the Germ Cell Tumour Subcommittee. Ben is also Co-Convenor (along with Renu Eapen) of the 2023 ANZUP ASM.

Michael Twycross is a survivor of advanced bladder cancer who, by providing a patient perspective to ANZUP, along with his colleagues on the CAP, hopes to assist in cancer research. He was invited to join ANZUP in 2019 and is a member of the BUP subcommittee. He is a tradesman with a background in chemical industry instrumentation who transitioned into sales management and business development. He also worked on 2 federal elections in ballot materials distribution and recently returned to sales.

Andrew Weickhardt is a medical oncologist at the Olivia Newton-John Cancer and Wellness Centre in Melbourne. He has an interest in using immunotherapy and personalised treatments for patients with genitourinary cancer. He is actively involved in translational research investigating biomarkers of response and resistance to these treatments, and is involved in several phase 1 trials of new drugs in development, including the ANZUP trial PCR-MIB using pembrolizumab with radiation in early bladder cancer.

Scott Williams is a consultant Radiation Oncologist and Professor with the Peter MacCallum Cancer Centre Uro-Oncology service in Melbourne where he has a special interest practice made up almost exclusively of prostate cancer patients. He is heavily involved in research, managing several national and international randomised trials in prostate cancer and is a member of PeterMac ethics as well as several national research and advisory committees. He holds a USA prostate cancer foundation creativity award, their highest individual honour for innovative research ideas. This award relates to novel translational research, while he is also a collaborator on active research grants for work ranging from clinical trials to functional imaging to mathematical modelling to genetics, with national and international collaborations.

Henry Woo is a urological surgeon with a subspecialised practice in prostate cancer. He is the Director of Uro-Oncology at the Chris O'Brien Lifehouse and a Staff Specialist at the Western Sydney Local Health District. He is an Honorary Professor at the ANU College of Health and Medicine and the Australian National University having previously served there as a Professor of Urology. He has previously been a Professor of Surgery at the University of Sydney. He serves on the Board of Directors of ANZUP and is also a Board Director of the Australasian Urological Foundation. He is a Fellowship Elected Councillor of the Royal Australian College of Surgeons and is also a Board Director of USANZ. He serves on the editorial boards of multiple international journals and is active in research and clinical trials. He has published approximately 200 peer reviewed articles and several book chapters. His research interests are clinical and covering all aspects of prostate cancer diagnosis and treatment.

Anne Woollett is the Clinical Trials Director of TrialHub, which is a federally funded pilot initiative. TrialHub works with partner sites in outer metro, regional and rural Victoria to establish a network to provide equitable access to high quality clinical trials; Mildura Base Public Hospital is one of these partner sites.

Anne has senior program management experience in Clinical Trials and Research Strategy, is a member of key industry working groups at state and federal level and is a regular speaker and panellist at national conferences.

Leonie Young has been a member of the ANZUP CAP since 2017 and a supporter and mentor for the CAP since 2012. She was diagnosed with breast cancer in 1987 and through her family, has personal experience and understanding of other cancers including prostate cancer.

Since her diagnosis she has been involved with many aspects of cancer consumer advocacy, support, training, and mentoring and contributes in numerous research initiatives as an experienced consumer representative with researchers both nationally and internationally. She regularly presents at conferences concerning topics relating to the lived experience. She is the Peer Support Coordinator for the Wesley Hospital Choices Cancer Support Centre (Choices) in Brisbane and an inaugural member and immediate past Chair of the Breast Cancer Trials Consumer Advisory Panel.

Leonie is the recipient of an Honorary Degree of Doctor of the University, Griffith University, Brisbane and the Reach to Recovery International Terese Lasser Award both in recognition of distinguished service to the community, particularly as an advocate for people diagnosed with cancer.

ANZUP Scientific Program and Pre-Conference Meetings 2023

'Bouncing Back'

SUNDAY 9 JULY 2023

0730 - 1230	**ANZUP Nurses & Allied Health Symposium** *Bouncing Back: Leading innovation, creativity & change* *Sponsored by* astellas ONCOLOGY · Prostate Cancer Foundation of Australia		*Meeting Room 203 & 204*
0730 - 0735 0740 - 0820	**Welcome,** Kath Schubach **RESEARCH UPDATES:**		
0740 - 0745	**Development, implementation and evaluation of a nurse-led survivorship intervention for men with prostate cancer receiving Androgen Deprivation Therapy (ADT)** – Sally Sara		
0745 - 0750	**PHd Progress update Identifying the Supportive Care Needs of People Affected by Non-Muscle Invasive Bladder Cancer: An Integrative Systematic Review** – Kath Schubach		
0750 - 0755	**Understanding the unmet needs of men in the first 12 months of undertaking active surveillance for prostate cancer** – Russell Briggs		
0755 - 0800	**2 PCSNs and a project: What we have learnt** – Sonia Strachan and Nicole Lewis		
0800 - 0805	**Genito-urinary and prostate cancers: Clinical Trials Perspectives** – Jasmine Brady		
0805 - 0810	**Patient management and the role of a theranostics nurse** – Liz Medhurst		
0810 - 0815	**Telehealth and teletrials** – Anne Woollett		
0830 - 1030	*Melbourne Room One* **Investigator Initiated Trials** ***The Perfect Pitch*** *Come hear a brilliant panel walk through trial idea generation and development so you can knock your next pitch out of the park!* Co-Chairs: Shankar Siva and Ciara Conduit	0820 - 0840	*Meeting Room 203 & 204* ***Responding to the call – the trials and tribulations of designing a Prostate Cancer Survivorship Care Plan*** Sally Sara
0830 - 0835	**The idea** Introduction Co-Chairs: Shankar Siva and Ciara Conduit	0840 - 0900	**The Sydney Cancer Survivorship Centre 10 years on – lessons learnt** Kim Kerin-Ayres
0835 - 0850	**Curveball, Fastball or Slider** *What makes a good idea?* Shankar Siva		
0850 - 0910	**Get your mechanics right** *What are the basics you need to decide?* Megan Crumbaker	**0900 - 0915**	**Morning tea**
0910 - 0930	**Prepare your pitch** *Putting it on paper (or slides)* Matthew Roberts		
0930 - 0950	**The pitch** *Throwing the Pitch: Investigator's perspective* Shahneen Sandhu	**0915 - 1215**	**Ideas Generation Workshop: Nurse Led GU Survivorship** Natasha Roberts
0950 - 1005	**Receiving the pitch** *Pharma perspective* – David Quinn		*Melbourne Room One*
1005 - 1020	**Is it a ball or a strike?** *Peer review perspective* – Martin Stockler		
1020 - 1035	**The strikeout and the homerun** *Tales of triumph and woe – what worked and what didn't* – Panel discussion		
1035 - 1105	**Morning Tea**		*Foyer*

Please note the program is subject to change. Speakers have been included in the program as at the time of publication.

Continued over

SUNDAY 9 JULY 2023 *continued*

1105 - 1230 1105 - 1110	**Translational Highlights Session** ***Latest Advances in Translational GU Research*** Co-Chairs: Renea Taylor & Luke Selth *Sponsored by* Prostate Cancer Foundation of Australia		*Melbourne Room One*
1110 - 1125	**Prospective ctDNA genotyping for treatment selection in metastatic castration-resistant prostate cancer –** Ed Kwan		
1125 - 1140	**Prostate cancer metabolism as a strategy to combat treatment resistance –** Jennifer Gunter		
1140 - 1155	**Update on Testicular Cancer: What do we need to learn and why** – Sarah Moody		
1155 - 1210	**Spatial transcriptomics: Defining the cellular milieu within the clear cell renal cell carcinoma microenvironment** – Arti Raghubar		
1210 - 1220	**Modifying the tumour microenvironment using carboplatin to enhance the efficacy of CAR T cell therapy for prostate cancer –** Laura Porter		
1220 - 1230	*Wrap up*		
1230 - 1330	**Lunch**		
1330 - 1500 1330 - 1335	*Melbourne Room One* **ANZUP Masterclass One** Chair: Carole Harris *Sponsored by* janssen	**1330 - 1500** 1330 - 1335	*Meeting Room 207* **Community Engagement Forum** ***'The ball's in your court'*** ***Welcome*** Leonie Young
1335 – 1415	**Bladder** Niara Oliveira	1335 – 1400	**What's ANZUP? *From an idea to a trial*** Ian Davis
1415 – 1455	**Kidney** Andrew Tan		
1455 - 1525	**Afternoon Tea** *Sponsored by* BAYER	1400 - 1420	**Is the ball in your court? Before you play? Finding information and asking the right questions. Decision making?** Ciara Conduit and Joe Bakhmoutski
1525 – 1700 1525 – 1535	**ANZUP Masterclass Two** Chair: Carole Harris *Sponsored by* janssen	1420 - 1440	**What balls do you need? Communication and consenting. Are we talking the same language?** Craig Gedye and Melissa Le Mesurier
		1440 - 1510	**The ball is in your court | Getting on with it** Tim Baker, Arun Azad Facilitator: Melissa Le Mesurier
1535 – 1610	**Early Prostate** Weranja Ranasinghe	1510 - 1540	**Q & A** Facilitator: Leonie Young
1610 – 1650	**Advanced Prostate** Megan Crumbaker	1540 - 1550	**Summary & Close – how can you help?** Ian Davis
1650 - 1730	**Germ Cell** Anna Kuchel	**1550 - 1600**	**Afternoon Tea**
1730 - 1830	**ANZUP Welcome Reception**		***Level Two Foyer***
1900 - 2200	**ANZUP Evening Symposium - *'Bouncing Back'*** Chair: Ben Tran ***Speakers: Darren Saunders, Andrea Apolo, David Quinn*** *Sponsored by* NOVARTIS ONCOLOGY		***Cargo Hall, South Wharf***

Continued over

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ANZUP Cancer Trials Group Limited

ANZUP Scientific Program and Pre-Conference Meetings 2023

'Bouncing Back'

MONDAY 10 JULY 2023

	Melbourne Room One		*Meeting Room 203*
0730 - 0820	**ANZUP sponsored Translational Science Breakfast**	**0730 - 0820**	**Supportive Care Breakfast: Supporting supportive care**
0730 - 0735	***Translational Rapid-Fire updates*** Co-Chairs: David Pook & Maggie Centenera	0730 - 0735	Welcome and introduction: Haryana Dhillon
0735 - 0740	**Kidney** – Craig Gedye	0735 - 0745	**Unmet needs in prostate cancer** – Natasha Roberts
0740 - 0745	**TheraP** – Ed Kwan		
0745 - 0750	**UpfrontPSMA** – Arun Azad	0745 - 0755	**Tele-health nurse-led survivorship care after prostate cancer** – Anna Green
0750 - 0755	**EnzaP** – Megan Crumbaker		
0755 - 0800	**CLIMATE** – Ciara Conduit	0755 - 0805	**Experiences of sexual well-being interventions in males affected by GU cancer and their partners – an integrated systematic review** – Kath Schubach
0800 - 0805	**PCR-MiB** – Andrew Weickhardt		
0805 - 0810	**BCG/MMC** – Andrew Redfern	0805 - 0820	**Panel discussion:** Haryana Dhillon, Natasha Roberts, Anna Green, Kath Schubach, Rebecca Martin & Laurien Buffart
0810 - 0815	**ENZAMET** – Lisa Horvath		
0815 - 0830	*Changeover to next session*	0820 - 0830	*Wrap up and move to Plenary*

0830 - 0845	**Welcome and Introduction – Ian Davis**	*Melbourne Room One*
0830 - 0835	ASM Co-Convenors Renu Eapen & Ben Tran	
0835 - 0840	**Sponsor Addresses:** AstraZeneca and Prostate Cancer Foundation of Australia (PCFA)	
0840 - 0845	**Welcome to Country**	
0845 - 1045	**Keynote Session – Challenges in the Clinic** Co-Chairs: Ben Tran and Renu Eapen	*Sponsored by* AstraZeneca Oncology
0845 - 0905	**Challenges and Pitfalls in GCT Management** – Darren Feldman	
0905 - 0925	**The Myths and Reality About Bladder Preservation in Muscle-Invasive Bladder Cancer** – Ananya Choudhury	
0925 - 0945	**Sexual function in bladder cancer, what do we know and how do we address this in practice?** – Rebecca Martin	
0945 - 1005	**Crossing borders and boundaries in exercise oncology research** – Laurien Buffart	
1005 - 1020	**PARP inhibitors in mCRPC: for a few, some or all?** – Arun Azad	
1020 - 1030	**ANZUPx: The power of passion in science** Laurien Buffart	
1030 - 1100	**Morning Tea**	*Sponsored by* IPSEN Innovation for patient care
1100 - 1230	**Translational Plenary**	*Sponsored by* MERCK
1100 - 1105	Co-Chairs: Anthony Joshua and Lisa Horvath	
1105 - 1125	**Molecular staging in Bladder Cancer: Ready for Clinical Application?** – Sima Porten	
1125 - 1145	**Biomarkers in muscle-invasive and localized urothelial carcinoma** – Andrea Apolo	*Sponsored by* MERCK
1145 - 1205	**How do we genotype de novo metastatic prostate cancer?** – Alex Wyatt	
1205 - 1225	**Investigating the tumour immune microenvironment of clear cell RCC** – Paul Neeson	
1225 - 1235	Panel discussion	
1235 - 1330	**Lunch**	

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MONDAY 10 JULY 2023 *continued*

1330 - 1500 1330 - 1335	**ANZUP Best of the Best Oral Abstracts** ***Co-Chairs: Les Land & Brandon Lau***	*Melbourne Room One* *Sponsored by* astellas ONCOLOGY
1335 - 1345	**Preclinical testing of Bipolar Androgen Therapy (BAT) with patient-derived models of castration-resistant prostate cancer –** Mitchell Lawrence	
1345 - 1355	**Feasibility, acceptability and safety of personalized adaptive enzalutamide therapy in people with metastatic castrate-resistant prostate cancer (mCRPC): EnzAdapt** – Craig Gedye	
1355 - 1405	**An exploration of experiences of survivors of testicular cancer experiencing retrograde ejaculation following retroperitoneal lymph node dissection – a sub-study of the PREPARE clinical trial** – Ciara Conduit	
1405 - 1415	**Factors affecting adherence to active surveillance in patients with stage 1 testicular germ cell tumours in South Western Sydney** – Roger Liang	
1415 - 1425	**Factors affecting treatment trends for metastatic renal cell carcinoma (mRCC) in Australia** – Elizabeth Liow	
1425 - 1435	**Real-world prescribing patterns for first-line and maintenance treatment of patients with advanced urothelial cancer (UC)** – Andrisha-Jade Inderjeeth	
1435 - 1445	**Rates of Participation of Aboriginal and Torres Strait Islander and Culturally and Linguistically Diverse communities in ANZUP theranostic prostate cancer clinical trials - current data and future directions** – Martin Hong	
1445 - 1455	***USANZ Best of the Best Oncology presentation*** **Surgical Outcomes of patients on the LuTectomy trial –** Jonathan O'Brien	
1500 - 1530	**Afternoon tea**	
1530 - 1650 1530 - 1535	**Surgical Plenary: Non-muscle invasive bladder cancer – medical urologist** ***Co-Chairs: Michael Twycross & Fairleigh Reeves***	
1535 - 1550	**Sequencing treatment options in BCG unresponsive NMIBC** – Sima Porten	
1550 - 1605	**Quality patient preparation for Cystectomy. The role of the specialist nurse** – Rebecca Martin	
1605 - 1620	**High Risk NMIBC- is it time for the oncologist to step in?** – Ananya Choudhury	
1620 - 1630	Panel discussion	
1630 - 1700	**Debate: Robotic versus open cystectomy**	
1630 - 1640	**Radical cystectomy: Openness is best** – Dickon Hayne	
1640 - 1650	**Robotic Cystectomy: Rise of the Machines** – Sima Porten	
1650 - 1700	Panel discussion	
1700 - 1710	**ANZUPx – Motivation and philosophy: approaching translational cancer research with a PhD** Alex Wyatt	
1710 - 1740	**AGM** – Members Only	
1740 - 1840	**Poster Walkaround and drinks** Poster discussants: Henry Woo and David Pryor	*Level Two Foyer*
1900 - 2300	**ANZUP Conference Dinner**	***Sovereign Room, MCEC***

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TUESDAY 11 JULY 2023

0715 - 0815	**Breakfast Session: Getting the ball rolling – using adjuvant therapy in renal cell carcinoma and other GU malignancies** Co-Chairs: Amy Hayden & Juliet De Nittis	*Melbourne Room One* *Sponsored by* MSD
0715 - 0745	**GU Cast battle: Adjuvant Immunotherapy for T3 RCC** Against: Declan Murphy For: Renu Eapen Adjudication/Commentary: Henry Woo	
0745 - 0815	**Macquarie versus Memorial: Adjuvant chemo in stage 1 non-seminoma** Against: Darren Feldman For: Howard Gurney Adjudication/Commentary: Ben Tran	
0815 - 0830	*Changeover to next session*	
0830 - 1000 0830 - 0835	**Plenary: Exercise in GU Cancers** Co-Chairs: Daniel Galvao & Colin O'Brien	*Sponsored by* AstraZeneca Oncology
0835 - 0850	**Towards personalized exercise medicine for patients with prostate cancer** – Laurien Buffart	
0850 - 0905	**Exercise adjuvant to radiation therapy to enhance effectiveness** – Oliver Shumacher	
0905 - 0920	**Preoperative exercise therapy to enhance outcomes for patients with bladder cancer** – Dennis Taaffe	
0920 - 0935	**Using digital behaviour change tools to help cancer survivors adopt and maintain regular exercise** – Camille Short	
0935 - 1000	Panel discussion	
1000 - 1030 1000 - 1005	**Leadership in GU Cancers** Chair: Carole Harris	*Sponsored by* Bristol Myers Squibb
1005 - 1020	**Leadership and Building a Career in Oncology** – Sima Porten	
1020 - 1030	Panel discussion: Carole Harris, Sima Porten, Ian Davis and Margaret McJannett	
1030 - 1100	**Morning Tea**	
1100 - 1230 1100 - 1105	**Plenary: Keynote Two** **Co-Chairs: Haryana Dhillon & Chun Gan**	*Sponsored by* astellas ONCOLOGY
1105 - 1125	**Ongoing Research and New Horizons for Urothelial Cancer** – Andrea Apolo	*Sponsored by* MERCK
1125 - 1145	**GCT in 2023: Updates and Future Directions** – Darren Feldman	
1145 - 1205	**Plasma ctDNA testing in advanced genitourinary cancers** – Alex Wyatt	
1205 - 1225	**Personalised Radiotherapy: what are we waiting for?** – Ananya Choudhury	
1225 - 1235	Panel discussion	
1235 - 1330	**Lunch**	

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TUESDAY 11 JULY 2023 *continued*

1330 - 1500 1330 - 1335	*Melbourne Room One* **ANZUP Trials in Action** Chairs: Ian Davis & Belinda Jago *Sponsored by* MSD
1335 - 1350	**Prostate** – Lisa Horvath and Jarad Martin
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1405 - 1420	**Renal** – David Pook
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1600 - 1630	**ANZUP Awards & ASM close** Co-Chairs: Ian Davis, Renu Eapen and Ben Tran
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Please note the program is subject to change. Speakers have been included in the program at the time of publication.

The Best of the Best Oral Abstracts

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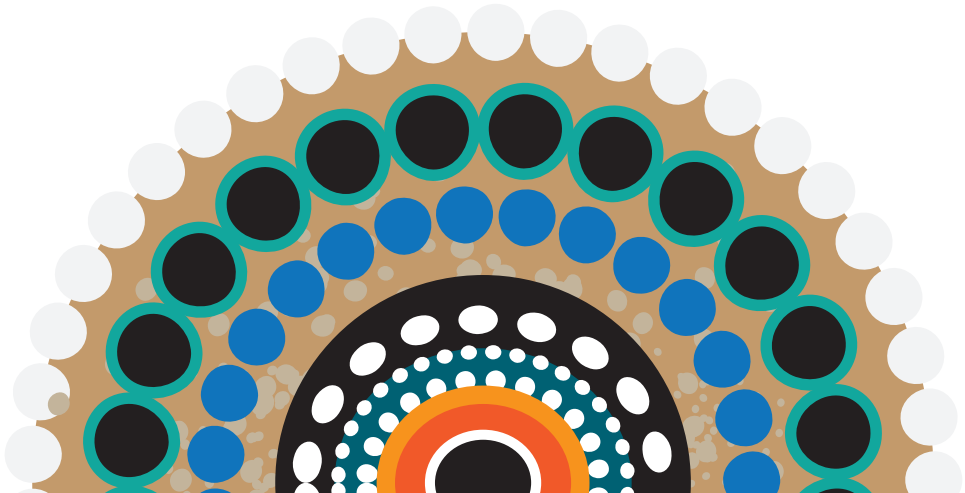
Martin Hong

USANZ Best of the Best Oncology presentation

Surgical Outcomes of patients on the LuTectomy trial

Jonathan O'Brien



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Poster Abstracts

#abs1 | A Historical Perspective of Renorrhaphy Techniques

Tan, Nicholas - Co-Author 1; Homewood, David - Author1; Corcoran, Niall - Co-Author 2[1]; Agarwal, Dinesh - Co-Author 3

[1]Department of Urology, Royal Melbourne Hospital, Melbourne, Australia

Partial Nephrectomy is an essential nephron sparing surgery in the urologist's toolkit. Many techniques have been used to seal the defect left by a partial nephrectomy. We explore a comprehensive historical perspective on the techniques used for renorrhaphy in partial nephrectomy. We first provide a brief overview of the history of partial nephrectomy and the conventional techniques that have been used to close renal parenchyma, highlighting their disadvantages. The article then explores the aims of renorrhaphy and the principles behind knotless closure with the sliding clip technique. Then follows detailed discussion of the modifications made to the sliding clip technique, complete with illustrative images. The debate on single-layer versus double-layer closure and continuous versus interrupted sutures is also examined, with new insights and perspectives offered. In addition, the article explores nonrenorrhaphy techniques, such as sealants and glues, that have been used to seal the renal defect. By examining the evolution of renorrhaphy techniques and the various modifications made over time, this article provides a comprehensive understanding of the improvements made in partial nephrectomy procedures. We provide novel insights to better understand the history and current state of renorrhaphy techniques in partial nephrectomy.

