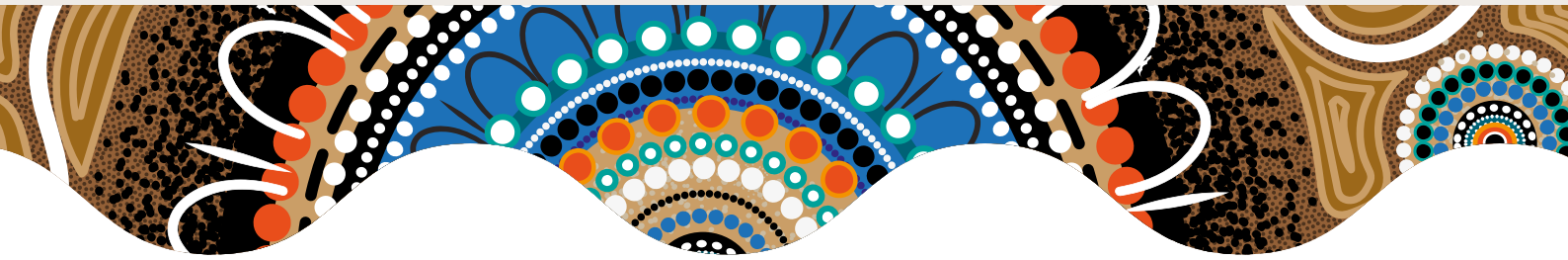
ANZUP
Cancer Trials Group Limited

ASIA-PACIFIC JOURNAL
OF CLINICAL ONCOLOGY
Volume 20, Issue S1



ANNUAL SCIENTIFIC MEETING

21–23 JULY 2024 • 'MAKING WAVES'

GOLD COAST CONVENTION & EXHIBITION CENTRE

Program and Abstracts

WILEY

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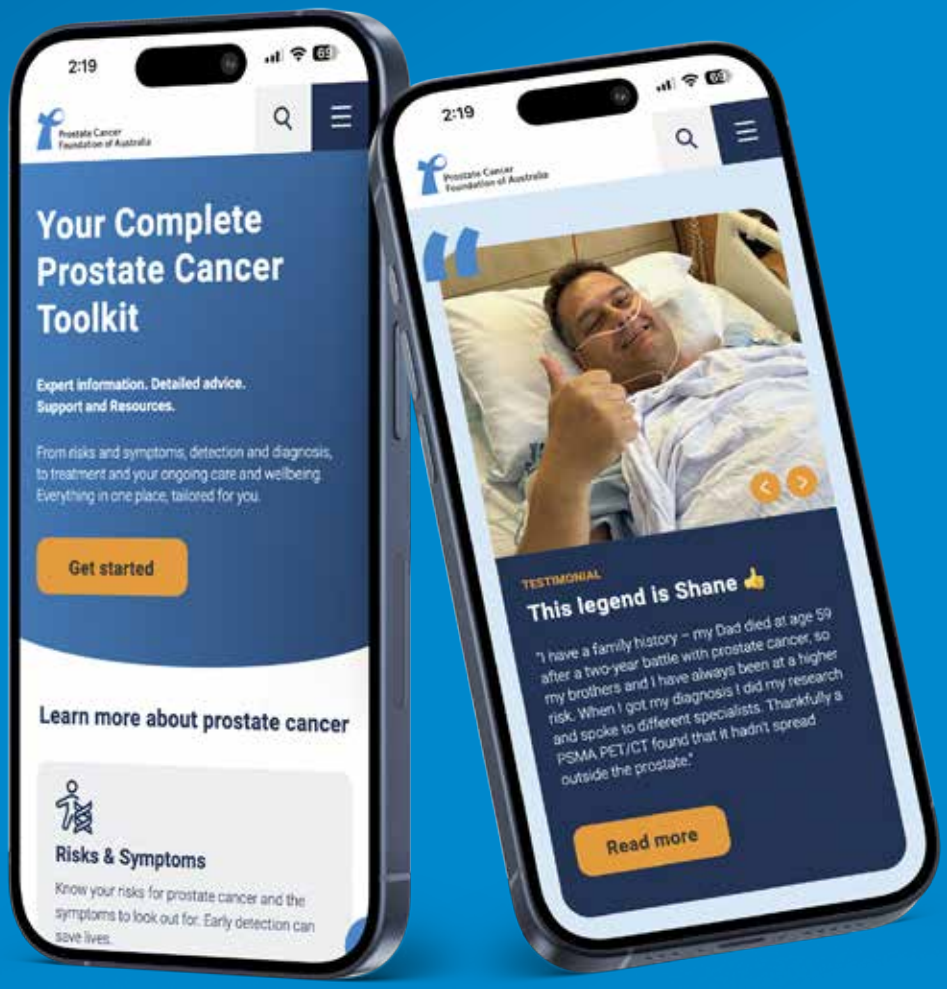

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ONCOLOGY

Astellas Pharma Australia Pty Ltd. ABN 81 147 915 482. Suite 2.01, 2 Banfield Road, Macquarie Park, NSW 2113.
Date of preparation: September 2021. XTD_2021_0056_AU. WED1624.

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ONCall

The new and improved ONCall website is here!

We've recently enhanced the ONCall website and a new user-friendly experience awaits. We're excited to provide you a better way to view the latest data, expert insights, clinical and patient resources and so much more.

What's new:

- User-friendly interface
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