#abs2 | A need for clear definitions and improved management for Bacillus Calmette-Guérin-unresponsive non-muscle invasive bladder cancer in Asia-Pacific

Lee, Lui Shiong - Author; Kanesvaran, Ravindran - Co-Author 1; Kikuchi, Eiji - Co-Author 2; Kitamura, Hiroshi - Co-Author 3; Ku, Ja Hyeon - Co-Author 4; Lin, Tzu-Ping - Co-Author 5; Nishiyama, Hiroyuki - Co-Author 6; Ng, Chi Fai - Co-Author 7; Ng, Junice Yi Siu - Co-Author 8; Poon, Darren - Co-Author 9; Seo, Ho Kyung - Co-Author 10; Spiteri, Carmel - Co-Author 12; Tan, Ee Min - Co-Author 13; Tran, Ben - Co-Author 14; Tsai, Yuh-Shyan - Co-Author 15

Introduction & Objectives Clinical practice guidelines recommend the use of different terminologies related to BCG-unresponsive non-muscle invasive bladder cancer (NMIBC) and different treatment approaches. We examined the level of understanding of terminologies and clinical management related to BCG-unresponsive NMIBC in Asia-Pacific. Methods This is a mixed methods study involving 2 parts: 1) a survey with 32 urologists and 7 medical oncologists (MOs) and 2) in-depth interviews with 23 urologists and 2 MOs. All clinicians had ≥8 years of experience managing NMIBC across Australia, Hong Kong, Japan, South Korea, Singapore, and Taiwan. Data from Part 1 were analysed descriptively. We used content and thematic analyses for Part 2. Results In part 1, clinicians defined BCG-unresponsive as BCG-refractory, BCG-relapse and BCG-resistant (35%), BCG-refractory and BCG-resistant (18%), BCG-refractory only (15%) and the remaining as combination of these terms or alone. Around 50% of clinicians selected radical cystectomy as preferred treatment for BCG-unresponsive patients; the other 50% of participants selected bladder-sparing treatments. BCG-retreatment was most frequently used as first-line treatment for BCG-unresponsive patients who are eligible but unwilling to undergo RC (34%). In part 2, we found that 32%, 88% and 48% of the clinicians, respectively, were aware of the terms BCG-unresponsive, BCG-refractory and BCG-relapse in clinical practice but had no consistent interpretation of these terms. When compared with the EAU definitions, up to 60% of clinicians appropriately classified tumour characteristics that are persistent or recurrent after adequate BCG. Clinicians reasoned that BCG-retreatment is still provided to BCG-unresponsive patients due to the lack of effective and low-cost bladder-sparing treatment. Conclusions The terminologies related to BCG-unresponsive NMIBC are ambiguous resulting in varied understanding in clinical practice. Clearer definition of BCG-

unresponsive NMIBC is needed to aid disease identification and management.

#abs3 | ADT or no ADT? Using the modified frailty index (mFI-11) to analyse the frailty determinants of neoadjuvant ADT + EBRT versus EBRT alone amongst men with intermediate risk PCa

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INTRODUCTION: Radiotherapy (EBRT) in conjunction with neoadjuvant androgen deprivation therapy (ADT) is a standard of care for frail men with localised intermediate risk PCa.Frail patients having received EBRT show reduced overall survival (OS) and higher all-cause mortality. The addition of ADT places these men at increased risk of fatigue, falls, loss of strength, lean body mass and increased cardiovascular morbidity. We aim to determine whether frailty impacts the decision to commence ADT + EBRT versus EBRT alone. **METHODS**: Retrospective data was obtained from 3 urological centres. Patients >70 years diagnosed with localised intermediate risk PCa following biopsy receiving EBRT +/- ADT were included. Age and Pathological features inclusive of Gleeson score, T stage and PSA were collected for multivariate analysis. Disease states were gathered for modified frailty index (mFI-11) scoring. Patients with MFI >0.27 were classified as frail. **RESULTS:** 39 patients met inclusion criteria. On univariate analysis the decision to treat with EBRT alone was significantly associated with frailty p=0.023 (OR 18 (1.537-58.702)) while multivariate analysis revealed no significant association between frailty and our primary outcome. Using Fisher's exact test no individual components of the mFI-11 were significantly associated with decision to treat with EBRT only however features of cardiovascular disease such as hypertension, ischaemic heart disease and two diabetes were proportionally higher in prevalence amongst those receiving EBRT only when compared to the ADT + EBRT group (62.5% vs 58.1%, 25% vs 9.7%, 25% vs 22.6%). **CONCLUSIONS:** Our results indicate frailty may influence the decision to treat men with intermediate risk PCa with EBRT alone. Despite this, when considering a patient's age, pathology and frailty together frailty was found to have no influence on the decision to exclude ADT. Features of cardiovascular disease may influence this decision however future studies with larger sample sizes are required.

#abs4 | AlphaBet: A Phase I/II trial evaluating the combination of Radium-223 and [177Lu]Lu-PSMA-I&T in patients with metastatic castration-resistant prostate cancer

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INTRODUCTION: Despite [177Lu]Lu-PSMA conferring a survival benefit in metastatic castration-resistant prostate cancer (mCRPC), progression is inevitable, with many developing progressive marrow disease. Due to a lack of crossfire radiation, micrometastatic osseous disease may not receive adequate radiation from beta-emitters such as 177Lu to induce double-stranded DNA breaks. Alpha-emitters are better suited for treating micrometastatic disease owing to the shorter path length (≤100 μm) and higher linear energy transfer. Radium-223 is a calcium-mimetic alpha-emitter that targets osteoblastic bone metastases. **OBJECTIVES:** To evaluate the safety and preliminary efficacy of radium-223 and [177Lu]Lu-PSMA-I&T in combination. **METHODS:** This phase I/II, single-arm, single-centre study will enrol 36 patients with mCRPC who have progressed on a prior androgen receptor pathway inhibitor. Up to 6 cycles of [177Lu]Lu-PSMA-I&T (7.4 GBq) and radium-223 (28 kBq/kg - 55 kBq/kg) will be given intravenously every 6 weeks, along with bone protective therapy. The dose of radium-223 will be escalated using a traditional 3+3 design. Key eligibility criteria include

ECOG status 0-2, adequate marrow and organ function, ≥2 untreated bone metastases visible on bone scan and PSMA-positive disease on PSMA PET/CT (SUVmax ≥20). Sites of FDG-positive disease must be either PSMA-positive or have increased uptake on bone scan. Patients treated with ≥1 line of chemotherapy are not eligible. **RESULTS:** The co-primary objectives are to determine the maximum tolerated dose of radium-223 when combined with [177Lu]Lu-PSMA-I&T, and the PSA 50% response rate. Secondary objectives include assessing safety (CTCAE v5.0), efficacy (radiographic and PSA progression-free survival, overall survival, objective response rate), and evaluation of pain and health-related quality of life. Exploratory objectives include identification of biomarkers through blood samples and biopsies taken at baseline, on treatment, and at progression. CONCLUSION: Enrolment began in September 2022 and will continue for 24 months. NCT05383079.

#abs5 | An exploration of experiences of survivors of testicular cancer experiencing retrograde ejaculation following retroperitoneal lymph node dissection – a sub-study of the PREPARE clinical trial.

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BACKGROUND: Retrograde ejaculation (RE) is a complication of retroperitoneal lymph node dissection (RPLND) in testicular cancer survivors. Whilst common immediately after surgery, the prevalence of persistent symptoms, and impact on health-related quality-of-life (HRQoL) has not been reported. We aimed to explore testicular cancer survivors' experiences of RE following RPLND. **METHODS:** In a sub-study of a single-arm phase 2 clinical trial, PREPARE (ACTRN12622000542796), we invited participants reporting RE at least 6 months following RPLND to participate in optional semi-structured interviews. Purposive sampling was used to sample from a range of participant characteristics. Interviews continued until thematic saturation was reached. Codebook thematic analysis was performed. **RESULTS:** 15 participants participated in an optional interview; median age 34 years (range 24-66), median time from surgery 41 months (range 17-113), 12/15 (80%) in a long-term relationship. We identified two overarching themes. The first identified the worth of RPLND and being alive despite development of RE. The second illuminated the impact of RE as closely related to the individual's age and stage of life. These factors influenced the impact of RE across five areas: fertility, sex, information needs, communication, and psychological wellbeing (including masculinity and body image). Fertility was a substantial source of stress and concern for younger participants. RE had no effect on sex for some participants while for others, sex was less pleasurable and was rarely reported to cause pain. A few participants reported RE as challenging their masculinity, confidence, and self-esteem. Participants wanted information about RE to be included in early conversations regarding RPLND. **CONCLUSIONS:** Most participants considered RE to have little impact on their sexual function and intimate relationships. However, for those who reported difficulties, these varied depending on age, stage of life and relationship status. Future research should examine interventions to reduce distress related to fertility, challenged masculinity and body image.

#abs6 | Applications of CRISPR in Urological Cancers: A Powerfully Versatile Tool

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INTRODUCTION: Urological cancers, including prostate, bladder, kidney, and testicular cancers, account for a significant portion of cancer diagnoses and mortality rates worldwide. Traditional treatment options such as chemotherapy and radiation can have significant side effects and become ineffective in refractory disease. The discovery of the CRISPR-Cas9 system has opened new avenues for cancer research, offering the potential for highly targeted and precise therapies. CRISPR has shown great promise

in the treatment of various types of cancer, including urological cancers, by targeting specific genes or mutations that play a role in cancer development and progression. In this review, we will summarize the current state of research on CRISPR in urology and discuss its potential for improving the diagnosis and treatment of urological cancers. **METHODS:** A comprehensive literature search was conducted on databases including PubMed, Embase, and Web of Science. Keywords included CRISPR and urology OR prostate OR renal OR bladder OR testicular cancer. Articles were included based on their relevance to the topic and publication in English. **RESULTS:** CRISPR-Cas9 has been used extensively in a preclinical setting to identify and target genes in prostate cancer including AR, NANOG, ERβ TP53, PTEN, and PD-1. Targeting PRRX2 and PTEN have also been shown to overcome enzalutamide and docetaxel resistance in vitro. In bladder cancer, CBP, p300, hTERT, lncRNA SNGH3, SMAD7e, FOXA1 have been targeted, with HNRNPU knockout demonstrating tumour inhibition, increased apoptosis and enhanced cisplatin sensitivity both in vitro and in vivo. Renal cancer has seen CRISPR target VHL, TWIST1, PTEN and CD70, with the first in-human clinical trial of Anti-CD70 CAR T-cell therapy showing an excellent safety profile and durable oncological results. Lastly, testicular cancer modelling has utilised CRISPR to knockout FLNA, ASH2L, HMGB4, CD24, VIRMA. A genome-wide CRISPR activation screen identified NAE1 to be over-expressed in cisplatin-resistant germ cell colonies. **CONCLUSION:** Pre-clinical studies have utilised CRISPR-Cas9 extensively to identify and target genes in all urologic cancers. This revolutionary technology is now ready to demonstrate its therapeutic potential in combination with chemotherapy and immunotherapy in the treatment of advanced urological malignancies.

#abs7 | Are we starting with a normal skeletal muscle and fat mass measures for men commencing Androgen Deprivation Therapy?

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INTRODUCTION: Body composition changes for men receiving Androgen Deprivation Therapy (ADT) for prostate cancer is well documented in the literature as are the long term effects. Baseline body composition of Skeletal Muscle Mass (SMM) and Fat Mass (FM) measurements commenced in May 2021 on men newly diagnosed with prostate cancer using the ImpediMed Bio Impedance SOZO Digital Health Platform. **OBJECTIVES:** Investigate and explore baseline Skeletal Muscle and Fat Mass measurements to consider the usefulness and consideration of imbedding the SOZO Digital health platform into nursing practice to improve the quality of care in patients. **METHODS:** An Observational study from May 2021 to March 2023. Baseline body composition measurements on newly diagnosed prostate cancer men using the ImpediMed Bio Impedance SOZO Digital Health Platform. The Prostate Cancer Specialist Nurse (PCSN) met with patient's following their consultation and discussion with the Radiation Oncologists to introduce and undertake the SOZO. Results: The SOZO results of 183 patients were analysed including data from patient ages ranging from 51-89 years (mean age 71.4years). More than 75% of patients presented with an abnormal baseline SMM prior to ADT commencement. Nil patients aged <60 (n=7) fell within 'normal' SMM baseline range. Less than 10% of patients had a fat mass within 'lean to good' reference range and 60% presented with very high fat mass. **CONCLUSIONS:** The SOZO has been successfully imbedded into routine patient care screening supported by the PCSN role as an objective noninvasive screening tool to measure SMM and FM. This has highlighted concerning results with the identification of abnormal baseline results for patients commencing ADT in the context of expected body composition changes. Future plans to monitor the direct effects of ADT with routine SOZO measures, will support the targeted monitoring of the effectiveness of exercises and potentially guide the care of patients who have muscle related comorbidities.

#abs8 | Avelumab first-line maintenance for advanced urothelial carcinoma: long-term follow-up from JAVELIN Bladder 100 in subgroups defined by first-line chemotherapy regimen and overall survival from start of chemotherapy

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INTRODUCTION AND OBJECTIVES: For platinum-eligible patients with advanced urothelial carcinoma (UC), cisplatin- or carboplatin-based chemotherapy followed by avelumab maintenance in patients without progression is the standard-of-care first-line treatment. This is based on the phase 3 JAVELIN Bladder 100 trial (NCT02603432), which showed significantly longer overall survival (OS) and progression-free survival (PFS) from start of maintenance (randomisation) with avelumab + best supportive care (BSC) vs BSC alone (median OS, 23.8 vs 15.0 months; hazard ratio [HR], 0.76 [95% CI, 0.63-0.91]; p=0.0036). We report exploratory analyses of long-term outcomes by first-line chemotherapy regimen and OS from start of first-line chemotherapy. **METHODS:** Patients with unresectable locally advanced or metastatic UC without progression following 4-6 cycles of first-line gemcitabine + cisplatin (GemCis) or carboplatin (GemCarbo) were randomised 1:1 to receive avelumab + BSC (n=350) or BSC alone (n=350). The primary endpoint was OS measured from randomisation. **RESULTS:** Median follow-up from randomisation was ≥38 months in both arms (data cutoff: 4 June 2021). OS (measured from randomisation) was prolonged with avelumab + BSC vs BSC alone in the GemCis subgroup (median OS, 25.1 vs 17.5 months; HR, 0.78 [95% CI, 0.607-1.008]) and the GemCarbo subgroup (median OS, 20.8 vs 13.0 months; HR, 0.70 [95% CI, 0.523-0.929]). Observations were similar for PFS. Safety findings were similar across subgroups. In the overall population, median OS measured from start of chemotherapy was 29.7 months (95% CI, 25.2-34.0) in the avelumab + BSC arm and 20.5 months (95% CI, 19.0-23.5) in the BSC alone arm (HR, 0.77 [95% CI, 0.635-0.921]). **CONCLUSIONS:** Long-term outcomes from JAVELIN Bladder 100 confirm that avelumab first-line maintenance provided similar efficacy benefits irrespective of first-line chemotherapy regimen, with an acceptable safety profile. Median OS measured from start of chemotherapy further supports avelumab first-line maintenance as standard-of-care treatment and provides a benchmark for future clinical trials. Funding Statement: This study was sponsored by Pfizer, as part of an alliance between Pfizer and Merck (CrossRef Funder ID: 10.13039/100009945). Medical writing support was provided by Lauren O'Brien on behalf of Clinical Thinking and was funded by Pfizer and Merck.

#abs9 | Belzutifan Plus Lenvatinib for Patients With Advanced Clear Cell Renal Cell Carcinoma After Progression on PD-1/L1 and Vascular Endothelial Growth Factor Inhibitors: Preliminary Results of Phase 1/2 KEYMAKER-U03B Arm B5

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INTRODUCTION AND OBJECTIVES: The HIF-2βinhibitor belzutifan demonstrated antitumor activity for clear cell renal cell carcinoma (ccRCC) as monotherapy and in combination with a VEGF-TKI. KEYMAKER-U03B (NCT04626518) is multicenter, multiarm, open-label, phase 1/2 adaptive umbrella study. We present preliminary results from arm B5 (belzutifan plus lenvatinib). **METHODS:** In all arms, adults with histologically confirmed ccRCC, KPS ≥70%, and disease progression on or after anti–PD-1/L1 and VEGF-TKI treatment (in sequence or in combination) were enrolled. In arm B5, patients received belzutifan 120 mg orally once daily plus lenvatinib 20 mg orally once daily. The study comprised a safety lead-in phase to establish the recommended phase 2 dose followed by an efficacy phase. Co-primary end points of the efficacy phase were safety and ORR per RECIST v1.1. ORR was evaluated in patients who had an opportunity for ≥2 postbaseline scans. End points will be evaluated in each arm separately. **RESULTS:** Overall, 32 patients were enrolled and 30 received treatment. Median follow-up was 6.9 months (range: 0.1-18.2). Of 10 evaluable patients in the safety lead-in phase, 1 experienced a dose-limiting toxicity (grade 1 dyspnea). Of 24 patients who had opportunity for ≥2 postbaseline scans, ORR was 50% (all PRs). Grade 3-4 treatment-related adverse events,

most commonly hypertension (27%) and anemia (17%), occurred in 15 patients (50%). One patient experienced grade 2 hypoxia. No patients died due to a treatment-related adverse event. **CONCLUSIONS:** Preliminary data from the belzutifan plus lenvatinib arm exhibited promising antitumor activity for ccRCC that progressed on PD-1/L1 inhibitors and VEGF-TKIs. Safety findings were consistent with individual profiles of each agent. The combination is being further evaluated in the phase 3 LITESPARK-011 study.

#abs10 | Breast Cancer Gene (BRCA) 1 and 2 Testing Results in Metastatic Castrate Resistant Prostate Cancer Patients at a Cancer Care Centre

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INTRODUCTION: Metastatic castrate resistant prostate cancer (mCRPC) has poor prognostic outcomes and few lines of available treatment. Since 2020, positive BRCA status has opened up olaparib and similar medications as an additional treatment line for these patients, with good evidence for their efficacy. The positive result rate for BRCA testing in this cohort should be approximately 5% (the incidence of this mutation in this cohort), however BRCA testing can return as inconclusive, which precludes patients from these medications and raises the dilemma of potential further invasive tissue sampling. **OBJECTIVES:** To assess the records of patients attending Mater Cancer Services Brisbane (Mater Cancer Care Centre (MCCC), Mater Cancer Care Springfield, Mater Private Hospital) between 2020 and 2023 with mCRPC who had BRCA testing sent and the outcomes of this testing. **RESULTS:** Between January 2020 and 2023, 135 patients with mCRPC received treatment across our hospital network. For 60% (n=82) of patients, no BRCA testing was sent, due to insufficient/inaccessible tissue (33%, n=17), transition to best supportive cares (23%, n=19) or ongoing benefit from current treatments (18%, n=15). BRCA testing was sent for 35% of all patients (n=50), on either their original histology samples from biopsy/surgery or subsequent biopsy. Of these, 2% (n=1) returned positive for a BRCA 1/2 variant, 64% (n=32) returned negative and 34% (n=17) returned inconclusive due to "quality control failure". No variants of unknown significance were noted. Additionally, 3 patients had serum samples sent for somatic testing, with one positive, 2 negative and 0 inconclusive results. **CONCLUSION:** Our data demonstrates substantially lower than expected positive BRCA results as well as a high rates of quality control (QC) fails leading to inconclusive results. The high rate of QC fails represents a potential area for quality improvement in tissue sampling/handling that will require further investigation.

#abs11 | Can Artificial Intelligence Devise Surveillance Regimens for Testicular Cancer?

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INTRODUCTION & OBJECTIVES: Post-surgical surveillance of stage 1 testicular cancer is grounded in a diverse foundation of evidence. ANZUP have consolidated this information into a series of follow-up recommendations that are presented in a simplified, algorithmic fashion that is easily followed by clinicians and patients. As artificial intelligence (AI) evolves, we question whether there is a role for AI models to aid in the formulation of surveillance regimens for patients when presented with objective medical information. ChatGPT is an AI chatbot forging a new frontier in online information that can provide instant responses to complex questions. This study aimed to evaluate ChatGPT-generated surveillance regimens for stage 1 testicular cancer. **METHODS:** ChatGPT was enquired for surveillance regimens for stage 1 testicular cancer specific to the pathology, either pure seminoma or non-seminoma (NSGCT) germ cell tumours, and whether the patient underwent adjuvant therapy. Responses were compared against the ANZUP recommendations. **RESULTS:** ChatGPT responses were delivered in bullet point format and addressed physical examination, tumour markers and imaging. All responses made a concluding conditional statement stating that the advice was generalised and physician input was required. ChatGPT recommended physical examinations and tumour markers for all seminomatous cancers and NSGCT without adjuvant therapy approximately twice as frequently as ANZUP. Regimens for NSGCT with no adjuvant therapy failed to recommend physical examination and

tumour markers at 1 month and provided an interval range of 2-3 months for the first year which is less frequent than ANZUP recommendations. Imaging intervals were similar to ANZUP for all pathologies and treatments, although imaging modality was not specified with the exception of lung imaging in the case of bleomycin therapy. None of the regimens included testosterone assessment. **CONCLUSION:** While ChatGPT responses were mostly similar to ANZUP recommendations, clinicians should be aware of the potential for AI chatbots to diverge from local guidelines which may impact patient management.

#abs12| CarbOplatin in Metastatic castrate resistant ProstAte Cancer - a reTrospective study of heavily pre-treated patients (COMPACT).

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INTRODUCTION AND OBJECTIVE: Despite a lack of up-to-date clinical trial data, many clinicians advocate the use of Carboplatin monotherapy to treat patients with advanced Castrate Resistant Prostate Cancer (CRPC) who have exhausted multiple other treatment options. The aim of this study was to determine the overall survival (OS) and response rate in patients with advanced CRPC treated with Carboplatin monotherapy after progressing on other chemotherapy agents. **METHODS:** Retrospective multicentre study of the use of Carboplatin in advanced CRPC patients in Australia. Demographic data, PSA response rates, survival data and Carboplatin treatment protocols, such as dose and duration, were collected. Exploratory analyses on potential prognostic parameters were performed. **RESULTS:** 51 patients received Carboplatin: median age 68 (range 55–86 years). Most patients (78.3%) received Carboplatin AUC 5 at 3-weekly intervals. The median number of cycles of Carboplatin was 3 (range 1-17). Median time on treatment 63 days (range 1-441). Median overall survival was 29.4 weeks (IQR 11.7 weeks). 6 (11.8%) patients had a PSA response ≥50%. The median time to PSA progression (as defined by PCWG*) on Carboplatin was 67 days (range 15-418). 16 patients (31%) required a dose delay or reduction and 8 patients (15.6%) ceased Carboplatin secondary to side effects/ toxicity. **CONCLUSION:** Our findings demonstrate that in heavily pre-treated CRPC, Carboplatin has a modest benefit in a minority of patients with a low rate of toxicity in the advanced prostate cancer population.

#abs13 | ChatGPT: can Artificial Intelligence communicate with patients better than surgeons?

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INTRODUCTION: ChatGPT is an artificial-intelligence language chatbot that has the power to interact with and educate patients regarding their medical care. It is important to understand the information that can be generated for accuracy and readability. It may represent a powerful way to improve patient communication. We aimed to compare patient information generated by ChatGPT about four common urological surgeries, and compare it to Urological Society of Australia and New Zealand's-endorsed material1. **METHODS:** ChatGPT was prompted to write a patient pamphlet on four urological surgeries: robotic assisted radical proctectomy; radical orchidectomy; rigid cystoscopy and bladder biopsy; transperineal prostate biopsy2. These were compared to the USANZ-endorsed material. Pamphlets were evaluated by four blinded clinicians. Pamphlets were assessed using the Patient Education Materials Assessment Tool, scoring understandability, actionability and procedure-specific items3. **RESULTS:** Average understandability of ChatGPT instructions ranged from 72.7% to 79.3%, compared to 78% to 83% for college-endorsed material. Average actionability scores ranged from 0% to 60% for ChatGPT generated pamphlets, compared to 40% and 65% for college-endorsed material. Finally, ChatGPT pamphlets took less than five minutes each to produce after a prompt had been developed, compared to several hours per USANZ pamphlet. **CONCLUSION:** ChatGPT has the potential to be a powerful tool to help improve patient understanding of medical procedures, at significantly lower time cost. Care must be taken when developing material to ensure its accuracy for generating patient materials. ChatGPT provided direct answers that could be pitched at an appropriate

level for patients, however was less accurate than endorsed material. With further development, this may help to save medical practitioners time in the future to develop these materials for patients, as well as act as a direct source of information for patients.
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#abs14 | Clinical characteristics and outcomes of early-onset metastatic prostate cancer

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INTRODUCTION AND OBJECTIVES: Early-onset prostate cancer(diagnosed at age ≤55 years) is considered to be a distinct clinical and biological entity and there is limited data available on metastatic prostate cancer(mPC) in this age group. **METHODS:** Patients aged ≤55 years diagnosed with mPC from 2015-2021 were included. Clinical details were retrieved through electronic medical records. **RESULTS:** A total of 186 patients were included. The median age at presentation was 52 (Interquartile range(IQR) 49-54)years. All except 5 patients were de-novo metastatic. Median PSA was 134.1 ng/ml. Histology patterns were: adenocarcinoma(n=178), adenocarcinoma with neuroendocrine differentiation(n=6) and neuroendocrine carcinoma(n=2). Of 175 available Gleason scores(GS), 12.5% had GS of 7, 27.5% of 8, 48% of 9 and 12% of 10. High-volume disease was present in 140 patients(75.3%). Metastatic sites at presentation were: bone(90.8%), non-regional lymph nodes(56.9%) and viscera(17.7%). Homologous recombination repair(HRR) testing was available in only 10 patients with one positive for BRCA2 and CDK mutation each. Median follow-up was 28.4 (IQR: 16.9-45.3)months. In the first-line, 59 patients received androgen-deprivation therapy(ADT) alone while 127 received additional docetaxel(n=85), abiraterone(n=22) and bicalutamide(n=12). Median time to castration resistance was 15.7 (95%CI: 12.9-18.5)months. Subsequent lines of therapy were received by 68.3%(second-line), 43.7%(third-line), 20.2%(fourth-line) and 9.3%(fifth-line). Median overall survival(mOS) was 46.2 (95%CI: 36.5-56.0) months with 3-year OS of 59.7%. mOS was significantly better in patients who received ADT+ docetaxel or abiraterone (79.7months) vs ADT±bicalutamide (39.6months) in hormone-sensitive setting(p=0.011). mOS after development of castration resistance was 25.0 (95%CI: 17-33)months. Eastern Cooperative Oncology Group Performance Status≥2, Gleason grade group 5 and visceral metastasis at baseline were significant predictors of poorer OS by multivariate analysis. **CONCLUSION**: Compared to reported outcomes in literature, mOS is lesser in this younger cohort of patients, possibly because ADT alone was used more frequently in earlier years. Use of HRR testing and newer therapies need to be improved.

#abs15 | Comparative assessment of BCG strains during the worldwide shortage: a matched case-control study of tolerability and short-term oncological efficacy

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INTRODUCTION & OBJECTIVES: Worldwide issues with supply of BCG continue to present challenges for management of high-risk non-muscle invasive bladder cancer. Alternative regimens for dose strength, scheduling and strains have been implemented since the cessation of Connaught strain production in 2012. Differences in clinical efficacy, immunogenicity, toxicity, and tolerability have been

demonstrated between strains. Our local response to the BCG shortage has been to limit treatment to induction scheduling only from 2018, and then using a more available ONCO-BCG strain from 2020. This study investigates the clinical implications of the change in strain. **METHODS:** Intravesical BCG naïve patients who received induction treatment at the Central Adelaide Local Health Network with ONCO-BCG (Serum Institute of India; 1 – 19.2 x 108 colony forming units) from 2020 were compared with those who were treated earlier with OncoTICE (Merck, Australia; 2 – 8 x 108 colony forming units). Case-matching was performed to control for disease as classified by the WHO 2004 histological criteria. Primary outcome measures were tolerability and completeness of induction. Intolerance was defined by the 2020 EAU Guidelines on Bladder Cancer as severe side effects preventing further BCG instillation before completion of treatment. Secondary outcome measures were disease-free survival at 3 months prior to any maintenance therapy, and BCG refractory disease status. Intention to treat analysis was performed. **RESULTS:** Outcomes for 42 patients treated with ONCO-BCG were compared with 42 patients treated with OncoTICE. There were no significant differences in age or gender between groups. There was no significant difference in rates of intolerance for ONCO-BCG compared to OncoTICE (7% versus 0%, p = 0.08). Completeness of 6 induction doses was delivered in 79% versus 93% for ONCO-BCG and OncoTICE respectively (p = 0.06). There were no significant differences in disease-free survival (p = 0.50) and BCG-refractory disease (p = 0.72) rates between BCG strains. **CONCLUSIONS:** BCG intolerance rates are comparable between ONCO-BCG and OncoTICE. The strains have similar oncological efficacy at short-term follow up after induction treatment. Longer term follow up is required, including assessment of the ramifications of restricted maintenance BCG.

#abs16 | Comparison of Intravesical Gemcitabine-Docetaxel and Re-induction BCG as Salvage Therapy for Bladder Cancer

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INTRODUCTION AND OBJECTIVES: Non-surgical therapeutic options for patients who fail initial BCG with non-muscle invasive bladder cancer (NMIBC) are limited. Re-induction of BCG is shown to have 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. **METHODS:** 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, 134 patients underwent induction BCG for NMIBC. Sixteen (11.9%) patients had high-grade non-muscle invasive recurrence following induction BCG. Of these, five (31.3%) were treated with re-induction BCG, five received intravesical gemcitabine-docetaxel, one (6.3%) underwent palliative radiotherapy and one had an early cystectomy. The remaining four (25%) patients had no further treatment. The median age of patients who received re-induction BCG and gemcitabine-docetaxel was 74 and 80 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 three (60%) patients had HGTa and two (40%) HGT1 prior to gemcitabine-docetaxel treatment. On initial post-treatment cystoscopy, one patient (20%) had high-grade recurrence (HGT1 + CIS) post BCG re-induction while none of the 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 three (60%) patients who had gemcitabine-docetaxel who experienced mild-moderate urinary frequency, dysuria and lethargy (p=0.490). **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. The main limitation in this study is the small sample.

However, further evaluation of longer-term outcomes is required.

#abs17 | Darolutamide in Combination With Androgen-Deprivation Therapy and Docetaxel in Patients with Metastatic Hormone-Sensitive Prostate Cancer by Disease Volume and Risk in the Phase 3 ARASENS Study

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INTRODUCTION AND OBJECTIVES: In patients with metastatic hormone-sensitive prostate cancer (mHSPC), darolutamide plus androgen-deprivation therapy (ADT) and docetaxel significantly reduced the risk of death by 32.5% (HR 0.68; 95% CI: 0.57–0.80; P<0.0001) vs placebo plus ADT and docetaxel in ARASENS (NCT02799602). Overall incidence of treatment-emergent adverse events (TEAEs) was similar between groups. The effect of darolutamide on overall survival (OS) was consistent in patients with de novo and recurrent disease. As extent of metastatic burden affects outcomes, we evaluated efficacy and safety by both disease volume and risk profile. **METHODS:** Patients with mHSPC were randomized 1:1 to darolutamide 600 mg twice daily or placebo, with concomitant ADT and up-front docetaxel. High-volume disease was defined as visceral metastases and/or ≥4 bone metastases with ≥1 beyond the vertebral column/pelvis. High-risk disease was defined as ≥2 risk factors: Gleason score ≥8, ≥3 bone lesions, and presence of measurable visceral metastasis. OS was assessed using an unstratified Cox regression model. **RESULTS:** Of 1305 patients, 1005 (77%) had high-volume disease; 912 (70%) had high-risk disease. Darolutamide plus ADT and docetaxel increased OS vs placebo, ADT, and docetaxel in patients with high- or low-volume disease (HR [95% CI]: 0.69 [0.57–0.82]; 0.68 [0.41–1.13], respectively) and those with high- or low-risk disease (0.71 [0.58–0.86]; 0.62 [0.42–0.90]). Darolutamide improved clinically relevant secondary endpoints vs placebo in volume and risk subgroups, with HRs similar to those observed in the overall population. Incidence of TEAEs was consistent with the overall ARASENS population across subgroups by high/low volume and risk. **CONCLUSION** Treatment intensification with darolutamide plus ADT and docetaxel improved OS by approximately 30% across volume and risk subgroups. A favourable darolutamide safety profile was confirmed in all subgroups. Darolutamide, ADT, and docetaxel should be considered one of the new standards of care for mHSPC patients. **FUNDING SOURCE:** Bayer AG and Orion Pharma.

#abs18 | Defining Frailty: Using the Modified Frailty Index (mFI-11) to describe the key determinants of Frailty amongst men diagnosed with intermediate to high risk PCa

Neerhut, Thomas - Author; Burgess, Belinda - Co-Author 1; Rhee, Handoo - Co-Author 2

INTRODUCTION: Elderly men with prostate cancer (PCa) are at risk of frailty. By correlating frailty with increasing morbidity and mortality, indices such as the modified frailty index (mFI-11) have predicted negative treatment outcomes among men with PCa. Using the mFI-11, we aim to determine the prevailing disease states among frail men with localised intermediate to high risk PCa. We hope this information will help define the prevalence of co-morbid conditions amongst an increasingly frail population. **METHODS:** Data was obtained from 3 urological centres. Patients >70 years diagnosed with localised intermediate to high risk PCa following biopsy were included. Age and Pathological data inclusive of Gleeson score, T stage and PSA were collected to adjust for pathological variability. Disease states were gathered for mFI-11. Patients with mFI-11 > 0.27 were defined as frail. **RESULTS** 79 patients met inclusion criteria. Amongst those classified as Frail (6/79) prevalent disease states included hypertension (HTN) and type two diabetes mellitus (T2DM) in 83% of individuals respectively. Ischaemic heart disease (IHD) was present in 67%

while Chronic obstructive pulmonary disease (COPD) was notable in 50%. Including individuals with mFI-11 <0.27, HTN and T2DM were most prevalent at 56% (44/79) and 27% (21/79). Compared with those undergoing radiotherapy (RT), 0 men suffered from T2DM (0/10) compared to 21 in the RT group (21/69) while 6 (6/69) receiving RT had diagnosed COPD compared to 1 within the surgical cohort (1/10). **CONCLUSIONS:** Using variables within the national surgical quality improvement program (NSQIP), the mFI-11 has demonstrated that elderly men with PCa are at increased risk of frailty related morbidity and mortality. Our findings highlight the high prevalence of cardiovascular and respiratory disease within this vulnerable population. We hope the identification of such disease states will improve PCa patient selection and pre-treatment optimisation to potentially reduce any unnecessary morbidity and mortality.

#abs19 | Determining Baseline Frailty: A Multicentre Analysis Exploring Baseline Frailty amongst Elderly Men with Prostate Cancer

Neerhut, Thomas - Author; Burgess, Belinda - Co-Author 1; Rhee, Handoo - Co-Author 2

INTRODUCTION: Frailty is known to negatively influence outcomes for men with prostate cancer (PCa).The Society for Geriatric Oncology (SIOG) recently recommended comprehensive geriatric assessment (CGA) be completed to identify those at risk however few clinical trials have incorporated these recommendations. Additionally, CGA is difficult to achieve in an already over-burdened hospital system. Using the validated mFI-11 we aim to establish the baseline frailty of elderly men referred with PCa and illustrate any observable relationships between frailty and management decisions. **METHODS:** Retrospective data was obtained from 3 metropolitan urological centres. Patients >70 years diagnosed with localised intermediate to high risk PCa following biopsy and/or referred with PSA >10 were included. Pathological data inclusive of Gleeson score, T stage and PSA were collected to account for variability in disease status. Comorbidities were gathered for mFI-11. Patients with mFI-11 >0.27 were defined as frail. Results A total of 114 patients were included. 35 (n=35) men received WW with a mean mFI-11 of 0.198 (+/- 0.105). 60 men (n=60) received ADT+EBRT while 9 men received EBRT only (n=9). Mean mFI-11 scores were 0.0975(+/- 0.08) and 0.1500 (+/- 0.112) respectively. 10 patients (n=10) with average mFI-11 0.108 (+/- 0.054) underwent prostatectomy. 39% of patients placed on WW (14/36) were classified as frail followed by EBRT with 33% (3/9). Only 3 individuals receiving ADT+EBRT (3/60) were classified as frail while none of those undergoing surgery (0/10) met frailty criteria. **CONCLUSIONS:** Frailty is proven to increase morbidity and mortality amongst the PCa population. Studies support the use of pre-intervention frailty assessments to prevent poor outcomes. Our data highlights the diverse prevalence of frailty amongst the PCa population. We hope this knowledge may encourage more widespread use of frailty tools such as the mFI-11 to identify frail elderly men and assist in both management decisions and patient optimisation.

#abs20 | Developing a state-wide model of care for penile and testicular cancer: applying international lessons in rare and less common cancers.

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INTRODUCTION: Challenges in rare and less-common cancers (RLCC) include accurate diagnosis and staging, access to evidence-based care, and enrolment to research and clinical trials. International approaches to overcome these barriers have limited success in Australia, due to contextual complexities related to geography and population numbers. Penile and testicular cancer are two RLCC (respective incidence <1/100,000 and <6/100,000) chosen by the VCCCA LCC working group for a

pilot state-wide health services research project. **METHODS:** A scoping literature review to inform project development was undertaken in March 2022. Primary focus was successful models of care improving outcomes in RLCC, with secondary focus opportunities for collaboration. Key themes of patients, research, education, and system innovation were identified. Consultations with stakeholders and existing Australian programs culminated in establishment of a state-wide, virtual multidisciplinary team meeting (MDTM) called PEN-TEST as part of the pilot project framework. Results Literature review identified evolving approaches to RLCC collaborations globally, with secure data sharing through technological advancements empowering efforts to improve knowledge. Multiple international programs exist with varied formats and objectives, but commonalities include centralised care, guideline adherence, and expert pathology review. A MDTM model was established for our project to incorporate key components of existing successful models. Added benefits hypothesised for the Australian context include minimising patient travel for expert case review, reduced time to expert opinion, and education and upskilling of referring clinicians through MDTM participation and continued patient care. Links with existing research programs (ARC Portal) are underway, with future research opportunities planned through development of a state-wide registry of patients with these cancers. **CONCLUSION:** To address barriers to RLCC care and research we have developed a project template incorporating a virtual-MDTM. The first pilot in penile and testicular cancers, PEN-TEST, is planned for go-live in July 2023. This model includes potential for up-scaling to other states and tumour types.

#abs21 | Dr Bot – Does AI Provide Quality Information to Prostate Cancer Patients?

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INTRODUCTION & OBJECTIVES: Patients frequently seek web-based health information which carries a widely acknowledged risk of encountering poor quality content. ChatGPT is an artificial intelligence (AI) chatbot forging a new frontier in online information. This study aimed to evaluate the quality of health information in ChatGPT responses to common patient enquiries about prostate cancer. **METHODS:** ChatGPT was enquired for the 10 most asked questions about prostate cancer. These questions were assessed for accurate representation against the top 25 Google searches related to prostate cancer in Australia in 2022 which were obtained using Google Trends. The ChatGPT response to each question was analysed for quality of patient health information using standardised tools. QUality Evaluation Scoring Tool (QUEST) appraised the quality of the information and Patient Education Materials Assessment Tool (PEMAT) adjudged the understandability and actionability. An experienced urologist with special interest in prostate cancer graded each response as 'appropriate' or 'inappropriate' advice relative to their standard clinical practice. **RESULTS:** 8 questions asked by ChatGPT were represented in the top 25 Google searches related to prostate cancer, with 6 represented in multiple searches. Predominant themes were causes, symptoms, diagnosis, and treatment. Responses averaged 206 words (range 109 to 313). ChatGPT responses received average PEMAT scores of 92% for understandability and 76% for actionability. QUEST yielded an average quality score of 40.3%. 8 responses referenced the patient-physician relationship, while only 2 referenced expert sources for the information presented. All responses employed cautious vocabulary regarding the information presented, with 3 of these responses making statements of limitations. All responses were appropriate clinical advice. **CONCLUSIONS:** ChatGPT can provide appropriate advice to patients in a comprehensible manner. AI should be further evaluated as a source of patient health information with the ultimate view to optimise the content it will inevitably provide to inquisitive patients.

#abs22 | Establishing a streamlined prostate cancer care pathway to improve post-biopsy wait times in a large volume tertiary centre

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INTRODUCTION & OBJECTIVES: Covid-19 has caused major delays in cancer care, inducing significant patient anxiety. We assessed the effectiveness of a new, streamlined Prostate Cancer Care Pathway (PCCP) initiated at a large tertiary academic centre to deliver timely care and ensure patient satisfaction. **METHODS:** All patients undergoing prostate biopsies at our centre were prospectively followed through PCCP and compared to patients immediately pre-PCCP implementation (2022) and Covid-19 lockdowns (2020). Waiting times between cohorts were compared using the Kruskal-Wallis H-test. Patient satisfaction was assessed using the Prostate Cancer Questionnaire for Patients (PCQ-P). **RESULTS:** Overall, 90 patients were included. 30 patients went through the PCCP, compared with 30 patients immediately prior to PCCP implementation and 30 patients from 2020 during the Covid-19 pandemic. The median time from biopsy to results after PCCP was 13.0 (IQR 13.0-15.0) days, significantly shorter than during 2020 Covid-19 lockdowns, 21.0 (18.0-21.0) days, and pre-PCCP, 17.5 (14.8-21.0) days ($p < 0.001$). Of patients undergoing PCCP, twelve (40.0%) did not have prostate cancer and were discharged, whilst two patients (6.7%) had low-grade cancer and underwent active surveillance. Sixteen patients (53.3%) requiring treatment were streamlined for MDT discussion following imaging studies at a median time of 29.5 (23.5-35.8) days post-biopsy and at consultant Urology and/or Radiation Oncology clinic for treatment discussion at a median of 33.0 (30.0-35.0) days, compared to 51.0 (44.3-66.0) days pre-PCCP and 59.0 (42.0-85.0) days in 2020 ($p=0.008$). 87.0% of PCQ-P participants (n=23) reported waiting time satisfaction for post-biopsy clinic and treatment consultations. Conclusions: Covid-19 caused significant delays in the timely delivery of Prostate Cancer care. Subsequently, implementation of the PCCP reduced waiting times in measured aspects of post-biopsy care. Streamlining available resources using similar pathways can reduce waiting times in cancer care and help alleviate patient anxiety in times of healthcare system strain.

#abs23 | Evaluating the Quality of Artificial Intelligence Chatbot Responses to Patient Questions on Bladder Cancer

Collin, Harry - Author; Roberts, Matthew - Co-Author 1

INTRODUCTION & OBJECTIVES: Patients frequently seek web-based health information which carries a widely acknowledged risk of encountering poor quality content. ChatGPT is an artificial intelligence (AI) chatbot forging a new frontier in online information. This study aimed to evaluate the quality of health information in ChatGPT responses to common patient enquiries about bladder cancer. **METHODS:** ChatGPT was enquired for the 10 most asked questions about bladder cancer. These questions were assessed for accurate representation against the top 25 Google searches related to bladder cancer in Australia in 2022 which were obtained using Google Trends. The ChatGPT response to each question was analysed for quality of patient health information using standardised tools. QUality Evaluation Scoring Tool (QUEST) appraised the quality of the information and Patient Education Materials Assessment Tool (PEMAT) adjudged the understandability and actionability. An experienced urologist with special interest in bladder cancer graded each response as 'appropriate' or 'inappropriate' advice relative to their standard clinical practice. **RESULTS:** 6 questions asked by ChatGPT were represented in the top 25 Google searches related to prostate cancer. Predominant themes were symptoms, risk factors, treatment, and surveillance. Responses averaged 189 words (range 118 to 266). ChatGPT responses received average PEMAT scores of 89% for understandability and 78% for actionability. QUEST yielded an average quality score of 40.7%. All responses presented balanced recommendations, albeit without citing specific limitations. 9 responses referenced the patient-physician relationship. Only 1 response mentioned expert sources. All responses were appropriate clinical advice. **CONCLUSIONS:** ChatGPT provides mostly appropriate advice to bladder cancer patients in a comprehensible and concise manner. AI should be further evaluated as a source of patient health information with the ultimate view to optimise the content it will inevitably provide to inquisitive patients.

#abs24 | Evolocumab in Metastatic Castration-Resistant Prostate Cancer - study schema

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INTRODUCTION: Despite advances in the treatment of metastatic castration-resistant prostate cancer (mCRPC), primary and secondary resistance to current therapies remains an issue. The role of aberrant lipid metabolism in treatment resistance and prostate cancer progression is increasingly recognised. Certain ceramides are associated with shorter progression free survival (PFS) and overall survival (OS) in men with mCRPC (1-3). PCPro is a clinically accessible, NATA-compliant plasma lipid biomarker assay developed to identify men with these poor prognostic lipid profiles (4). It has successfully identified those with poorer OS in two independent cohorts of men with mCRPC (4). The next step is to determine whether this poor prognostic lipid signature can be modulated. One potential lipid-lowering agent is the PCSK9-inhibitor evolocumab, which is used to manage cardiovascular disease where statins alone are insufficient (5). **OUR PRIMARY OBJECTIVE** is to assess whether treatment with evolocumab during chemotherapy or androgen receptor signalling inhibitor (ARSI) therapy can safely reverse the PCPro signature in men with mCRPC. Methods: In this multi-centre, open label phase 2 trial, men with mCRPC commencing docetaxel, cabazitaxel, abiraterone or enzalutamide for disease progression will be screened for the presence of the PCPro signature. Those who test positive will receive a 12-week course of evolocumab concurrent with their standard therapy. Dosage is as per cardiovascular guidelines (420mg subcutaneously every 4weeks). PCPro will be repeated after 12 weeks. Our primary endpoint is reversal of PCPro. Our secondary endpoint is detailed lipid profiling before and after evolocumab. Results: Recruitment has begun at one site and is expected to open at two more sites in New South Wales over the course of 2023. **CONCLUSION:** This study will evaluate whether evolocumab can safely reverse the PCPro signature in men with mCRPC, providing essential data to the development of precision metabolic therapy in the management of prostate cancer. **REFERENCES:**

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#abs25 | Exploratory biomarkers to predict the benefit of adding mitomycin (MM) to BCG as intravesical therapy for high-risk, non-muscle-invasive urothelial bladder cancer (NMIBC)

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INTRODUCTION & OBJECTIVES: The BCG-MM trial (ANZUP 1301, NCT02948543) explores the benefit of adding intravesical MM to first-line intravesical BCG in NMIBC. The integrated translational program assesses the predictive value of biological factors in identifying patients who may benefit from addition of MM. **METHODS** A panel of biomarker candidates was identified for immunohistochemical testing based on a literature review for predictors of BCG or MM benefit in NMIBC. Six biological domains had potential predictive roles. To avoid risk of bias to the main trial outcome, the biomarker panel was applied to a test cohort of 23 relapsing and 23 non-relapsing patients matched by Ta/T1 and presence of CIS from

a single centre. Results for bladder cancer sub-type (CK20/GATA3 – luminal, CK5/CK14 - basal), EMT status (E-cadherin – epithelial, vimentin – basal), and receptor signaling (HER2 and androgen receptor (AR)) are presented. Results For tumour subtypes, no overall difference in outcome between luminal and mixed/basal tumours was seen. Considering the therapeutic arms, benefit from MM addition was observed more frequently for mixed/basal patients (8/13 (62%)) compared to BCG alone (3/11 (27%)), p=0.09. Regarding EMT, no vimentin expression was observed in any tumour. For the whole cohort, there was no outcome difference between high or low E-cadherin expression. Considering T1 tumours alone, patients with low e-cadherin in the BCG only arm had a higher relapse rate, 9/12 (75%) v 1/8 (12%), p=0.006. Comparing the therapeutic arms, E-cadherin low patients had a lower relapse rate with MM addition (9/12 (75%)) compared to BCG alone (3/8 (38%)), p=0.09. For AR, positive expression correlated with lower relapse 7/22 (32%) v 16/24 (67%), p=0.02. The magnitude of difference was similar between therapy arms such that AR status did not appear to guide therapy choice. In contrast HER2 status did not appear to predict either outcome overall or by treatment arm. **CONCLUSIONS:** Both bladder cancer sub-typing and EMT assessment showed promises as predictors of optimal therapy with both tumours having a basal subtype component and E-cadherin low T1 tumours showing potential benefit for the addition of MM to BCG alone. In contrast, although AR expression was prognostic as it was associated with lower relapse, it did not predict for optimal therapy choice. Analyses of DNA repair, immune infiltration and proliferation are ongoing. Biomarkers with positive signals will be prioritized for study in the full 500 patient trial cohort.

#abs26 | Exploring clinical decision-making among the uro-oncology MDT: A qualitative study.

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INTRODUCTION AND OBJECTIVE: Uro-oncology multidisciplinary teams (MDTs) deliver comprehensive cancer care across Australia although little is known about the clinical decision-making among MDTs and how patients' needs, and preferences are embedded. Additionally, many patients do not receive a timely MDT review. This study was undertaken to gain insight into the experiences of healthcare professionals' clinical decision-making processes and the process for referral, or not, for patients diagnosed genitourinary cancers. **METHODS**: This study was conducted in a Metropolitan Cancer Regional Hospital in Australia. Semi-structured interviews were undertaken with healthcare professionals of a Uro-oncology MDT from June 2022 to July 2022. The cognitive continuum theoretical model of clinical decision-making along with Braun and Clark's six-steps of thematic analysis were applied, and a narrative synthesis undertaken. **RESULTS:** Three themes emerged, 1) the 'role and scope of the Uro-oncology MDT', 2) 'lack of person-centred clinical decision-making' and 3) the 'barriers and facilitators.' The MDT has a biomedical focus, and patients are not included in the MDT discussion, nor are they able to attend. Psycho-social issues (including urinary, bowel and sexual dysfunction) are scantly discussed, however, patients' preferences for treatments are considered in the clinical decision-making process. The main barriers included: incomplete referral documentation, lack of attendance from all members of the MDT and personality clashes among individuals of the MDT. During the COVID-19 pandemic the MDT transitioned to a virtual platform which resulted in greater efficiency, attendance, and convenience. **CONCLUSION:** This study has provided a valuable insight into the real-world experience and functioning of MDTs. The multidisciplinary team has a biomedical focus which dominates holistic care; within the current structure and system the whole individual is not being treated.

#abs27 | Extended follow-up results from the CheckMate 274 trial

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INTRODUCTION AND OBJECTIVES: The 2 primary endpoints of the CheckMate 274 trial were met as nivolumab (NIVO) improved disease-free survival (DFS) versus placebo (PBO) in the intent-to-treat (ITT) population and patients with tumor programmed death ligand 1 (PD-L1) expression ≥1%. We report extended follow-up data. Methods: CheckMate 274 is a phase 3, double-blind trial of adjuvant NIVO versus PBO for high-risk muscle-invasive urothelial carcinoma (MIUC) after radical resection. Eligible patients with pathologic evidence of UC at high risk of recurrence were randomized 1:1 to NIVO 240mg every 2 weeks or PBO for ≤1 year of treatment. Primary endpoints were DFS in ITT patients and patients with tumor PD-L1 ≥1%. Overall survival and non-urothelial tract recurrence-free survival (NUTRFS) in ITT patients and in patients with PD-L1 ≥1% were secondary endpoints. Distant metastasis-free survival (DMFS) and safety were exploratory endpoints. **RESULTS:** Among 353 patients randomized to NIVO (PD-L1 ≥1%, n=140) and 356 to PBO (PD-L1 ≥1%, n=142) with median follow-up of 36.1 months (minimum, 31.6 months), median DFS was 22.0 months with NIVO versus 10.9 months with PBO in ITT patients (hazard ratio [HR], 0.71) and 52.6 months with NIVO versus 8.4 months with PBO in patients with PD-L1 ≥1% (HR, 0.52). NUTRFS (ITT HR, 0.72; PD-L1 ≥1%, 0.53) and DMFS (ITT HR, 0.74; PD-L1 ≥1%, 0.58) benefits with NIVO versus PBO were also observed in both populations. **CONCLUSIONS:** With extended follow-up, NIVO continued to show DFS, NUTRFS, and DMFS benefits versus PBO. The HR for DFS and NUTRFS in PD-L1 ≥1% patients and for DMFS in both ITT and PD-L1 ≥1% patients also continued to improve. No new safety signals were identified. These results further support adjuvant NIVO as a standard of care for high-risk MIUC after radical resection.

#abs28 | Factors affecting adherence to active surveillance in patients with stage 1 testicular germ cell tumours in South Western Sydney

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INTRODUCTION AND OBJECTIVES: Adherence to active surveillance in patients with stage 1 testicular cancers may be influenced by factors affecting capacity and motivation to attend follow up. Loss-to-follow-up (LTFU) rates have measured up to 18% in previous Australian studies [1,2], which can compromise early detection of recurrence. South Western Sydney (SWS) has higher prevalence of culturally and linguistically diverse (CALD) communities and socioeconomic disadvantage compared to other metropolitan areas, which may adversely affect adherence in these populations. Our aim was to assess adherence to active surveillance in SWS and analyse factors which may impact adherence. **METHODS:** A retrospective cohort study was conducted with patients with stage 1 testicular cancer initially managed with active surveillance at three sites in SWS between 2005 and 2020. Adherence with active surveillance was classified into three groups defined based on previous literature: 'optimal', 'adequate' or 'LTFU'. Risk factors for non-adherence were analysed using multivariable logistic regression. Disease recurrence was analysed using multivariable Cox regression. **RESULTS:** 126 patients were included in this study. Adherence with active surveillance was assessed as optimal in 65 (52%), adequate in 14 (11%), and LTFU in 47 (37%). Multivariable analysis demonstrated that patients from CALD backgrounds (odds ratio [OR] 3.95, 95% confidence interval [CI] 1.14-13.69; p=0.0302), patients with a partner (OR 2.73, 95% CI 1.12-6.66; p=0.027), non-smokers (OR 4.06, 95% CI 1.53-10.79; p=0.005) and unemployed (OR 3.45, 95% CI 1.11-10.72; p=0.0322) were significantly more likely to be in the optimal or adequate adherence categories. 21 patients (17%) had disease recurrence; all but one were detected during active surveillance. **CONCLUSIONS:** Adherence to active surveillance in SWS was poorer compared to other institutions in Australia. Patients from CALD backgrounds and those that were non-smokers, unemployed and with a partner were more likely to be adherent with active surveillance. Further research is needed to identify other predictive factors for adherence in order to optimise and personalise surveillance programs. **REFERENCES:** [1] Honeyball, F., MuraliβGanesh, R., Hruby, G., & Grimison, P. (2015). Compliance of males with stage 1 testicular germ cell tumours on an active surveillance protocol. Internal Medicine Journal, 45(10), 1081-1084. [2] Cheung, K. T., Dat, A., Wong, P., Dowling, C., Davis, I. D., & Sengupta, S. (2021). Compliance with followβup for

patients with stage 1 testicular germ cell tumour. ANZ Journal of Surgery, 91(1-2), 184-186.

#abs29 | Factors affecting treatment trends for metastatic renal cell carcinoma (mRCC) in Australia

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INTRODUCTION AND OBJECTIVES: Recent kidney cancer trials have produced notable results. CheckMate-214 established the benefit of first-line (1L) dual immune-checkpoint inhibitors (ICI), while CARMENA challenged the long-standing paradigm of cytoreductive nephrectomy (CN). The impact of these 2 trials, as well as the subsequent Pharmaceutical Benefits Scheme (PBS) subsidization of ipilimumab-nivolumab, on local prescribing practices and surgical trends has not been reported. **METHODS:** We performed an analysis of all-comers in KRAB (Kidney Cancer Australian Registry and Biobank) diagnosed with mRCC between 30 June 2007 to 21 April 2023. Cohorts were segregated by publication date of CheckMate-214 and CARMENA results (5 April 2018 and 2 August 2018, accordingly) and date of PBS listing for ipilimumab-nivolumab on 1 March 2019. Descriptive statistics were employed. **RESULTS:** Among 505 patients included for analysis, 250 patients (49%) underwent CN. In the pre-CARMENA cohort, 61% (64/105) with synchronous metastatic disease underwent upfront CN (32 (50%) had intermediate/poor-risk). In the post-CARMENA cohort, 32% (51/145) underwent upfront CN (33 (65%) had intermediate/poor-risk), a statistically significant difference ($p<0.001$). Prior to publication of CheckMate-214 results, only 2% (2/96) received ipilimumab-nivolumab, whilst 31% (n=30) received sunitinib and 47% (n=45) received pazopanib. Following CheckMate-214 publication, prescribing patterns were similar 3.8% (3/78) ipilimumab-nivolumab, 36% (n=28) sunitinib and 42% (n=33) pazopanib. However, following PBS listing, prescribing of ipilimumab-nivolumab increased to 58% (117/202) mirrored by a decline in sunitinib use to 15% (n=30) and pazopanib use to 9% (n=18), a statistically significant difference ($p<0.001$). **CONCLUSION:** In Australia, changes in surgical practice occur in response to publication of high quality evidence, whereas prescribing patterns of novel medicines are impacted by PBS reimbursement rather than best evidence or regulatory approval, highlighting constraints to utilization of high-cost drugs despite proven benefit. References 1. Motzer, Robert J., et al. "Nivolumab plus ipilimumab versus sunitinib in advanced renal-cell carcinoma." New England Journal of Medicine 378.14 (2018): 1277-1290. 2. Méjean, Arnaud, et al. "Sunitinib alone or after nephrectomy in metastatic renal-cell carcinoma." New England Journal of Medicine 379.5 (2018): 417-427.

#abs30 | Feasibility, acceptability and safety of personalized adaptive enzalutamide therapy in people with metastatic castrate-resistant prostate cancer (mCRPC): EnzAdapt

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INTRODUCTION: Androgen receptor pathway inhibitors (ARPi) extend survival in mCRPC but treatment inevitably fails due to treatment resistance caused by tumour heterogeneity or evolution. Personalized adaptive therapy exploits evolutionary game theory to extend treatment benefit, by pausing and restarting an effective therapy to slow tumour evolution. A small study suggested adaptive abiraterone in mCRPC was safe and gave longer clinical benefit (1,2). EnzAdapt is a Below The Belt Pedalthon funded investigator-sponsored pilot trial testing adaptive enzalutamide therapy. The primary

objective was acceptability and feasibility; secondary objectives included safety and clinical benefit; tertiary objectives included quality of life (QOL), health economic cost-consequences, and qualitative patient experience. **METHODS:** Eligible participants had mCRPC, ECOG <=2, no prior ARPi, PSA => 10 ng/mL; a real-world population versus registration trials (3-5). Participants starting PBS reimbursed enzalutamide took 4-weekly PSA blood tests, pausing enzalutamide if PSA response occurred (<50% of baseline). Treatment restarted when PSA exceeded baseline value, each pause/restart cycle is designated as a 'loop' of therapy. If PSA or radiological progression occurred whilst on treatment, enzalutamide was dosed continuously until clinical progression as per usual care. Other assessments included 12-weekly imaging, QOL and clinical review. **RESULTS:** Adaptive therapy appears acceptable. Between March 2019 and April 2023, 39 patients were approached, 26 consented. Only one patient declined adaptive dosing; common reasons for non-enrolment were a competing clinical trial or travel/logistics. None of 20 enrolled participants withdrew consent. Nine participants had previously taken docetaxel. Adaptive therapy appears feasible and safe. The primary endpoint of feasibility and safety was met, with only two of the first ten participants commencing adaptive therapy unable to complete three treatment loops. Efficacy appears promising. Four of 20 participants had <50% decline in PSA from baseline. In responders, the median number of treatment loops was 2 (range 1-6), the median duration of treatment break was 2.8 months (range 1.1 to 18.5 months). Participants both naïve and refractory to prior docetaxel appeared to experience a similar number of treatment loops. With median followup of 12.0 months, median PSA and radiographic progression-free survival on treatment across all participants was 14.8 and 15.3 months respectively, with many experiencing long and ongoing cancer control. **CONCLUSIONS:** Adaptive therapy with enzalutamide is acceptable, feasible and safe in people with mCRPC, and appears to improve clinical outcomes. An ANZUP/LUMC randomised trial of adaptive versus continuous ARPi has commenced, aiming to confirm the survival advantage of adaptive therapy in mCRPC.

#abs31 | Final prespecified overall survival (OS) analysis of the phase 3 CLEAR trial: 4-year follow-up of lenvatinib plus pembrolizumab (L+P) vs sunitinib (S) in patients with advanced renal cell carcinoma (aRCC)

Motzer, Robert J. - Author; Porta, Camillo - Co-Author 1; Eto, Masatoshi - Co-Author 2; Powles, Thomas - Co-Author 3; Grünwald, Viktor - Co-Author 4; Hutson, Thomas E. - Co-Author 5; Alekseev, Boris - Co-Author 6; Rha, Sun Young - Co-Author 7; Merchan, Jamie R. - Co-Author 8; Goh, Jeffrey C. - Co-Author 9; De Giorgi, Ugo - Co-Author 10; Melichar, Bohuslav - Co-Author 11; Hong, Sung-Hoo - Co-Author 12; Gurney, Howard - Co-Author 13; Rodriguez-Lopez, Karla - Co-Author 14; He, Cixin S. - Co-Author 15; Okpara, Chinyere E. - Co-Author 16; McKenzie, Jodi - Co-Author 17; Choueiri, Toni K. - Co-Author 18

BACKGROUND: In CLEAR, L+P showed significant benefit in PFS (primary endpoint), OS, and ORR versus S in first-line aRCC. We report 4-yr follow-up results from the final prespecified OS analysis (data cutoff date: 31/7/2022). **METHODS:** Treatment-naïve patients (n=1069) with aRCC were randomized (1:1:1) to receive lenvatinib 20mg QD + pembrolizumab 200mg Q3W; or lenvatinib 18mg + everolimus 5mg QD; or S 50mg QD (4 weeks on/2 weeks off). Stratification factors were geographic region and MSKCC prognostic risk group. Herein, OS, PFS, ORR, DOR, and PFS2 were assessed for L+P and S. PFS, ORR and DOR were assessed per independent review using RECIST v1.1. **RESULTS:** At median follow-up (L+P: 49.8 mos, IQR 41.4-53.1; S: 49.4 mos, IQR 41.6-52.8), 149 and 159 deaths had occurred, respectively. OS benefit with L+P versus S was maintained overall (HR, 95% CI; 0.79, 0.63-0.99) and across MSKCC risk groups (HR, 95% CI; favorable: 0.89, 0.53-1.50; intermediate: 0.81, 0.62-1.06; poor: 0.59, 0.31-1.12). PFS benefit of L+P versus S was maintained overall (HR, 95% CI; 0.47, 0.38-0.57) and across MSKCC risk groups (HR, 95% CI; favorable: 0.46, 0.32-0.67; intermediate: 0.51, 0.40-0.65; poor: 0.18, 0.08-0.42). ORR was greater with L+P (71.3%; CR, 18.3%) versus S (36.7%; CR, 4.8%) (relative risk, 95% CI; 1.94, 1.67-2.26). Fewer patients in the L+P arm (56/355, 15.8%) received subsequent PD-1/PD-L1 checkpoint inhibitors versus the S arm (195/357, 54.6%). PFS2 was longer with L+P versus S (43.3 vs 25.9 mos; HR, 95% CI; 0.63, 0.51-0.77). Grade ≥3 treatment-related

adverse events occurred in 74.1% and 60.3% patients in the L+P and S arms, respectively. **CONCLUSIONS:** L+P continues to demonstrate clinically meaningful efficacy benefit versus S in the first-line treatment of patients with aRCC at the final analysis, supporting the robustness of the CLEAR primary analysis data.

#abs32 | Functional outcomes of ureteric reimplantation following ureteric injury in patients undergoing complex major colorectal surgery and cytoreductive surgery in a high-volume centre

Santucci, Jordan - Co-Author 1; O'Brien, Jonathan - Co-Author 2; Alexander, Heriot - Co-Author 3; Kelly, Brian - Co-Author 4

INTRODUCTION & OBJECTIVES: Ureteric injury is a rare but recognised complication in pelvic surgery, with a high rate in the literature for patients undergoing redo surgery and CRS. Our objective was to assess the functional outcomes for patients undergoing ureteric reimplantation in a centre where the GU and colorectal teams operate jointly on complex cases. **METHODS:** A review of a prospectively maintained database from Jan 2021 to July 2022 at a tertiary referral institution was performed. Primary endpoints were perioperative morbidity and mortality. Secondary endpoints were GU functional outcomes, renal function, and development of a stricture. **RESULTS:** From Jan 2021 to July 2022, 21 intraoperative ureteric injuries occurred. Eleven were planned resections, ten were unplanned resections. Sixteen had a psoas hitch reimplant (two performed robotically), four had a boari flap and one patient had a primary uretero-uretero anastomosis. Four patients developed an anastamotic stricture; all four were undergoing CRS and all had previous pelvic radiation. All 4 were managed with a ureteric stent. One patient had a delayed presentation of a high ureteric injury and underwent a retroperitoneal laparoscopic nephrectomy. **CONCLUSIONS:** Ureteric injury can occur during major pelvic resections. Patients undergoing CRS, redo surgery and those with previous pelvic radiation are at a higher risk of an anastamotic stricture and is an important aspect to explain to patients during the consent process.

#abs33 | Genitourinary outcomes in patients undergoing Total Pelvic Exenteration in an Australian tertiary centre

Al Saffar, Haidar - Author; Santucci, Jordan - Co-Author 2; Alexander, Heriot - Co-Author 2; Kelly, Brian - Co-Author 4

INTRODUCTION & OBJECTIVES: Total Pelvic Exenteration (TPE) is the standard of care for management of locally advanced and recurrent rectal cancer. This procedure requires multiple specialties coordinating and performing advanced cancer surgery that is known to have high short-term and long-term morbidity, in particular from the urological perspective. **METHODS:** A review of a prospectively maintained TPE database from July 2016 to July 2021 at a tertiary referral institution was performed. Primary endpoints were perioperative morbidity and mortality. Secondary endpoints were long term renal function preservation and the incidence of ureter-ileal anastamotic strictures. **RESULTS:** From July 2016 to July 2021, 117 TPE with ileal conduit was performed. 74 were male with a mean age of 61 (range 24-85) with a mean length of stay of 25.3days. 90 were performed for colorectal cancer, 10 for anal cancer, 2 for gynaecological cancer and 2 for genitourinary cancer. 76 patients underwent neoadjuvant radiation. 37 patients also underwent a sacrectomy. 1 patient had a nephrectomy and all underwent an ileal conduit. 8 patients had a urinary leak, 4 were managed conservatively and 3 required a nephrostomy and 1 needed a return to theatre. The long-term stricture rate was 9%. 14 patients developed severe AKI and 21 patients developed urosepsis within 30 days. 30 day mortality was 0.9%. **CONCLUSIONS:** Our experience with TPE over a medium follow-up period demonstrates urological complication rates consistent with the literature associated with urinary diversion and anastomosis, with low rates of urine leak and ureteric stricture.

#abs34 | HPV prevalence and stereotyping in penile cancer

Yang, Changheng - Author; Shamassi, Maryam - Co-Author 1; Gilmore, Paul - Co-Author 2; Corcoran, Niall - Co-Author 3

INTRODUCTION: Penile cancer is rare with 8 cases per 1 million in Australia[1]. Preliminary studies such as Kidd et al. are inconclusive about HPV's prognostic values in penile cancer[2]. The most common serotypes, HPV-16 and 18 have a strong association with cervical cancer in females and have also been demonstrated to have an association with penile cancer[3]. However, the prevalence of different HPV serotypes in penile cancer, and their prognostic value for clinical outcomes is unclear. **METHODS:** This study endeavor to investigate HPV's prevalence and its prognostic value in penile cancer. A retrospective search of Peninsula health medical records was conducted from 2012 to 2022. A list of suitable patients was generated from urology multi-disciplinary team list with diagnosis of penile cancer (ICD-10: C60). We compare penile cancer with and without HPV and assess their clinical outcome. Outcome comprises disease severity/ staging and 10-year survival rate. Sub-category on HPV serotype will be established. Sub-category analysis on different serotypes' implication on penile cancer will also be investigated. Similar process occurs at 8 other sites (Peter Mac cancer centre, Austin, St. Vincents, Epworth, Warringal, Western health, Linacre private and Alfred), results will be cumulated for final analysis. **RESULTS:** 18 patients were recruited at Frankston site for this study. Mean age is 74.7 years. 72% of the patients had squamous cell carcinoma and 28% had carcinoma in situ. 89% of the patients received operative management and 50% received adjuvant chemotherapy. 61% of the specimens showed high grade lesion. 44.4% of the patients were in remission. **CONCLUSION:** Research team anticipate concluding positive relation between HPV exposure and poor survival. Also, common serotypes of HPV such as HPV-16 and 18 may or may not associate with worse survival. State-wide database can be formed. These findings could lead to screening or immunisation program for high-risk groups to improve overall outcome. **REFERENCES:** [1.]Penile Cancer Overview | Cancer Council Victoria [Internet]. Cancervic.org.au. 2022 [cited 4 October 2022]. Available from: https://www.cancervic.org.au/cancer-information/types-of-cancer/penis_cancer/penis-cancer-overview.html#:~:text=or%20connective%20tissue.-,How%20common%20is%20penile%20cancer%3F,also%20occur%20in%20younger%20men. [2.]Kidd L, Chaing S, Chipollini J, Giuliano A, Spiess P, Sharma P. Relationship between human papillomavirus and penile cancer – implications for prevention and treatment. Translational Andrology and Urology. 2017;6(5):791-802. [3.]Wiener J, Effert P, Humphrey P, Yu L, Liu E, Walther P. Prevalence of human papillomavirus types 16 and 18 in squamous-cell carcinoma of the penis: A retrospective analysis of primary and metastatic lesions by differential polymerase chain reaction. International Journal of Cancer. 1992;50(5):694-701.

#abs35 | Impact of worldwide BCG shortage on non-muscle invasive bladder cancer patients missing out on maintenance: a matched case-control study of oncological outcome.

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INTRODUCTION AND OBJECTIVE: Intravesical Bacille Calmette-Guérin (BCG) is used in some cases of Non-muscle invasive bladder cancer (NMIBC) to reduce rate of recurrence and progression. The global shortage of BCG has resulted in patients in Central Adelaide Local Health Network (CALHN) missing out on maintenance BCG. The aim of this study was to evaluate the oncological impact of the BCG shortage on patients who received induction therapy only. **METHODS:** A prospective database of BCG naïve patients who underwent BCG treatment at CALHN was maintained for quality assurance purposes. Between April 2019 and September 2021, BCG naïve patients who underwent induction-only BCG for NMIBC were included. Case-matching to BCG naïve patient who underwent maintenance therapy before April 2019 was performed to control for disease classified by the WHO 2004 histological criteria. Patients were only included if they had adequate induction or maintenance BCG exposure,

defined by European Association of Urology (EAU) as completion of at least 5 of 6 induction doses or 2 of 3 maintenance doses. **RESULTS:** 33 induction BCG only patients were compared to 33 patients who underwent induction and maintenance BCG. There was no significant difference between age, gender, and EAU prognostic risk group. The induction only arm had significantly high number of recurrence (P = 0.009). However, there was no significant difference between rate of upstaging, progression free survival, and disease-free survival. **CONCLUSION:** Patients who underwent induction BCG only had a greater number of recurrences as compared to those who received induction and maintenance BCG. This puts induction BCG only patients at risk of needing another endoscopic resection and its associated complication.

#abs36 | Initial diagnostic accuracy of FDG-PET compared to PSMA-PET for newly diagnosed high risk prostate cancer prior to treatment: FIND Trial

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INTRODUCTION & OBJECTIVES: High-risk prostate cancer accounts for most prostate cancer-related deaths, however variable tumour biology complicates prediction of disease course. Molecular imaging, such as Prostate Specific Membrane Antigen (PSMA) and fluorodeoxyglucose (FDG)-positron emission tomography (PET) may assist with prognostication. The comparative performance of PSMA- and FDG-PET at diagnosis is unclear. The primary objective of the FIND trial was to determine the additive diagnostic value of FDG PET compared to PSMA PET in high risk prostate cancer patients. **METHODS:** High risk prostate cancer (EAU classification) patients staged with PSMA PET-CT were recruited from three sites. FDG PET-CT was acquired centrally and reported according to standardised template. The primary outcome was FDG PET-CT diagnostic accuracy compared to PSMA PET-CT, based on hard/soft criteria (per proPSMA trial). Secondary outcomes included management change, histological comparison, oncological outcomes and influence on patient reported outcomes. Descriptive statistical analysis was performed. The trial was prospectively registered (ACTRN12621001185853). **RESULTS:** 32 participants underwent FDG-PET. Median (interquartile range) age was 69 (66-72) years and PSA was 14 (8-28) ug/L. Variable PSMA-PET tracers were used (68Ga-PSMA-11 41%, F18-PSMA-1007 44%, F-18-PSMA-DCFPyL 15%). Median SUVmax of the primary tumour was 14.3 (9.8-23). Overall, FDG-PET did not detect any additional definite/probable metastasis according to physician interpretation. 93% of FDG-PET scans showed no definite/probable regional or distant metastasis. Remaining positive FDG-PET results (n=2) were concordant with PSMA-PET. FDG-PET showed no uptake at the primary tumour for 34% of patients, with only 4 tumours showing SUVmax >10. No predictive factors (PSA, PSA density, PIRADS score, biopsy histology, PSMA-PET SUVmax) for FDG-PET positivity were identified. **CONCLUSION:** Initial analysis indicates that FDG-PET does not provide additive staging information above PSMA-PET for high-risk de novo prostate cancer patients. Final analysis will be presented after minimal 12 months follow-up in all participants. Funders: RBWH Foundation Project Grant

#abs37 | Low toxicity of focal low-dose-rate (LDR) brachytherapy for intermediate risk prostate cancer

Harkin, Timothy - Author[1,2]; Smyth, Lloyd - Co-Author 2[2]; Anderson, Elliot - Co-Author 3[1,2]; O'Sullivan, Richard - Co-Author 4[1,3]; Ryan, Andrew - Co-Author 5[4]; Lawrentschuk, Nathan - Co-Author 6[5,6,7,8]; Katz, Darren - Co-Author 7[5,9,10]; Grummet, Jeremy - Co-Author 8[1,11]; See, Andrew - Co-Author 9[2]

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INTRODUCTION AND OBJECTIVES: While whole-gland LDR brachytherapy is a standard treatment option for localised prostate cancer, the burden of genitourinary and rectal side effects remains considerable. Focal therapy in highly selected patients aims to minimise adverse events without compromising oncological outcomes. This study describes the acute genitourinary and rectal toxicity following focal LDR brachytherapy for intermediate risk prostate cancer. **METHODS:** An ongoing, prospective, multi-centre clinical registry of patients who undergo focal LDR brachytherapy for intermediate risk prostate cancer from September 2019 was utilised to evaluate toxicities up to 12 months following implant. Clinician assessments for genitourinary or rectal toxicity were conducted at three-monthly intervals following implant, and were graded according to CTCAE v5 guidelines. Toxicities at three months, 6-12 months, and 12 months were evaluated to ascertain prevalence over time. **RESULTS:** Seventy-one, 63, and 44 patients were included for analysis at three months, 6-12 months, and 12 months respectively. Urinary toxicities, most commonly frequency and urgency, occurred in 35.2% of patients within the first three months, and 42.9% over the subsequent nine months. At 12 months, 18.2% of patients exhibited any Grade 1 urinary toxicity; no Grade 2 or 3 toxicities were observed. Urinary incontinence occurred in 4.8% of patients, and resolved in all cases by 12 months. New or worsened erectile dysfunction occurred in 23.9% of patients within the initial three months, 50.8% from 6-12 months, and 43.2% at 12 months. Anorectal toxicity was uncommon, affecting 1.4% of patients within the first three months, 7.9% from 6-12 months, and 4.5% at 12 months. **CONCLUSIONS:** These results suggest that focal LDR brachytherapy for the treatment of intermediate risk prostate cancer has a favourable side effect profile, supporting the rationale for focal therapy to maximise quality of life in selected patients undergoing treatment with curative intent.

#abs38 | Lu-PSMA Therapy – Practical Considerations for Urologists

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INTRODUCTION & OBJECTIVES: Lutetium-177-PSMA-617 (Lu-PSMA) therapy is an emerging therapeutic option for metastatic castrate-resistant prostate cancer. Lu-177 is a radioligand that delivers radiation to cells expressing prostate-specific membrane antigen (PSMA). While recent studies have demonstrated its safety and efficacy, there is limited data regarding urological complications and functional outcomes of therapy. Contemporary trials enrolled cohorts with lengthy multimodal treatment histories. As Lu-PSMA therapy becomes more widely adopted, urological guidance will inevitably be required for pre-therapy optimisation and complication management. **METHODS:** A literature review on the practical urological considerations of Lu-PSMA therapy was performed. **RESULTS:** The rapid renal excretion of Lu-PSMA has raised concerns for ligand concentration and radiation emission from excreted urine. Current practice for incontinent patients is to catheterise prior to therapy to prevent contamination. Strong urinary urgency, frequency, and incontinence have hindered accurate urine collection in studies. Furthermore, the European Association of Nuclear Medicine (EANM) guidelines list hydronephrosis, obstruction or high risk of retention as contraindications to Lu-PSMA therapy. Two clinical trials for Lu-PSMA, VISION and TheraP, did not include these contraindications at enrolment. PSMAfore is a newer trial which lists both incontinence and unmanageable bladder outlet obstruction as exclusion criteria. TheraP reported lower incidence of troublesome urinary

symptoms amongst those receiving Lu-PSMA than with cabazitaxel (38% v.s. 62%). Conversely, VISION reported increased incidence of UTI amongst patients receiving Lu-PSMA compared to standard care (3.8% v.s. 0.5%). For patients with obstruction or haematuria secondary to locally advanced disease, Lu-PSMA would presumably impact symptoms, but the data is not clear on whether this effect would be positive or negative. **CONCLUSIONS:** Lu-PSMA appears to be generally well tolerated by patients, but with variable and unclear urological complications. Pre-therapy considerations include management of incontinence and obstruction. Further investigation of functional post-therapy outcomes is a necessary adjunct to existing data supporting the safety and efficacy of Lu-PSMA therapy.

#abs39 | LuCAB: A Phase I/II trial evaluating cabazitaxel in combination with [177Lu]Lu-PSMA-617 in patients with metastatic castration-resistant prostate cancer

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INTRODUCTION: [177Lu]Lu-PSMA-617 is FDA-approved for use in the post-taxane, post-androgen receptor pathway inhibitor (ARPI) setting in patients with metastatic castration-resistant prostate cancer (mCRPC). Despite conferring a survival benefit, progression is inevitable. Likely mechanisms limiting the durability of responses are heterogeneity in tumour PSMA expression, and ineffective treatment of micrometastatic disease. Radiosensitising properties of cabazitaxel may enhance the cytotoxic effect of [177Lu]Lu-PSMA-617, whilst also treating any PSMA-negative disease. **OBJECTIVES:** To evaluate the safety and preliminary efficacy of cabazitaxel and [177Lu]Lu-PSMA-617 in combination. **METHODS:** This single-centre, single-arm phase I/II trial will enrol 32-38 patients with progressive mCRPC over 18 months. Up to 6 doses of [177Lu]Lu-PSMA-617 (7.4 GBq) will be administered intravenously every 6 weeks. Cabazitaxel will be given concurrently (dose range 12.5 - 20 mg/m2), on Day 2 and Day 23 of each 6-week cycle. The dose of cabazitaxel will be escalated using a traditional 3+3 design. Key eligibility criteria include a diagnosis of mCRPC with PSMA-positive disease on PSMA PET/CT (SUVmax ≥15), with no evidence of diffuse marrow disease or sites of discordance on FDG PET/CT. Patients must have received prior docetaxel and an ARPI, have adequate bone marrow and organ function, and an ECOG performance status of 0-1. **RESULTS:** The primary objective is to establish the maximum tolerated dose of cabazitaxel with [177Lu]Lu-PSMA-617. Secondary objectives include assessing safety (CTCAE v5.0), efficacy (PSA 50% response rate, radiographic and PSA progression-free survival, overall survival, objective response rate), and evaluation of pain and health-related quality of life over the first 12 months. Exploratory objectives include ctDNA analysis at baseline, during treatment and at progression, and identifying potential biomarkers of response or resistance through optional tissue biopsies. **CONCLUSION:** Patient enrolment began in August 2022. NCT05340374.

#abs40 | Management of Seminoma in Undescended Testes: is Surgery Really Needed ?

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INTRODUCTION AND OBJECTIVES: Data for the optimal management of germ cell tumours(GCT) in undescended testes are limited. Patients usually require up-front chemotherapy. Surgical resections are usually more challenging than the high-inguinal orchidectomy practised for scrotal testes. We audited our treatment practices for patients with seminoma in undescended testes. Our objective was to determine if the masses resected post-chemotherapy contained any viable disease.

MATERIALS AND METHODS: Retrospective analysis of our prospectively maintained testicular cancer database. Treatment decisions were taken in our multi-disciplinary clinics. We selected patients with biopsy-proven seminoma occurring in patients with undescended planned for upfront chemotherapy. IGCC Risk (International Germ Cell Consensus) was defined considering pre-chemotherapy tumour markers. Medical records were reviewed to see the imaging used, the nature of the response, the surgical details and the post-operative histopathology. **RESULTS:** Over 5 years, we identified 9 suitable patients. 8 were good risk and 1 was intermediate risk as per IGCC. All received chemotherapy upfront(B: Bleomycin, E: Etoposide, P: Cisplatin, V: Etoposide, I: Ifosfamide): 3 cycles BEP(n=4), 1 cycle BEP (n=1), 1 cycle EP(carboplatin) as prephase followed by 4 cycles VIP(n=1), 4 cycles EP(n=3). Response evaluation was as follows: PET scan: partial response (PR) (n=2), Complete metabolic response(n=3); Contrast-enhanced CT scan: PR (n=4). 8 patients underwent surgery with no gross residual disease. 1 patient had residual disease in the retroperitoneum for which he received radiotherapy. The post-operative histopathology showed no viable disease in all 9 patients. At the time of writing, all patients were alive and disease-free. **CONCLUSIONS:** The management of seminoma in undescended testes is complex, requiring a multidisciplinary approach. Resected specimens, even in patients with PR on imaging, showed no viable tumour. This brings into question the need for complex surgical resections in this subset of patients. These findings need to be evaluated prospectively in a larger cohort.

#abs41 | Misdiagnoses and physician-related factors impacting the delay in diagnosis of testicular cancer.

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BACKGROUND: Early diagnosis and management of testicular cancer (TCa) has high cure rates. Despite effective therapies in TCa treatment, various factors continue to hinder early diagnosis and prognosis for some TCa patients. **OBJECTIVES:** This review aimed to identify the major physician-related factors associated with diagnostic and treatment delay of TCa; and establish the impact that the physician-related component has on the overall length of delay from symptom onset to treatment. **METHOD:** The researchers conducted a systematic review of the literature between 1996 and 2020 in the electronic databases CINAHL and MEDLINE in accordance with the PRISMA guidelines. In total, 303 articles were identified and 15 were included in the final review. **RESULTS:** Nine articles reported a physician delay, represented as the time from first presentation to diagnosis (median 5–164 days), or the time from general practitioner to specialist review (median 1–56 days). Four physician-related factors were identified; recognition of differing presenting symptoms, misdiagnoses', inappropriate management with antibiotics and challenges of clinical examinations. Seminoma tumours had a longer time to presentation, and an overall longer delay from presentation to treatment than non-seminomatous germ cell tumours (NSGCT). Testicular lump was the most common presenting symptom in up to 48% of cases, followed by testicular pain. Epididymitis and/or orchitis was the most frequent misdiagnosis, subsequently leading to inappropriate prescribing of antibiotics. A range of clinical challenges were acknowledged amongst physicians including documented investigative delays, with up to 93% of suspected TCa referrals in the literature requiring an ultrasound scan prior to diagnosis. **CONCLUSION:** The physician plays a critical role in the prognosis of a patient with a new diagnosis of testicular cancer. Many modifiable physician-related factors were identified contributing to delays along the diagnostic and treatment pathway, indicating the importance for further physician and patient education, clinical training and streamlined referral routes for investigations.

#abs42 | Modifying the tumour microenvironment using carboplatin to enhance the efficacy of CAR T cell therapy for prostate cancer

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INTRODUCTION: CAR T cells, which activate the immune system, have transformed haematological cancers. The immunosuppressive tumour microenvironment (TME) prevents T cell invasion, activation, and cytotoxicity after antigen identification, making CAR T cells less efficient against solid tumours. These barriers must be overcome to improve treatment efficacy. Our aim was to assess prostate cancer target expression and the effectiveness of Lewis Y (LeY) CAR T cell therapy in vitro and in vivo. **METHODS:** Expression of LeY was assessed on 800 prostate cancer patient specimens plus 49 patient-derived xenografts (PDXs) using immunohistochemistry. On target specificity of LeY CAR T cells was determined in organoids established from PDXs. In vivo efficacy of LeY CAR T cells was assessed in combination with carboplatin, docetaxel or checkpoint inhibitor nivolumab, and TME modulation was assessed using flow cytometry and RNA-seq. Results: LeY was expressed on 12% of localized and 20% of metastatic tumors, and in 57% of prostate cancer PDXs. LeY-CAR T cells directly killed PDX-derived androgen receptor (AR)-positive or AR-null tumour organoids via perforin/granzyme-dependent granule exocytosis. In vivo, LeY CAR T cells alone did not affect tumour growth, but a single prior dose of carboplatin (but not docetaxel or checkpoint inhibitor nivolumab), eradicated tumours. Carboplatin caused tumour cell death and a pro-inflammatory effect on the TME that facilitated early and durable CAR T cell infiltration. Mechanistically, this involved an altered cancer-associated fibroblast phenotype, enhanced extracellular matrix degradation and re-orienting M1 macrophage differentiation. In a PDX line less sensitive to carboplatin treatment, carboplatin did not boost CAR T cell infiltration; however, a reduction in tumour burden was still observed with increased T cell activation. **CONCLUSIONS:** Low-dose carboplatin improves the efficacy of CAR T cell treatment, with the extent of the response dependent on changes induced within the tumour microenvironment.

#abs43 | Multiomic analysis workflow for biomarker discovery in human prostate cancer

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INTRODUCTION AND OBJECTIVES: Prostate cancer is a heterogenous disease. Mortality for men with localised disease is low, however 5% will develop metastases despite curative-intent treatment(1). Although few men relapse after presenting with localised disease, they account for two-thirds of prostate cancer deaths. Risk stratification with clinicopathological features is imperfect; most men are overtreated, while others remain undertreated. Traditionally, prognostic biomarkers are discovered using homogenised samples that fail to capture tumour heterogeneity. Multiomic approaches that include spatial transcriptomics (ST), metabolomics, as well as single-cell transcriptomics, are promising methods for advancing our understanding of prostate cancer. Analysing the spatial distribution of molecules in the tumour microenvironment (TME) can help identify different cell types and their functions and provide valuable information on the heterogeneity of prostate cancer. **METHODS:** Radical prostatectomy specimens identified from the Australian Prostate Cancer BioResource (APCB) will be divided into two groups for comparison, groups are well-matched for intermediate and high-risk disease. One group with no recurrence after prostatectomy (cured) and a second group with recurrence (relapsed). Our multiomics approach will be a combination of ST, metabolomics, and single-cell transcriptomics. This approach is critical for studying the TME and understanding its complex interaction with malignant cells. The use of

ST and metabolomics will allow for the identification of metabolic pathways that are specific to prostate cancer. Frozen primary tumour samples will be placed onto ST slides, containing a spatially barcoded array. The transcribed cDNA libraries will then be sequenced using next-generation sequencing methods. Bioinformatic integration of data from single-cell and ST will be performed to identify clusters relating to compartments of the TME. Lipid profiling will be performed using mass spectrometry-based imaging. **RESULTS AND CONCLUSION:** Using this multiomic workflow, we hope to discover signatures in the different compartments of the TME that identify aggressive disease at the time of diagnosis. **REFERENCES:** 1. Hamdy FC, Donovan JL, Lane JA, Metcalfe C, Davis M, Turner EL, et al. Fifteen-Year Outcomes after Monitoring, Surgery, or Radiotherapy for Prostate Cancer. N Engl J Med. 2023 Mar 11. DOI: 10.1056/NEJMoa2214122.

#abs44 | Online resources from the Cancer Australia Quality of Life Technical Service (CQUEST)

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INTRODUCTION: The Cancer Quality of Life Expert Service Team (CQUEST) is the Cancer Australia funded Quality of Life Technical Service, hosted by UTS (University of Technology Sydney). One of CQUEST's aims is to support the use of patient-reported outcome measures (PROMs) in cancer clinical trials by developing up-to-date, practical, and accessible resources. This poster will introduce three online resources for ANZUP members, and provide an opportunity for members to request further resources. **METHODS:** The CQUEST website (www.uts.edu.au/cquest) includes a repository with the following resources: 1. A list of translated and culturally validated PROMs that will improve access to cancer trials for patients from culturally and linguistically diverse and Indigenous backgrounds. The list currently includes 76 PROMs commonly used in cancer clinical research and will be updated periodically over time. 2. Informative graphics and videos that will help improve PROM data quality and minimise missing data by educating patients and clinical trial staff on rationales and processes for PROM data collection. 3. Updated resources for the two most utilised PROM suites in cancer clinical trials (EORTC and FACIT). This includes a calculator which converts raw mean scores from the EORTC QLQ-C30 and FACT-G into norm-based T-scores which allow for comparison with the general Australian cancer population. Results: CQUEST's online resources will help ANZUP members increase access to trials, improve PROM data quality, and enrich data interpretation for the EORTC QLQ-C30 and FACT-G. ANZUP members are invited to request further online resources that will improve use of PROMs in their research. These can be suggested to the CQUEST team during discussion of the poster. **CONCLUSION:** CQUEST invites ANZUP members to engage with our online resources to improve the use of PROMs in cancer clinical trials.

#abs45 | OUTCOME OF NEO-ADJUVANT CHEMOTHERAPY IN PATIENTS WITH RADICAL CYSTECTOMY

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INTRODUCTION: Bladder cancer is the most common urinary cancer and the 9th most common in the world (1). For patients who will undergo cystectomy, having cisplatin based neo-adjuvant chemotherapy (NAC) is usually indicated for survival benefit and recurrence reduction. Despite good international data, there remains a gap in robust local data. This study performs a retrospective analysis of NAC use in patient with radical cystectomy (RC) for bladder cancer including 5-year survival outcome. The primary objective of this research is to analyse survival outcome, recurrence, and complication in patients with NAC+RC. The secondary objective is to investigate whether NAC use is superior, non-inferior or inferior to RC alone. **METHODS:** A retrospective search in Peninsula Health medical records was performed between 2018 and 2022. Those who underwent RC for bladder cancer will be included. Clinical data will be collected accordingly to list of variables. A de-identified copy will be made and will be used for statistical analysis. This will involve comparison of data following subcategorization of records from patients with NAC and without. Statistical analysis will be conducted via dedicated program. Descriptive statistics will be used to illustrate the data collected. **RESULTS:** 23 patients were recruited in this study. 69.5% are male patients and 30.5% are female patients. Mean age of patients receiving radical cystectomy is 65 years.

86% of the patients with muscle-invasive bladder cancer (MIBC) received only NAC before RC. 7% of them received neoadjuvant + adjuvant therapy. 7% received no other therapy prior to RC. 7% patient had recurrence at 5 years for those who received NAC, which equals the percentage for patients who didn't receive NAC. Conclusion Research team found NAC reduces recurrence but showed no difference in survival benefit. A RC registry and in turn, a state-wide database can be set up to facilitate future research for improved patient care. References 1 Ploeg M, Aben K, Kiemeney L. The present and future burden of urinary bladder cancer in the world. World Journal of Urology. 2009;27(3):289-293.

#abs46 | Outcomes for advanced clear cell renal carcinoma in the Waikato – are we falling short?

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INTRODUCTION AND OBJECTIVES: In New Zealand there are only two anti-VEGF tyrosine kinase inhibitors (TKI), Pazopanib and Sunitinib, funded for the first line treatment of advanced clear cell renal carcinoma (ccRCC). There is no publicly funded immunotherapy. Recent studies have demonstrated that Mβori patients have worse outcomes compared with non-Mβori across a number of cancer types. This study was undertaken to establish if advanced ccRCC patients in the Waikato region have similar outcomes to the IMDC database, and if Mβori patients have worse outcomes compared with non-Mβori. **METHODS:** A retrospective audit was made of all patients with advanced ccRCC treated with a first line TKI by the Waikato Medical Oncology service between 2011-2018. Baseline demographics, clinical, laboratory and outcome data were collected. Primary outcome was overall survival (OS) from date of starting first line treatment, and this was analysed according to IMDC risk groups and ethnicity. **RESULTS:** 108 patients were eligible for inclusion in the study. Of the total cohort 14% of patients were of favourable risk, 53% intermediate, and 33% poor risk. There were 10 Mβori patients included in the study (20% good risk, 70% intermediate risk, 10% poor risk). Median OS (mOS) for the total cohort was 17 months (good risk), 16 months (intermediate) and 7 months (poor risk). There was no statistically significant difference between Mβori and non-Mβori patients with regards to mOS (p=0.72). Only 8% patients in the Waikato region had any second line therapy. **CONCLUSIONS:** The data presented supports that patients with advanced ccRCC treated with a first line TKI in the Waikato region between 2011-2018 had outcomes inferior to the IMDC database figures, particularly for the favourable risk group. Only a small proportion of patients had second line therapy. Mβori patients had similar outcomes for overall survival compared with non-Mβori.

#abs47 | Outcomes of patients with stage I non-seminomatous germ cell tumours (NSGCT) of the testis at a tertiary care cancer centre in a low resource country: Is strict surveillance necessary?

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INTRODUCTION AND OBJECTIVES: Early-stage non-seminomatous germ cell tumours (NSGCT) are associated with a good prognosis. Treatment options include chemotherapy, nerve-sparing retroperitoneal lymph node dissection (NS-RPLND) and active surveillance (AS), with excellent outcomes. Problems with chemotherapy include social stigma and apprehension; for NS-RPLND, the need for surgical expertise, morbidity and cost. AS needs adherence to a strict follow-up schedule, besides expenditure for imaging and markers, leading to non-compliance and dropouts in resource-constrained settings. Our objective was to determine real-world outcomes of these modalities in a developing country like India. **METHODS:** Retrospective analysis of prospectively collected data from our testicular cancer database. Patients were evaluated with clinical examination, imaging and tumour markers. Stage I NSGCT patients with normal post-orchidectomy markers were selected. **RESULTS:** 43 patients with stage I NSGCT, median age 29 years, were treated over 4 years. Patients with high-risk criteria in primary (embryonal carcinoma predominance, lympho-vascular emboli, epididymis/cord involvement) were treated with 2-3 cycles of BEP (bleomycin, etoposide, cisplatin) chemotherapy (n=18) or NS-RPLND (n=2). All patients the chemotherapy arm

were alive without disease at median follow-up of 60 (1-108) months. One developed lung metastases post-RPLND and died despite salvage chemotherapy. Those without high-risk criteria (n=23) were advised standard surveillance protocol. Two relapsed and were salvaged with chemotherapy. All on surveillance were alive and disease-free, whether they adhered to stringent surveillance (n=12) or not (n=11). The 5-year relapse-free survival and overall survivals were 91.8% and 97.2% respectively. **CONCLUSIONS:** Patient outcomes were excellent irrespective of the treatment strategy selected. Patients who defaulted surveillance also had outcomes similar to those who followed up stringently. This challenges the need for adherence to stringent, resource-intensive follow-up protocols in this population and has long-term implications for resource allocation and treatment planning in our setting. This merits further evaluation in a randomized clinical trial.

#abs48 | Outcomes of Stage I Germ Cell Tumours at Chris O'Brien Lifehouse

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INTRODUCTION: Stage I testicular germ cell tumours (GCT) post orchidectomy are managed with either adjuvant chemotherapy or active surveillance. Without adjuvant chemotherapy, recurrence occurs in around 10-15% of seminomas, 20% of IA nonseminoma, and 50% of IB nonseminomas. As survival rates are high even after recurrence, it is uncertain whether adjuvant chemotherapy confers a superior risk-benefit profile than active surveillance. **OBJECTIVE:** To evaluate the clinicopathological features and outcomes of patients with Stage I GCT undergoing active surveillance following orchidectomy at Chris O'Brien Lifehouse (LH). **METHODS:** Patients referred to LH between January 2018 and December 2020 with Stage I GCT were identified. Data on clinical and pathological features, management and outcomes were extracted from a retrospective database. **RESULTS**: 54 patients were identified of whom 37 had seminoma and 17 had nonseminoma (12 Stage IA, 6 Stage IB). Median age at diagnosis was 34 (range 18-57). Median follow up time was 34 months (range 1-56). Management for seminoma was carboplatin in 2 and surveillance in 35. Management for nonseminoma was BEP chemotherapy in 0 and surveillance in 17. Recurrence occurred in 5/37 (14%) seminomas, 4/12 (33%) IA non seminomas and 3/5 (60%) IB nonseminomas. All patients had metastases to retroperitoneal lymph nodes, 1 also had mediastinal metastases and 1 also had cervical metastases. Amongst patients with recurrence, 2 received primary retroperitoneal lymph node dissections, 3 received radiotherapy and 7 received chemotherapy. No patients required resection of residual disease. 2 patients had long term neuropathy. 1 patient had a second recurrence. No deaths occurred. **CONCLUSION:** Recurrence rates in the LH cohort were similar to previously reported studies for seminoma but higher for both IA and IB nonseminoma. Surveillance with treatment after recurrence were mostly curative with a low complication rate. Nevertheless, adjuvant chemotherapy is an option for IB nonseminoma to prevent recurrence. **ACKNOWLEDGEMENTS:** The WEHI iTestis registry database (supported by ANZUP) was used for data collection.

#abs49 | Patient-reported outcome measures following focal low-dose-rate (LDR) brachytherapy for intermediate risk prostate cancer

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INTRODUCTION AND OBJECTIVES: Whole-gland LDR brachytherapy, a conventional management for localised prostate cancer, is associated with significant genitourinary and rectal side effects. In appropriately-selected patients, focal therapy holds promise as an approach that minimises adverse effects without compromising oncological control. This study describes the initial patient-reported outcome measures following focal LDR brachytherapy for intermediate risk prostate cancer.

METHODS: Patients enrolled in an ongoing, prospective, multi-centre clinical registry of focal LDR brachytherapy for intermediate risk prostate cancer from September 2019 with a minimum of 12 months of follow-up were included in this study. Serial validated questionnaires (International Prostate Symptom Score [IPSS]; International Index of Erectile Function [IIEF-5]; Expanded Prostate Cancer Index Composite [EPIC] Bowel Assessment) were provided to patients at baseline, six weeks, six months, and 12 months post-implant. **RESULTS:** Thirty-five, 35, and 26 patients responded to IPSS, EPIC Bowel Assessment, and IIEF-5 questionnaires respectively over the 12 months following implant. At baseline, 45.7%, 48.6%, and 5.7% of the cohort had IPSS scores consistent with mild, moderate, and severe urinary symptoms respectively. Urinary function declined transiently by six weeks with 24.0% of patients demonstrating severe symptoms, improving to 6.5% by six months. At 12 months, 45.7%, 45.7% and 8.6% of patients had mild, moderate, and severe urinary symptoms respectively. Bowel function exhibited a similar pattern, with a decrease of 6.3 (IQR 1.7–10.9) in EPIC scores at six weeks, and a more mild decrease of 3.0 (IQR 0.6–5.4) by 12 months. Serial IIEF-5 scores showed a variable effect on erectile function, with no statistically-significant change in score by 12 months, though an additional 7.7% of patients reporting severe erectile dysfunction. **CONCLUSIONS:** These results suggest that focal LDR brachytherapy is a well-tolerated intervention for the treatment of intermediate-risk prostate cancer, with minimal change to patient-reported urinary, bowel, and erectile function by 12 months.

#abs50 | Pattern of recurrence following radical cystectomy and perioperative chemotherapy in muscle-invasive bladder cancer and outcomes to salvage systemic therapy

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INTRODUCTION AND OBJECTIVES The management of muscle-invasive bladder cancer typically involves radical cystectomy and perioperative chemotherapy, with neoadjuvant treatment being the preferred approach. This study aims to investigate the pattern of recurrence and outcomes to salvage systemic therapy (SST). **METHODS:** This was a retrospective analysis using electronic medical records of year 2013 to 2020. Patients who had undergone cystectomy with neoadjuvant/adjuvant chemotherapy and subsequently developed recurrence were included. **RESULTS:** During the above period, 64 out of 182 patients developed recurrence after radical cystectomy and perioperative therapy. The median age at recurrence was 59 years. Eastern Cooperative Oncology Group Performance Status(ECOG-PS) at recurrence was: 1 (n=29), 2 (n=21), 3 (n=12) and 4 (n=2). Median time to recurrence was 8.42 (IQR: 4.04–18.80) months. Disease recurred within 12 months of surgery in 38 patients. The pattern of recurrence was locoregional(n=9, 14.1%), systemic(n=33, 51.5%) and locoregional with systemic(n=22, 34.4%). The sites of distant recurrence were lung(21.9%), liver(21.9%), bone(18.8%), peritoneum(14.1%) and brain(4.7%). Only 31 out of 64 patients(48.4%) went on to receive SST, while 33 patients were offered only best supportive care(BSC) due to poor ECOG-PS. Platinum-based chemotherapy was re-challenged in 16 patients. The other regimens that were used were paclitaxel (n=9), immunotherapy (n=5) and gemcitabine(n=1). Overall response rate to SST was 65.2%, with a median progression-free survival (95%CI) of 7.03 (5.9-8.2) months. Further, third and fourth-line regimens were received by 11 and 3 patients respectively. The overall survival (OS) (95%CI) in the SST cohort was 10.6 (5.6-15.6) months versus 4.3 (2.6-6.1) months in the BSC cohort ($p<0.001$). ECOG-PS>2 at recurrence was the only significant factor associated with poorer OS. **CONCLUSIONS:** Only half of the patients could receive SST at recurrence. Third and fourth-line therapies are practically not feasible in relapse settings. This reinforces the importance of delivering more effective systemic therapy in the perioperative period.

#abs51 | PCPro: a clinically accessible, circulating lipid biomarker signature for poor-prognosis metastatic prostate cancer

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INTRODUCTION AND OBJECTIVES: Using comprehensive plasma lipidomic profiling from patients with metastatic castration-resistant prostate cancer (mCRPC), we previously identified and validated that circulating sphingolipids, especially ceramides, are associated with shorter progression-free and overall survival (OS). We hypothesise that the outcomes of patients with this poor prognostic lipid profile can be improved by therapy targeting lipid metabolism. To identify men with this metabolically actionable lipid profile, we require a clinically accessible and regulatory approved plasma lipid biomarker assay. **METHODS:** Using liquid chromatography-mass spectrometry, we optimised a single assay capable of accurately quantifying a panel of candidate lipids according to NATA guidelines. We performed the assay on plasma samples from two cohorts of men with mCRPC prior to starting taxane or androgen receptor signalling inhibitor therapy (Discovery: 105 patients, Validation: 183 patients), and developed PCPro, a cox-regression based risk-model capable of predicting men with poor prognostic mCRPC. **RESULTS:** PCPro, the lipid biomarker, contains Cer(d18:1/18:0), Cer(d18:1/24:0), Cer(d18:1/24:1), triglycerides and total cholesterol. Within the Discovery and Validation cohorts, patients who were PCPro positive had significantly shorter OS compared to those who were PCPro negative (Discovery: median OS 12.0months vs 24.2months, hazard ratio (HR) 3.75 [95% confidence interval (CI) 2.29 – 6.15], p<0.001; Validation: median OS 13.0months vs 25.7months, HR = 2.13 [95% CI 1.46 – 3.12], p<0.001). **CONCLUSIONS:** We have developed PCPro, a lipid biomarker assay capable of prospectively identifying men with mCRPC with a poor prognosis. Prospective clinical trials are required to determine if men who are PCPro positive will benefit from therapeutic agents targeting lipid metabolism.

#abs52 | Penile Cancer in Regional Queensland: A Retrospective Audit of Diagnosis, Treatment, and Outcomes

Ravichandran, Kapilan - Author

Despite centralisation of care for penile cancer worldwide, care for patients with PC in regional Australia is challenging due to geography. The objective of this 10 year audit was to investigate the clinical features, management, and outcomes of patients with penile cancer treated at two regional centres in Australia; which serve a catchment of 250,000 km2, and located up to 1200 kilometres away from a metropolitan hospital. The retrospective audit via chart review was conducted on all patients diagnosed with penile cancer at Townsville Hospital and Toowoomba Hospital between January 2013 to January 2023. 34 patients were identified. Mean age at diagnosis was 77 years (range 25-89). 33 (97%) had squamous cell carcinoma (SCC). 90% of the SCC were located on the glans and/or the foreskin. The mean time from symptom onset to diagnosis was 5 months. 12% had Tis and Ta, 44% had T1, 26% had T2 disease, 6% had T3 disease and 3% had T4 disease. 26% on presentation had inguinal node disease. These presenting pathologies are more advanced than reported in the literature. 50% of patients underwent penectomy (12 partials and 5 total penectomies). 21% had inguinal lymph node dissection. Kaplan-meier cancer-specific survival at 5 years demonstrated decreasing survival based on

tumour stage- 89% in T1, 75% in T2, and 65% in T3 disease. Complications post-surgery occurred in 18%, with the most common complication being seroma post lymph node dissection. In patients where care was offered at a metropolitan centre 40% refused the transfer. Regional patients with penile cancer present later with more advanced disease and their refusal to transfer care to metropolitan centres underscore the importance of increasing awareness of the disease and ongoing care in regional centres. Additionally, the outcomes achieved are comparable with the literature.

#abs53 | Photodynamic Therapy in the 21st Century. Primary, adjuvant and neo-adjuvant roles?

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INTRODUCTION: Photodynamic therapy(PDT): a cancer cell specific treatment, involving a photosensitiser(PS) mediated, light wave energy to bio-chemical energy reaction. PDT together with irradiation(XRT), radio-frequency(RFA) and neonatal jaundice light-bed therapy, represent four different therapeutic roles for Electromagnetic Radiation(EMR) energy. The 1980's space age development of a chlorophyll based water soluble PS, evolved from the 1926 Porphyria description and the ensuing potentially toxic, haemoglobin based lipid soluble PS. While also recognizing the shared, chlorophyll and haemoglobin structural relationship and bilirubin, a light sensitive haem derivative. This study utilises the photosynthesis energy equation, involving a PS^, red light energy and oxygen. Described in the 2012/14 Phase 1 study* as an uncontrolled, destructive intra-cytoplasmic individual cancer cell event, representing an evolutionary step away from the TGA approved, historic haem based agents. Our technique is an adaption of the metronomic(m) light treatment for neonatal jaundice. **AIM:** To study mPDT using a GMP certified PS, for patients with biopsy proven, localized primary prostate cancer, including patients with prostatic or prostatic fossa relapse, following prior attempted curative surgery/irradiation therapies. **METHOD:** The trial involves, twelve trans-luminal prostate cancer mPDT episodes over ten weeks, mediated by sub-lingually administered PS.

RESULTS: All safely aspects have been satisfied for this treatment. Most PSA results at 3 months post treatment, have returned to stable low levels. The IPSS and Quality of life data recorded low scores as improved or unchanged, while no alteration/ deterioration has been reported for erectile function. The positive scientific assessments of mpMRI, PMSA pet scan, fluorescent imaging and comparative urinary proteomic and CTC data will be presented. Prostate size reduction has been described post mPDT. **CONCLUSION:** The TGA safety criteria are being met. The clinical and scientific investigational responses are described; of particular interest is the prostatic cancer immune system stimulation and the post treatment, prostate size reduction.

* HREC approved / TGA registered. ^ Patents.

#abs54 | Preclinical testing of Bipolar Androgen Therapy (BAT) with patient-derived models of castration-resistant prostate cancer

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INTRODUCTION AND OBJECTIVES: Bipolar Androgen Therapy (BAT) is a potential new treatment for castration resistant prostate cancer where patients cycle between castrate and supraphysiological levels of testosterone to prevent tumours adapting to therapy. Clinical trials show varying responses to BAT and it is unclear why some tumours respond to BAT while others do not. The aim of this study was to use patient-derived xenografts to compare the efficacy of BAT in different cases of metastatic

CRPC. **METHODS:** We used seven patient-derived xenografts (PDXs) from the Melbourne Urological Research Alliance (MURAL) with diverse phenotypes of CRPC. The PDXs were from patients who progressed on 1-4 systemic therapies post-ADT. PDXs were treated with vehicle or BAT (fortnightly intramuscular injections, 1mg testosterone cypionate) for 6-weeks, or until tumours reached an ethical volume of 1000 mm3. Serum testosterone (mg/dl) was measured on day 1, 5, 7, 14 after each injection. The abundance and localisation of the full-length androgen receptor (AR) and AR-variants were examined using immunohistochemistry. **RESULTS:** Changes in serum testosterone of mice across a cycle of BAT mirrored levels observed in patients. Based on a reduction in tumour volume compared to vehicle, three of seven (42%) of PDXs responded to BAT. The BAT-sensitive PDXs represented different mechanisms of castration-resistance, including AR mutations and amplifications. They also represented different pathologies, including ductal adenocarcinoma and amphicrine prostate cancer. BAT-sensitive PDXs had high expression of full-length AR, but low expression of AR-variants, which was under auto-regulation in response to supraphysiological testosterone. **CONCLUSIONS:** Patient-derived models of metastatic CRPC have heterogeneous responses to BAT, similar to patients in clinical trials. BAT-sensitive PDXs have high levels of full-length AR. Combination therapies may increase the efficacy of BAT in tumours that are resistant to BAT alone.

#abs55 | Predictors of survival in radical cystectomy – a review over 20 years

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INTRODUCTION: Despite curative intent, radical cystectomy (RC) provides 5 year overall survival rates of approximately 60%. Besides histopathological characteristics, comorbidity and perioperative factors such as blood transfusion have been noted to have a negative prognostic impact. Our study sought to identify predictors of survival in relation to survivorship. **METHODS:** A single surgeon, prospectively maintained database of patients who underwent RC from 2012 to 2021 was analysed, examining predictor variables collected including age at diagnosis, operative and anaesthetic times, blood loss, transfusion, and peri-operative support including total parenteral nutrition (TPN) and unplanned intensive care unit (ICU) admission. Outcome variables specifically examined included survivorship at 30 and 90 days, presence of metastatic disease, relapse and death. **RESULTS:** Analysis showed that death was more likely with increasing age at the time of cystectomy (p=0.046); increasing anaesthetic time (p=0.005), increased intraoperative blood loss (p=0.030) and decreased operative times (p=0.046). Metastatic relapse was significantly more likely to be associated with increased intra-operative blood loss (p=0.045). 44/263 patients were transfused, of which 50% died. A greater length of stay was associated with increased intra-operative blood loss (p=0.012); unplanned ICU admission (p <0.001); return to theatre (p=0.017) and female gender (p=0.022). **CONCLUSION:** We demonstrate that increased blood loss, age at cystectomy and anaesthetic time are predictive factors for poor outcomes in RC patients in relation to survivorship. Further research regarding transfusion rate and the impact on the risk of disease recurrence and death is needed to better understand and treat and manage patients post-RC.

#abs56 | Preliminary outcomes in patients with low SUVMax: a sub-study of the prospective proPSMA imaging study

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INTRODUCTION AND OBJECTIVES: Prostate specific membrane antigen positron emission tomography/computed tomography (PSMA PET/CT) is widely used in the initial staging and diagnosis of CaP. However, there is a paucity of evidence assessing outcomes of patients with low PSMA expression and negative PSMA PET/CT scans. Current literature reports the incidence of negative PSMA

PET scans to be approximately 4% (1), however studies were conducted in a retrospective manner. Our study aims to assess the impact of negative PSMA PET/CT imaging on clinical outcomes in the proPSMA study. **METHODS:** The proPSMA study (2) prospectively randomised 302 men with biopsy proven prostate cancer with high-risk features across 10 sites comparing the diagnostic accuracy of PSMA PET/CT and conventional imaging. Patients were followed up to a maximum of 54 months, with retreatment or biochemical recurrence recorded. In this study, we identified patients who had a PSMA PET/CT SUVMax <4 assessing outcomes and rates of recurrence. Results: In the proPSMA study, 10 of 200 patients were identified to have biopsy-proven CaP with a PSMA PET/CT SUVMax <4 (range 2.5-3.8). Grade group 5 disease was present in five of the ten patients. Notably, three patients had very low PSA levels (0.68 ng/ml, 1.8 ng/ml, 3.71 ng/ml). At 6 and 18 months, 4 and 7 patients respectively had biochemical recurrence. Two patients received retreatment for recurrent disease at 18 months, of which one had new metastatic disease. At 42 months, five patients were lost to follow up or withdrawn. The remaining two patients continued to have biochemical disease recurrence. **CONCLUSIONS:** Patients with a PSMA PET SUVMax <4, have a higher risk of biochemical recurrence and consequent retreatment in the long term. Patients with negative PSMA PET/CT will require close examination for treatment selection and surveillance of disease recurrence. **REFERENCES:**
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#abs57 | Preliminary phase 2 results of the CYPIDES study of ODM-208 in metastatic castration-resistant prostate cancer patients

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INTRODUCTION AND OBJECTIVES: ODM-208 is a first-in-class, oral, non-steroidal, selective inhibitor of CYP11A1 that suppresses production of all steroid hormones and precursors that may activate the androgen receptor (AR) signalling pathway. This is particularly relevant in patients with AR ligand binding domain (AR-LBD) activating somatic point mutations, a mechanism of resistance to hormone-based therapies in metastatic castration-resistant prostate cancer (mCRPC). We report the first results of the phase 2 expansion of the CYPIDES trial. **METHODS:** ODM-208 5 mg BID (with dexamethasone and fludrocortisone) was evaluated in an open-label expansion cohort in patients with progressing mCRPC who had previously received ≥1 line of 2nd generation AR pathway inhibitor and ≥1 line of taxane-based chemotherapy. All patients had a pre-specified activating AR-LBD mutation by pre-screening of cell-free DNA (Guardant 360). Study objectives were safety and preliminary efficacy assessed by PSA and RECIST response. ODM-208 treatment was continued until subsequent disease progression. **RESULTS:** 81 of 390 pre-screened patients (20.8%) had a pre-specified AR-LBD mutation, of which 45 (median age, 69 years) were enrolled and initiated ODM-208 treatment (data cut-off, 25 July 2022); 53% had received both abiraterone and enzalutamide, and 69% received both docetaxel and cabazitaxel. ODM-208 profoundly suppressed androgen synthesis, resulting in >50% best PSA reduction in 53% of patients and 6 RECIST partial responses in 23 evaluable patients (26%). ODM-208 has been well tolerated,

with a much lower rate of hospitalisation for adrenal insufficiency than in the phase 1 portion and typically higher doses (6.7% vs 31.8% to date). Efficacy and safety data will be presented for the complete cohort, with 5 months of follow-up after the last patient was enrolled. **CONCLUSIONS:** Administration of ODM-208 to heavily pre-treated mCRPC patients with AR-LBD mutation was highly effective in blocking the production of steroid hormones and showed promising antitumor activity. ClinicalTrials.gov identifier: NCT03436485.|

#abs58 | PREPARE: Exploring the activity of pseudoephedrine in treating retrograde ejaculation following retroperitoneal lymph node dissection in survivors of testicular cancer

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BACKGROUND: Retrograde ejaculation is a complication of retroperitoneal lymph node dissection occurring due to interruption of sympathetic nerves intraoperatively. Whilst common immediately after surgery, the prevalence of persistent symptoms, and impact on health-related quality-of-life (HRQoL) in testicular cancer survivors is unknown. Few treatments have been evaluated prospectively in testicular cancer survivors; however, pseudoephedrine was effective in a small study of participants with retrograde ejaculation due to other causes. **METHODS:** In a two-part, single-arm phase 2 clinical trial, participants receiving follow-up after retroperitoneal lymph node dissection at least 6 months prior will be invited to participate. In part A (ACTRN12622000537752), eligible participants complete questionnaires to explore the prevalence of retrograde ejaculation and HRQoL issues. Questionnaires include EORTC QLQ-C30/QLQ-TC26 (sexual function items), Brief Male Sexual Function Inventory and tailored questions regarding retrograde ejaculation. 45/50 (90%) participants have been enrolled; 41/4 (91%) completed questionnaires. If retrograde ejaculation is reported, participants are invited to Part B (ACTRN12622000542796), where if there are no contraindications to pseudoephedrine, and retrograde ejaculation is confirmed, they receive pseudoephedrine hydrochloride 60mg QID for one-day, followed by 60mg 4 hours and 30-60 minutes prior to ejaculation. The primary endpoint is total sperm count in antegrade ejaculate of at least 39 million (5th centile) following treatment. We assumed that pseudoephedrine is ineffective if less than 10% of participants achieve a normal sperm count in antegrade ejaculate. Using an exact binomial power analysis for a one-sample proportion test, a sample size of 25 participants provides 80% power to detect 36% (9 out of 25) of participants achieving a normal sperm count against a reference proportion of 10% with βof 0.05. Secondary endpoints include change in ejaculate volume, HRQoL and others. 19/25 participants (76%) have been enrolled. Fifteen participants reporting retrograde ejaculation were invited to participate in optional, semi-structured interviews to further evaluate impact(s) of retrograde ejaculation; this data will be thematically analysed. Recruitment is anticipated to complete by the end of quarter 3, 2023.

#abs59 | Presentation Skills In The Virtual Meeting Era – An Analysis of #EAU21

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INTRODUCTION & OBJECTIVES: The COVID pandemic rapidly catapulted scientific conferences into a virtual or hybrid format. The format of traditional scientific communication has abruptly changed from physical presentations at conferences, to virtual pre-recorded contributions and participations. We assessed the quality of presentation

skills at a major urology conference, the European Association of Urology Annual Meeting (#EAU21), to identify areas for improvement. **METHODS:** Using the EAU Urosource Resource Centre, we reviewed on-demand sessions posted from the #EAU21 virtual meeting, focusing on Plenary, Industry, Poster, Semi-live and Specialty sessions. Using a pre-defined matrix based on industry experts, a panel of reviewers rated presentations using quality criteria including camera angle, audio quality, virtual content optimised for virtual viewers which was assessed on both laptop and iPhone to replicate typical viewer experiences. Levels of quality were defined from Level I (minimum standard), to Level 3 (excellent). **RESULTS:** 2068 virtual appearances and 158 hours of content were assessed by the investigators. A total of 1314 presentations (56%) were poster presentations, 366 (16%) were delivered by special representatives, 256 (11%) were delivered by Urologists outside of Europe, 160 (7%) were talks related to conference themes, 101 (4%) were plenary talks, 95 (4%) were semi-live recordings, and 40 (2%) were delivered by representatives from industry. Overall scoring for the 1161 presentations highlighting that 137 (12%) presentations achieved Level 1 competency, 14 (1%) presentations achieved Level 2 competency and 1010 (87%) failed. Areas for presentation optimization include audio (34%), video 58 (27%) and content 58 (27%) were and all 3 in 26 (12%). **CONCLUSIONS:** A high proportion of virtual presentations did not achieve a reasonable minimum standard for scientific communication during the virtual #EAU21 meeting. Simple technical measures can significantly improve the quality of virtual presentations and enhance viewer experience and information flow. Further training will help the scientific community communicate more effectively in the virtual and hybrid meeting era.

#abs60 | PRIMARY2 Trial Protocol: Phase III, multi-centre, randomised controlled trial investigating the additive diagnostic value of [68Ga]Ga-PSMA-11 PET/CT in men with negative/equivocal MRI in the diagnosis of clinically significant prostate cancer

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INTRODUCTION: Multi-parametric magnetic resonance imaging (MRI) has an established role for the diagnosis of clinically significant prostate cancer (sPCa). PRIMARY demonstrated significant improvement in sensitivity and negative predictive value with the addition of [68Ga]Ga-PSMA-11 PET/CT (PSMA PET/CT). We hypothesise that PSMA PET/CT can improve the investigation for suspected prostate cancer, without compromising detection of sPCa. **OBJECTIVES:** The co-primary objectives are to estimate the percentage difference in sPCa between the experimental and control arms, and the percentage of participants who avoid transperineal prostate biopsy in the experimental arm. sPCa is defined as Gleason Score 3+4(≥10%)=7, grade

group 2 or higher on transperineal prostate biopsy. Avoidance of transperineal prostate biopsy will be measured at 6 months from randomisation. The primary endpoints will be analysed on the intention-to-treat principle. Key secondary objectives are the percentage difference between arms in insignificant prostate cancer, in complications following biopsy, in health-related quality of life, generalised anxiety, cancer worry, and the health economics impact. **METHODS:** This multi-centre, two-arm, randomised controlled, phase III trial will recruit 660 participants. Eligible patients have PI-RADS 2 with high clinical suspicion of sPCa or PI-RADS 3 on MRI, have never undergone prostate biopsy, <cT3, and PSA ≤20 ng/mL. Participants will be randomised in a 1:1 ratio in permuted blocks, stratified by centre. In the experimental arm, patients will undergo a pelvic PSMA PET/CT. Local and central reviewers will interpret independently, based on the PRIMARY Score. Participants with a positive result will undergo targeted transperineal prostate biopsies, whereas those with a negative result will undergo PSA monitoring, not biopsy. In the control arm, patients undergo template transperineal prostate biopsies. Patients will be followed for subsequent clinical care for up to two years post-randomisation. **CONCLUSION:** Patient enrolment began in March 2022. NCT05154162.

#abs61 | Prostate Cancer Donor Program

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INTRODUCTION AND OBJECTIVES: Effective preclinical research relies on accurate models of prostate cancer. Patient derived xenografts (PDX) are human tumour samples grown in mice and allow preclinical studies on prostate cancers similar to those seen in clinical practice. This allows more accurate preclinical evaluation of treatment options before they are tested in clinical trials. Patients die from prostate cancer that has developed resistance to all available treatments. Therefore in order to accurately test new therapeutic options, PDX from resistant tumours need to be created and collecting these samples has proved challenging. **METHODS:** We created a cancer donor program to allow patients to donate prostate cancer samples after death. This study has HREC approval at Monash Health, Cabrini Health and Bethlehem Calvary Health. Patients are consented and family members also sign consent and indicate whether they wish to receive any information on potential familial cancer genes if they are discovered in the sample. Within 6 hours of inpatient death, the study team retrieves tumour samples via core biopsy and bone marrow biopsy. These samples are immediately xenografted into mice. **RESULTS AND CONCLUSIONS:** To date, 2 patients have consented and 1 patient has had samples collected. The collected sample has been xenografted and tumour cells were present on histology. A follow-up call was made to the family who described the program as a positive experience. Recruitment to the program is ongoing. We will report family satisfaction and xenograft take rates in future publications.

#abs62 | Prostate Cancer Survivorship Essentials for men with prostate cancer on androgen deprivation therapy: protocol of an effectiveness-implementation hybrid (Type 1) randomised trial of a tele-based nurse-led survivorship care intervention (PCEssentials)

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INTRODUCTION AND OBJECTIVES: Androgen deprivation therapy (ADT) is commonly used to treat men with locally advanced or advanced prostate cancer. Men on ADT often experience a number of side effects and often report unmet supportive care needs. An essential part of any quality cancer support is survivorship care. Unfortunately, survivorship care is often not optimally delivered, or easily accessible, and there is currently no survivorship care model for men on ADT. We are undertaking a randomised trial of tele-based nurse-led survivorship care with prostate cancer survivors undergoing ADT to: 1. Determine the effectiveness of a nurse-led survivorship care intervention (PCEssentials), relative to usual care, for improving health-related quality of life (HRQoL) in men with prostate cancer undergoing ADT. 2. Evaluate PCEssentials implementation strategies and outcomes, including cost-effectiveness, with respect to usual care. **METHODS:** This is an effectiveness-implementation hybrid (Type 1) trial with participants randomised to one of two arms: i) minimally enhanced usual care; and ii) nurse-led Prostate Cancer Survivorship Essentials (PCEssentials) delivered over four tele-based sessions, with a booster session six months after session one. Eligible participants are Australian men with prostate cancer commencing ADT and expected to be on ADT for a minimum of 12 months. Participants are followed-up at 3-, 6-, and 12-months post-recruitment. Primary outcomes are HRQoL and self-efficacy. Secondary outcomes are psychological distress, insomnia, fatigue, and physical activity. A concurrent process evaluation with participants and study stakeholders will be undertaken to determine effectiveness of delivery of PCEssentials. **CONCLUSIONS:** ADT is associated with multiple, often debilitating side effects. There is an urgent need for survivorship care in this patient cohort. This study will provide effectiveness and implementation data to inform the potential for implementation of PCEssentials at scale to address this gap.

#abs63 | Prostate-specific antigen (PSA) kinetics following focal low-dose-rate (LDR) brachytherapy for intermediate risk prostate cancer

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INTRODUCTION AND OBJECTIVES: While patterns in PSA kinetics following conventional whole-gland irradiation are well-established, the behaviour of serum PSA following focal treatment with LDR brachytherapy remain less clear. This study aims to evaluate the initial changes in PSA following focal LDR brachytherapy in intermediate risk prostate cancer. **METHODS:** An ongoing, prospective, multi-centre clinical registry of intermediate risk prostate cancer cases treated with focal LDR brachytherapy was utilised. Baseline characteristics were obtained, and serial PSAs recorded at time of implant and three-monthly thereafter. The Memorial Sloan Kettering Cancer Center (MSKCC) algorithm was used for calculation of PSA doubling time (PSADT) and PSA velocity (PSAV). Biochemical recurrence (BCR) was defined by Phoenix criteria of 2 ng/mL above nadir. Patients with fewer than 18 months' PSA follow-up were excluded from the study, and those with fewer than six months' PSA follow-up following nadir were excluded from calculation of PSADT and PSAV. **RESULTS:** Thirty patients with a minimum PSA follow-up of 18 months were included for analysis. Mean (95%CI) baseline PSA and prostate volume were 6.48 (5.69 – 7.26) ng/mL and 36.5 (31.1 – 41.6) mL respectively. Average nadir PSA was 1.76 (1.22 –¬ 2.30) ng/mL, reached within 12.6 (11.0 – 14.2) months. Eighteen (60.0%) patients reached nadir within 12 months, with nine (30.0%) patients ultimately achieving a nadir below 0.5 ng/mL. Average PSADT post-nadir was 21.6 (5.7 – 37.6) months, with PSAV 1.18 (0.72 – 1.64) ng/mL/year. Biochemical recurrence occurred in two (6.7%) patients at 12 and 15 months post-implant. **CONCLUSIONS:** These results illustrate some of the complexities of PSA surveillance following focal LDR brachytherapy, including the limitations of conventional PSA cut-offs for determining treatment success in this cohort. With the majority of prostate tissue remaining unaffected following focal therapy, the Phoenix criteria are unlikely to be appropriate for determining BCR.

#abs64 | Quantifying the prevalence of mental health issues following prostate cancer diagnosis in South Australian men using linked state-wide registry data

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INTRODUCTION AND OBJECTIVES: Prostate cancer diagnoses bring substantial morbidity and uncertainty into men's lives, yet its toll on mental health is ill-defined. We aim to use population level data to describe the prevalence of mental illness following prostate cancer diagnosis. **METHODS:** Linked data from 29,915 men consecutively diagnosed with prostate cancer between 2002 and 2020 in the South Australian Prostate Cancer Clinical Outcomes Collaborative and the South Australian Cancer Registry were analysed. Their data was linked to national prescription data (Pharmaceutical Benefits Scheme), national health service utilisation data (Medicare Benefits Schedule), and state-wide hospital admissions and emergency department presentations data. A panel of mental health and urological professionals identified flags for mental illness within these resources. Prevalence and utilisation rates were extracted for the five years before and after diagnosis. Rates were adjusted for variable follow-up and censoring. **RESULTS:** Fifty percent of men were prescribed at least one psychotropic medication following diagnosis. Mental health service utilisation doubled (30 v. 15 services per 1000 person-years). Hospitalisation and emergency presentations for mental health issues more than doubled (7 v. 3 per 1000-person-years, 5 v. 2 per 1000-person-years respectively). Twenty-five percent of men were on an anti-depressant post-diagnosis, 44% more than prior (RR: 1.44 [95% CI: 1.40 to 1.49]). Anxiolytic use increased by 43% (RR: 1.43 [1.36 to 1.50]) and anti-addiction medication by 36% (RR: 1.36 [1.24 to 1.50]). Emergency presentations for substance abuse (0.76 v. 0.44) and anxiety or stress-related issues (1.18 v. 0.61) almost doubled. Increases in mental-health service use were largely general practitioner delivered, but specialist psychiatrist visits also increased and, to a lesser extent, psychologist and other allied-health input services. **CONCLUSIONS:** Mental illness was more common following prostate cancer diagnosis. Substance abuse and anxiety were particularly over-represented, and Medicare-funded psychology and allied-health services appeared under-utilised compared to pharmacotherapies, highlighting potential areas for intervention and investigation.

#abs65 | Rates of Participation of Aboriginal and Torres Strait Islander and Culturally and Linguistically Diverse communities in ANZUP theranostic prostate cancer clinical trials - current data and future directions

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INTRODUCTION AND OBJECTIVES: ENZA-p (ANZUP1901) and TheraP (ANZUP1603) are two pivotal theranostic clinical trials that have the potential to help men with advanced prostate cancer to live better and longer1, 2 It is well known that ethnic minorities are under-represented in cancer clinical trials, and that they are not adequately captured in standard demographic data collection.3 This study sought to report on the currently collected data from these two studies regarding patients from Aboriginal and Torres Strait Islander and CALD backgrounds. **METHODS:** Both ENZA-p and TheraP

had a single data point regarding Aboriginal and Torres Strait Islander participation and a single data point regarding language spoken at home. This data was analysed using descriptive statistics. **RESULTS:** There were 201 participants in TheraP and 162 in ENZA-p. Of those participants, 1/201 (0.5%) and 2/162 (1.2%) identified as Aboriginal or Torres Strait Islander background. 178/201 (88.6%) and 146/162 (90.1%) used English as the main language at home. 1 participant in each trial used Māori as their main language at home (0.5% and 0.6% respectively). **CONCLUSIONS:** Our data shows that there is limited representation of diversity in current ANZUP trials, especially when compared to the diversity present in the Australian community. However, this also represents one of the few times an Australian cancer clinical trial has reported on diversity of its trial population and we hope this becomes routine. Secondly, the results highlight the limitations of current data collection around diversity in cancer clinical trials. We acknowledge the fact that theranostic trials can only be conducted in certain centres, usually large academic centres, and this may have influenced this data. Nevertheless, greater granularity around country of birth and English proficiency is needed to allow performance tracking and generalisability of trial results. This information will assist in developing strategies to engage with diverse communities and encourage future research participation.

#abs66 | Real World Impact of Germline Genetic Testing Results On Clinical Decision Making for Prostate Cancer Patients

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BACKGROUND: Approximately 10-15% of unselected prostate cancer (PCa) patients (pts) have a pathogenic germline variant (PGV). Identification of a PGV can inform cancer screening, treatment selection, and family cascade testing. Limited data are available on clinician recommendations following germline genetic testing (GGT) in PCa pts. This study collected clinician-reported changes to PCa care (treatment, follow up and cascade testing) based on GGT results. **METHODS:** Unselected PCa pts were prospectively recruited from 15 community and academic urology practices. Pts underwent an 84-gene panel test and results were grouped as positive (≥1 PGV), VUS (variant(s) of uncertain significance)-only, or negative. Clinician recommendations were collected via electronic case report forms 60-90 days post GGT. Statistical significance was determined by two-tailed Fisher's exact test and significance was set at p<0.05. Results: 982 predominantly white (76%), non-metastatic (81%) PCa patients were recruited; 50% met 2019 PCa National Comprehensive Cancer Network (NCCN) GGT criteria. 102 PGVs in 24 cancer risk genes, most commonly CHEK2 and BRCA2, were identified in 100 (10%) pts, 50% of whom did not meet GGT criteria. Positive pts had 243 recommendations made and were more likely to have changes to treatment, follow up and cascade testing than those with negative or VUS-only results. Among positive pts, there were no significant differences in recommendations for pts who met NCCN criteria versus those who did not. Significantly more treatment changes were made for metastatic pts than non-metastatic pts and those with Grade Group 4 and 5 disease compared to Grade Group <4 disease (p=0.05 and p=0.02, respectively). **CONCLUSIONS:** This study showed that GGT did influence PCa pt care and lends support to universal testing of PCa pts. Genetics education and post-test genetic counselling should continue to be encouraged.

#abs67 | Real-world Clinical Outcomes in Non-metastatic (M0) Castration-Resistant Prostate Cancer (CRPC) Patients in Australia

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INTRODUCTION: The non-metastatic castrate resistant prostate cancer (M0 CRPC) treatment landscape has evolved following the availability of second generation androgen receptor signalling inhibitors (ARSIs) that improve both metastasis-free survival (MFS) and overall survival (OS). Given the recent approval of Enzalutamide, Apalutamide and Darolutamide via the Pharmaceutical Benefits Scheme, we aimed to assess real-world treatment patterns in Australian M0 CRPC patients. **METHODS:** We identified patients with no metastases at time of CRPC diagnosis from the electronic Prostate Cancer Australian Database (ePAD), a multi-center online clinical registry collecting treatment and outcome data from consecutive prostate cancer patients. Primary outcomes were treatment patterns, patient and disease characteristics, MFS and OS. **RESULTS:** We identified 158 M0 CRPC patients, diagnosed between June 2006 and August 2022. The median age at time of CRPC was 75 years (Range: 37-94 years). 38% (60/158) of these patients had a Gleason score of ≥ 8 and 67% (106/158) had an ECOG of 0. 69% (109/158) had prior local therapies including 30% (47/158) with previous prostatectomy. Median time to CRPC was 43 months (Range: 1-303 months). PSA doubling time was <6 months in 41% (63/158) and 7-12 months in 85% (28/158). 73 patients (46%) received systemic therapy for M0 CRPC, 79% (58/73) of whom received an ARSI, (53% (39/73) Enzalutamide, 26% (19/73) Darolutamide). The 12 month MFS in the Enzalutamide and Darolutamide groups were 90% and 70% which is comparable to those in PROSPER and ARAMIS studies. Median MFS and OS were not reached. **CONCLUSIONS:** Our study is the largest real-world report of M0 CRPC treatment patterns in Australia. The results reflect the recent approval of ARSIs in Australia and preliminary outcomes are consistent with those of pivotal studies. As outcome data mature, further analysis of real-world survival impact and toxicity will allow comparison of treatment choices and further inform clinical care.

#abs68 | Real-world data from early access and patient access programs of avelumab first-line maintenance treatment in patients with locally advanced or metastatic urothelial carcinoma in Australia

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INTRODUCTION AND OBJECTIVES: In the phase 3 JAVELIN Bladder 100 trial (NCT02603432), avelumab first-line maintenance (1LM) + best supportive care (BSC) significantly prolonged overall survival vs BSC alone in patients with advanced urothelial carcinoma (aUC) that had not progressed after 1L platinum-based chemotherapy (PBC). Avelumab 1LM is now recommended as standard of care in international guidelines with level 1 evidence. We report real-world data from early access and patient access programs (EA/PAPs) of avelumab 1LM therapy in patients with aUC in Australia. **METHODS:** Data were collected from Australian EA/PAPs from February 2021 to September 2022, before the reimbursement of avelumab in Australia (October 2022). Patients eligible for data collection had aUC, were progression-free following 1L PBC, and had received ≥1 avelumab dose. Avelumab treatment duration was estimated by the Kaplan-Meier method. **RESULTS:** 295 patients (median age, 73.9 years [interquartile range, 67.0-78.5]) received avelumab; the majority were male (79%) and from New South Wales (34%) or Victoria (27%). Most patients had received carboplatin and/or cisplatin + gemcitabine (94%), and the median number of 1L PBC cycles was 4. For 164 patients with available data, the median treatment-free interval (date from end of 1L PBC to avelumab initiation) was 35 days (interquartile range, 28-49). At the time of analysis, 123 of 295 patients (42%) had discontinued avelumab, most commonly due to progressive disease (66%) and adverse events (15%). Of 264 patients with available data, an estimated 35.1% (95% CI, 27.1-43.1) remained on avelumab after 1 year. The estimated median time on avelumab treatment was 37 weeks (95% CI, 31-42). **CONCLUSIONS:** These real-world data provide insights about how avelumab 1LM, which is the standard-of-care treatment for patients with aUC whose disease has not progressed

with 1L PBC, is being incorporated into treatment practice in Australia. **FUNDING STATEMENT:** This study was sponsored by Merck (CrossRef Funder ID: 10.13039/100009945) as part of an alliance between Merck and Pfizer. Medical writing support was provided by Manoshi Nath on behalf of Clinical Thinking and was funded by Merck and Pfizer.

#abs69 | Real-world prescribing patterns for first-line and maintenance treatment of patients with advanced urothelial cancer (UC)

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INTRODUCTION AND OBJECTIVES: Clinical trials demonstrated improved survival for advanced UC from maintenance avelumab, however real-world outcomes remain uncertain for patients who may be frail, elderly or have comorbidities. We describe treatment patterns for first-line therapy and avelumab use in a real-world population.

METHODS: Data was analysed from BLADDA, an Australian multi-site, prospectively-maintained UC registry containing >600 participants, diagnosed since 2011 at selected sites. Eligible individuals had predominant urothelial histology, received first-line, palliative-intent systemic therapy, and sufficient data for analysis. **RESULTS:** 123 individuals were eligible; 75.6% male, median age 70 years (range 29-86), 61% had denovo metastatic disease. Evaluable data revealed 43.9% had visceral metastases, 96.5% performance status (ECOG) 0-2 and 63.1% eGFR>60mL/min. Hearing impairment (13.2%) and neuropathy (1.1%) were pre-existing. The predominant first-line treatments were carboplatin/gemcitabine (35.8%) and cisplatin/gemcitabine (35%; 76.8% standard, 23.2% split-dose). Of these, 78.2% received ≥4 cycles and 39.1% ≥6. 65.5% completed planned treatment. 13.8%, 9.2% and 3.4% stopped due to toxicity, progressive disease, and death, respectively. Dose reductions occurred upfront (9.2%) and during treatment (42.5%), 18.4% had dose delays. Carboplatin-based chemotherapy was preferred to cisplatin if eGFR<60mL/min (OR 3.95, 95%CI 1.45-10.74). Since 2011, 64.7% patients potentially eligible for avelumab received maintenance. Other first-line treatments included immunotherapy in 13.8%, almost all (94.1%) of whom recurred after perioperative chemotherapy; 10.6% received treatment on a clinical trial. The overall response rate to any first-line treatment was 60.3%. 69.7% of all patients received second-line treatment. From first-line palliative treatment; median overall survival was 19.12 months (95% CI 13.8-24.5) with a median follow-up of 25.1 months, and the median progression-free survival was 10 months (95% CI 7.4-15). **CONCLUSIONS**: Real-world first-line palliative systemic therapy yielded comparable responses, progression-free and overall survival to existing trial data, despite comorbidities including renal impairment. Uptake of maintenance avelumab appears suboptimal and may represent access barriers.

#abs70 | Revolutionary New Protocol. A Prospective Trial for Nurse-Led Post Radical Cystectomy Follow Up

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INTRODUCTION: In 2021 an evidence-based risk-stratified radical cystectomy protocol was developed, with the intention of implementing the protocol in a prospective trial to compare outcomes before and after implementation. **OBJECTIVES:** This work revolutionises the post operative follow up of cystectomy patients. A comprehensive post radical cystectomy follow-up protocol can be implemented by suitably trained nurses. **METHODS:** A retrospective audit was conducted via reviewing the digital medical record for all post cystectomy patients since 2015 until 2021. Their follow up investigations were recorded and reviewed against the proposed protocol. A literature review was conducted which resulted in the development of the evidence-based follow-up protocol. This new protocol was ratified by an expert national body for review and consensus. The prospective trial was then commenced in a major tertiary teaching hospital in Australia. Data was collected live from March 2021- January 23 and analysed in 2023 looking at the following outcomes: successful adherence to the protocol, retrospective audit comparison and cost analysis. **RESULTS:** In the retrospective trial, there was heterogeneity of the doctor providing the follow up consultation and therefore varied adherence to the protocol. We found that some patients were either lost to or inadequately followed up. In the prospective trial patients follow up was largely on schedule and well documented patient factors were main contributors to non-adherence. The nurse-led protocol driven follow up was more precise and systematic than conventional doctor led follow up in all measures including: imaging, blood tests, cytology and ureteroscopy. Additionally, a nurse led follow up was more cost efficient to deliver compared to doctor led consultations. **CONCLUSION:** Post radical cystectomy patients can be followed-up with a single comprehensive protocol administered via a nurse led clinic. Nurses have been shown to be rigorous and methodical in follow up and may provide a better service at reduced cost.

#abs71 | Salvage Prostatectomy Following Neoadjuvant Radioligand Therapy: Prospective Evidence of Surgical Difficulty from the Lutectomy Trial

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INTRODUCTION & OBJECTIVES: Lutetium-177 attached to prostate-specific membrane antigen (LuPSMA)-617 has proven effective for treating metastatic prostate cancer (PCa). LuTectomy is an open-label phase I/II prospective clinical trial evaluating the dosimetry, efficacy, and toxicity of neoadjuvant LuPSMA in men with high-risk localised/locoregional advanced PCa and high PSMA tumour expression before curative intent robot-assisted radical prostatectomy (RARP) with pelvic lymph node dissection (PLND). Here we present a video abstract describing the surgical findings and intraoperative technique for this novel patient population. **METHODS:** Men with high/intermediate-risk (International Society of Urological Pathology (ISUP) Grade 3-5) and/or locoregional (cN1) PCa based on International Society of Urological Pathology (ISUP) standards. All men underwent 68Ga-PSMA positron emission tomography (PET) staging, and those with PSMA avidity of SUVmax ≥20 were considered for inclusion. Ten patients received one dose of LuPSMA, and ten received 2 LuPSMA doses in six-week intervals. Standard RARP + PLND was performed six weeks after treatment completion. Experienced uro-oncologists performed all procedures, and videos were centrally reviewed

for surgical difficulty and tissue treatment effect. **RESULTS:** Eight (40%) patients demonstrated visible treatment effects noted by the operative team during RARP and PLND. Central assessment of operative videos assessed five (25%) having increased (level 2) surgical difficulty. The video highlights cases where focal effect from LuPSMA treatment was observed during RARP + PLND. Tips for safe dissection are described, and a comparison is made to the previous experience of salvage prostatectomy following conventional radiotherapy. **CONCLUSIONS:** Salvage prostatectomy following neo-adjuvant radioligand therapy represents a novel operative patient population where focal treatment effects were unique to conventional radiotherapy. Here we demonstrate that experienced uro-oncologists can safely perform salvage prostatectomy following neoadjuvant LuPSMA therapy with minor adaptions to the traditional RARP + PLND technique. Ongoing follow-up and further studies on a large, randomised patient population are needed to determine the future role of curative intent neoadjuvant LuPSMA before prostatectomy.

#abs72 | SPADE: Design of a real-world observational study of avelumab first-line maintenance (1LM) in advanced urothelial carcinoma in the Asia-Pacific region

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INTRODUCTION AND OBJECTIVES: Urothelial carcinoma (UC) is common, with >200,000 new cases reported in 2020 in the Asia Pacific (APAC) region. In the global Phase JAVELIN Bladder 100 trial, avelumab 1LM + best supportive care (BSC) significantly prolonged overall survival (OS) and progression-free survival (PFS) versus BSC alone in patients with advanced UC who had not progressed with first-line (1L) platinum-containing chemotherapy (median OS, 23.8 vs 15.0 months [p=0.0036]; median PFS, 5.5 vs 2.1 months [p<0.0001]), leading to regulatory approvals worldwide, and incorporation into international treatment guidelines with level 1 evidence. Here, we describe the design of SPADE, an ongoing, real-world, non-interventional study of avelumab 1LM in patients with advanced UC in the APAC region. **METHODS:** SPADE is a multicenter, prospective, observational study ongoing in Australia, Hong Kong, India, Japan, Republic of Korea, Singapore, Taiwan, and other countries. Overall, 286 patients with unresectable locally advanced or metastatic (stage IV) measurable UC of any histology that has not progressed with 1L platinum-containing chemotherapy, for whom avelumab 1LM therapy is planned, will be enrolled. All patients will receive avelumab 800 mg intravenously every 2 weeks (or per local marketing authorization) and will be followed up for 12 months or until avelumab discontinuation. Data collected will include patient demographics, treatment details for 1L platinum-based chemotherapy (regimen, cycles, and response per RECIST), treatment details for avelumab 1LM, and treatment outcomes with avelumab 1LM (6- and 12-month OS and health-related quality of life [HRQoL]). OS will be analyzed using the Kaplan–Meier method. HRQoL will be measured using the EQ-5D-5L and National Comprehensive Cancer Network/Functional Assessment of Cancer Therapy Bladder Symptom Index (NCCN/FACT FBISI-18) questionnaires. An interim analysis is planned after ~30% of patients have been enrolled. This abstract was accepted and previously presented at the 2023 ASCO Genitourinary Cancers Symposium.

#abs73 | The Carbon Footprint of Reusable Versus Single use Flexible Cystoscopes for Bladder Cancer Diagnosis and Surveillance.

Lee, Ashley - Author

INTRODUCTION: The flexible cystoscope is an integral part of bladder cancer diagnosis and surveillance as well as many other urological purposes. Recently single use cystoscopes have emerged in the market claiming convenience, accuracy, and cost efficiency. This project investigates the environmental impact of single use versus reusable flexible cystoscopes. **OBJECTIVES:** To advise urologists of the most environmentally superior product to use in their daily practice. The hypothesis is that reusable cystoscopes with multiple uses over the lifetime of the product will be the more environmentally sound option. **METHODS:** A literature review was conducted using online scholarly search engines. Looking exclusively at flexible cystoscopes excluding ureteroscopes. The brands for comparison were Ambu for the single use and Olympus for the reusable. Five key articles met the search criteria and were analysed for credibility, thoroughness of investigation and lack of sponsorship. **RESULTS:** Commonalities discussed in the articles were: waste, C02 emitted for the lifecycle of the product from manufacturing to disposal, water usage, disinfection and sterilisation. Each of the articles reviewed slightly different outcome parameters. Many studies were international and data regarding energy use is difficult to be translated. Hospital based research is not translational as hospitals vary in their waste disposal policies. The case vs case analysis results differed from the lifecycle analysis results in that on a single case by case analysis the Olympus scope was superior and on a lifecycle analysis the Ambu scope was superior. **CONCLUSION:** The primary contributor to the lifecycle carbon footprint of reusable cystoscopes is energy consumption of reprocessing the instrument and repairs. Moving into the future this can be a focus for improvement in hospital environmental sustainability policy. Changes in the utilisation of water, energy and decontamination products can be offset with recyclable, renewable and safer products.

#abs74 | The Environmentally Sustainable Pathway for Prostate Cancer Investigation. The Carbon Footprint of the One Stop Prostate Clinic Versus the Usual Care Pathway.

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INTRODUCTION: The provision of high-quality modern urological care is a credit to Australia's healthcare system. However, this comes at a considerable cost to the environment with resource use contributing to landfill, CO2 emissions and pollution. Strategic planning and forethought are necessary to develop innovative strategies for reducing the impact of urological care on the environment. **OBJECTIVES:** To analyse the environmental impact of streamlining prostate cancer diagnosis into only one or two in person clinical episodes, compared to the standard model of three. This new standard of care provides more equitable access to healthcare to rural men requiring investigation for prostate cancer and is hypothesised to have reduction on C02 emissions from travel. **METHODS:** A retrospective quantitative analysis of the patient journey on the Usual Care Pathway (UCP) was analysed comparing the journey for the One Stop prostate clinic (OSPC). The journey map used refers to the report published by the instigating institution (1). The carbon footprint of men's attendance was calculated using the air travel emissions expressed in C02/ RPK for rural patients and road travel via vehicle in C02/km for metro patients. Travel was the exclusive parameter used in this analysis. **RESULTS:** Between 2011 and 2017, 1000 men attended the clinic. The OSPC generated 1076 less consultations which equated to 543 in person patient episodes for rural men saving 1.5 million km of travel. Fuel burn monitoring and C02 estimation is based on the International Council on Clean Transportation data (2) And vehicle emissions from the National Transport Commission (3). The C02 saved for metropolitan patients is 4.2 tonnes C02. And rural patients saved 439 tonnes of C02. **CONCLUSIONS:** This work has demonstrated a considerable reduction in the carbon footprint of investigating for prostate cancer. This approach is safe, effective and a more environmentally sustainable pathway which should be adopted by other urology departments.

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#abs75 | The initial Australian experience with intracavitary Jelmyto instillation for low grade upper tract urothelial cancer

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INTRODUCTION & OBJECTIVES: Low grade upper tract urothelial cancer (UTUC) is typically initially managed with a kidney-sparing approach. However, this is associated with a high rate of recurrence. Chemoablation with mitomycin-containing reverse thermal gel (Jelmyto®) is shown to have a complete response rate of 59%. We describe the first case in Australia of intracavitary Jelmyto® instillation for low grade UTUC. **METHODS:** A patient treated with induction intracavitary Jelmyto® at our institution was prospectively reviewed. The emergency treatment protocol was weekly instillations of Jelmyto® (16 mg) for six doses via a nephrostomy. Weekly blood tests and toxicity were assessed. Therapeutic Goods Administration (TGA) and local institutional approvals were obtained. **RESULTS:** The patient was a 56-year-old female with Lynch syndrome. A 7 mm right pelviureteric junction lesion in her solitary kidney was discovered on surveillance CT-IVU following left nephroureterectomy in 2018 for high grade non-invasive UTUC. Biopsy confirmed low grade non-invasive UTUC. Despite endoscopic ablation and induction intravesical gemcitabine with a ureteric stent in situ, persistent tumour was evident on endoscopic assessment. A nephrostomy was placed by interventional radiology prior to treatment. All six instillations were completed. Symptoms reported were grade 1 pruritus, anorexia, headache, nausea, constipation and fatigue as per Common Terminology Criteria for Adverse Events. Serum investigations were normal throughout treatment period. Ureteropyeloscopy and retrograde pyelogram five weeks post-treatment demonstrated complete response with no evidence of ureteric stricture. The one-year post-treatment CT-IVU demonstrated no occult lesion nor any filling defect, accompanied by negative urine cytology monitoring. **CONCLUSIONS:** Our initial experience with Jelmyto® demonstrates it is well tolerated and an effective kidney-sparing treatment for low grade UTUC. Although Jelmyto® has not been approved for general use by the TGA, special access can be granted and should be considered in an Australian context where radical treatment for UTUC has a higher morbidity than usual.

#abs76 | Treatment patterns and criteria used to determine platinum eligibility in metastatic urothelial cancer: a real-world survey in Australia

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INTRODUCTION: Treatment guidelines for metastatic urothelial cancer (mUC) recommend first-line (1L) treatment based on platinum eligibility. In Australia, at data collection, the standard approach for 1L treatment of mUC was platinum-based chemotherapy (PBC), whilst immune checkpoint inhibitors (ICIs) were commonly used as second-line treatment. This study investigated treatment patterns and clinical practice criteria used to determine platinum eligibility in patients with mUC in Australia. **METHODS:** Data were drawn from the Adelphi mUC Disease-Specific Programme, a cross-sectional survey conducted in December 2021-June 2022 in Australia. Oncologists/urologists extracted data from medical charts for their next 8 consecutive eligible adult patients with mUC. Demographics, clinical characteristics, and treatment patterns were collected. Descriptive analyses were conducted. **RESULTS:** 29 physicians

provided data on 239 patients (mean age, 70 years [sd 9.61]); male, 72%; ECOG performance status [PS] 0-1, 71%). The most common initial tumour location was bladder (84%), and the most common metastatic sites were lymph node (66%), visceral organ (64%), and bone (32%); 30% of patients had 1 metastasis, 38% had 2, and 32% had ≥3. Of patients with known platinum-eligibility status at 1L (n=236), 90% (n=213) were platinum-eligible (54% cisplatin-eligible, 36% carboplatin-eligible/cisplatin-ineligible). Renal function and ECOG PS were considered most frequently regarding eligibility for cisplatin (92%/65%) and carboplatin (86%/40%). On average, cisplatin-eligible patients were younger than cisplatin-ineligible patients (66.0 vs 73.5 years). Of cisplatin-eligible patients (n=128), 84% received PBC (cisplatin in 81% [n=104]; carboplatin in 3% [n=4]), and 16% (n=20) received ICI treatment. Of carboplatin-eligible/ cisplatin-ineligible patients (n=85), 91% (n=77) received PBC (cisplatin in 2% [n=2]; carboplatin in 88% [n=75]). **CONCLUSIONS:** A majority of patients with mUC in Australia were platinum-eligible, and these patients primarily received 1L PBC. Future studies should continue to evaluate concordance with and deviation from guideline recommendations, and outcomes by platinum eligibility. This data is required for determining subsequent treatment options.

#abs77 | Ultra-sensitive detection of circulating tumour DNA enriches for patients with higher risk disease in clinically localised prostate cancer

Corcoran, Niall - Author

INTRODUCTION: Circulating tumour DNA (ctDNA) has demonstrated utility for diagnostic and prognostic applications in many cancer types. However, previous methods have proven less effective in localised prostate cancer. We assessed the limits of detection of ctDNA in this context using the high-sensitivity INVAR method, and tested the hypothesis that ctDNA detection is associated with high risk disease. **METHODS:** A total of 128 individuals with clinically localised prostate cancer were selected, and 27 healthy individuals were included as negative controls. Plasma cell-free DNA (cfDNA) samples from cases and controls were profiled using custom targeted sequencing panels, with saturating coverage of patient-specific mutations identified by WGS. We assessed ctDNA detection in cases using the highly sensitive INVAR pipeline, leveraging consensus sequencing alignments, background error modelling and integration of signals across thousands of patient-specific variants. Biochemical recurrence and metastasis-free survival curves were used to assess the relationship between ctDNA detection and disease progression. **RESULTS:** We combined signals across the maximum number of genome-wide patient specific mutations and leveraged an established analysis pipeline that corrects for background error rates and calculates a global integrated mutant allele fraction. ctDNA was detected in 9.3% of cases. Furthermore, ctDNA detection was significantly associated with biochemical recurrence ($p=0.01$) and shorter metastasis-free survival ($p < 0.0001$). **CONCLUSION:** Our study provides clear insights into the required analytical sensitivity and potential utility of ctDNA analysis in localised prostate cancer. This raises the potential for including ctDNA detection as an additional tool for patient stratification in future neo/adjuvant treatment trials.

#abs78 | Unmet needs in prostate cancer care

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INTRODUCTION AND OBJECTIVES: Patient reported outcome measures are effective in identifying key outcomes for those diagnosed with and treated for prostate cancer in a clinical trial. The main objective of this study was to identify unmet needs for men diagnosed and treated for prostate cancer within a large public health service. **METHODS:** A cross sectional survey was created which included demographic information and qualitative questions exploring patient experience and a validated patient reported outcome measure (Supportive Care Needs Survey Short Form 34). The survey was distributed to all men that had accessed prostate cancer services through our tertiary teaching hospital in the last 12 months. Quantitative analyses included descriptive, chi square and regression analyses. Qualitative analyses included a framework method with two researchers. Mixed methods analysis was completed using an embedded correlational model. **RESULTS:** 162 of 387 patients chose to take part. The highest ranked items with unmet needs related to domains about sexual health, followed by

mood and information sources. Qualitative data also identified 'relationships', 'information' and 'the value of hindsight' as key themes. Those who identified 3 or more unmet needs expressed treatment regret (p=0.01). **CONCLUSIONS:** Mixed methods approaches using patient reported outcomes can effectively identify key areas of interest. This study identified that unmet needs for men impacted by prostate cancer are not well understood. Further research that investigates interventions that directly meet the needs of men, and their supports, are warranted.

#abs79 | Upper tract urothelial carcinoma survival and stage at diagnosis between different ethnicities in the US population: A SEER analysis

Qin, Shane - Author; Woon, Dixon - Co-Author 1; Ischia, Joseph - Co-Author 2; Tempo, Jake - Co-Author 3

INTRODUCTION AND OBJECTIVES: Urothelial carcinoma (UC) is the 6th most common cancer in developed countries. It can be classified into lower and upper urinary tract tumours. Bladder tumours account for the majority of UCs (over 90%) while upper tract urothelial carcinomas (UTUC) account for 5-10%. Risk factors include smoking, aristolochic acid and Lynch syndrome. Patients who are black or Hispanic have poorer cancer outcomes in the US and this has been well reported in literature. Over 5% of the US population is people of Asian ethnicity and this group is under-represented in epidemiological studies. **METHODS:** Data were extracted from the Surveillance, Epidemiology and End results (SEER) Program database of the National Cancer Institute (NCI) in the United States for all patients diagnosed with UTUC between 1988 and 2014. Demographics were analysed, including ethnicity, insurance and marital status. Multivariable logistic regression and competing risks analysis were performed for overall survival and metastases at diagnosis. **RESULTS:** 12,124 patients were identified, 87.7% Caucasian, 6.5% Asian and 4.8% Black. Patients of Asian ethnicity were found to have a statistically significant higher risk of metastatic UTUC at diagnosis with an Odds Ratio of 1.38 (95%CI 1.09-1.74) compared to the Caucasian population. Despite no difference in surgical management, the risk of UTUC in Asian patients was higher than Caucasian patients (HR 1.27, 95% CI 1.10-1.45). **CONCLUSIONS:** UTUC is an important urological cancer however it is not as well studied as bladder cancer. Patients of Asian ethnicity have worse overall survival and present with more advanced disease. Further exploration of socioeconomic risk factors and genetics for UTUC in Asian patients are required.

#abs80 | Using computer adaptive testing to assess Quality of Life in Cancer clinical trials

Mulhern, Brendan - Author; Ng, Carrie-Anne - Co-Author 1; Luckett, Tim - Co-Author 2

Patient Quality of Life (QoL) in cancer clinical trials is generally assessed using fixed form Patient Reported Outcome Measures (PROMs) such as the EORTC QLQ-C30 and the FACT-G. The advantage of fixed form PROMs is that they provide comparable scores across the key domains of QoL both internally (within a trial) and externally (for example with published data). However, fixed form instruments are a potential burden for patients, and certain items or domains may not be relevant. In response to these issues, Computer Adaptive Testing (CAT) instruments for use in the assessment of QoL have been developed. CAT instruments include 'banks' of items that have been calibrated using psychometric approaches. This generates flexible instruments that can iteratively deliver a targeted set of items to patients based on their previous responses, with all patients still scored on the same scale. The most well-known CAT based instruments are the Patient Reported Outcome Measurement System (PROMIS) item banks. There are also CAT versions of the symptom and functional domains included in the EORTC QLQ-C30. The use of these CAT instruments in cancer clinical trials is limited, partly due to lack of knowledge about their development, use, and advantages and disadvantages. Therefore, the aim of this presentation is to introduce CAT approaches to the ANZUP membership. The presentation will include an overview of the approaches, and how they can practically be implemented in trials. The advantages presented will include the potential to reduce patient burden whilst increasing measurement precision. Disadvantages presented will include practical considerations such as the complexity of programming CAT within trial data collection software, and the lack of knowledge about how to implement CAT, and interpret the data. Other disadvantages discussed

will be the lack of comparability with other trial data. Solutions to these issues will be discussed.

#abs81 | VIOLET: A phase I/II trial eValuation of radIOLigand treatment in mEn with metastatic castration-resistant prostate cancer with [161Tb] Tb-PSMA-I&T

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INTRODUCTION: Lutetium-177-PSMA is an effective therapy for men with metastatic castration-resistant prostate cancer (mCRPC). Progression remains inevitable, partially explained by micrometastases. Terbium-161 has abundant emission of Auger electrons that deposit a higher concentration of radiation over a shorter path, particularly to single tumour cells and micrometastases. We hypothesise that Terbium-161-PSMA will deliver effective radiation with an acceptable safety profile. **OBJECTIVES:** The co-primary objectives are to establish the maximum tolerated dose and safety profile [CTCAE v5.0] of [161Tb]Tb-PSMA-I&T. Secondary objectives include measuring absorbed radiation dose [Gray], evaluating anti-tumour activity [PSA 50% response rate, radiographic and PSA progression-free survival, overall survival, objective response rate], and evaluation of pain [BPI-SF] and health-related quality of life [FACT-P and FACT-RNT] over the first 12 months after treatment commences. Exploratory objectives include ctDNA analysis at baseline, during treatment and at progression, to determine biomarkers of treatment response and resistance. **METHODS:** This single-centre, single-arm, phase I/II trial will recruit 30 to 36 men with progressive mCRPC. The phase I dose-escalation is designed with a 3+3 model to establish the safest dose of [161Tb]Tb-PSMA-I&T (dose levels: 4.4, 5.5 and 7.4 GBq). The phase II dose-expansion will include 24 participants. Up to six cycles of [161Tb]Tb-PSMA-I&T will be administered intravenously every six weeks. Key eligibility criteria include a diagnosis of mCRPC with progression after at least one line of taxane chemotherapy and a second-generation anti-androgen, PSMA-positive disease on PSMA PET/CT (SUVmax ≥20), no sites of discordance on FDG PET/CT, adequate bone marrow, hepatic and renal function, ECOG performance status ≤2, and no prior treatment with another radioisotope. **CONCLUSION:** Patient enrolment began in October 2022. NCT05521412

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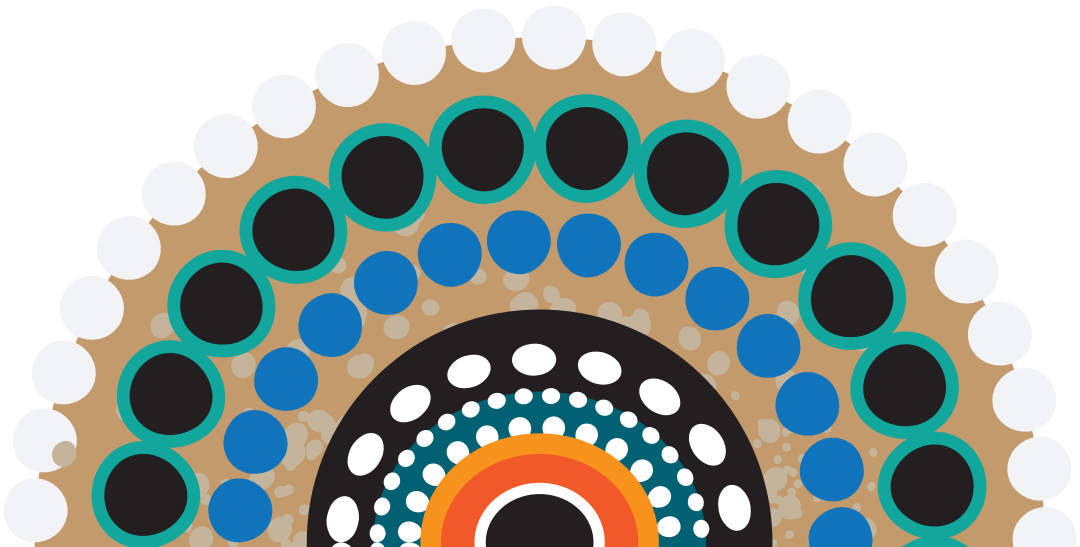

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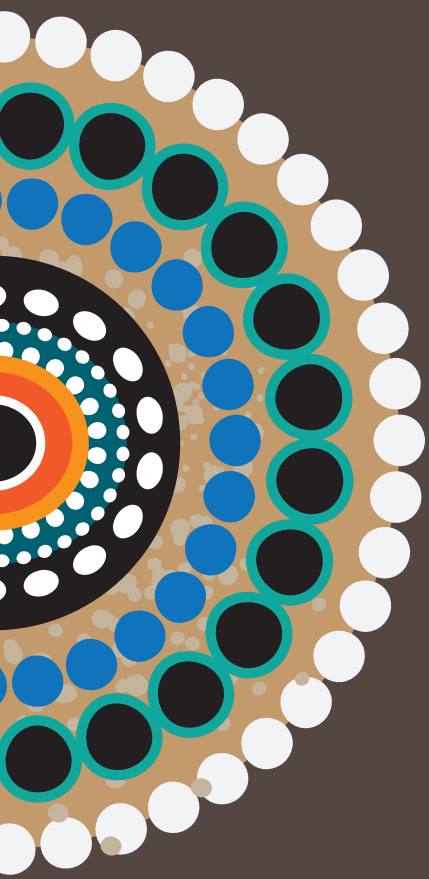

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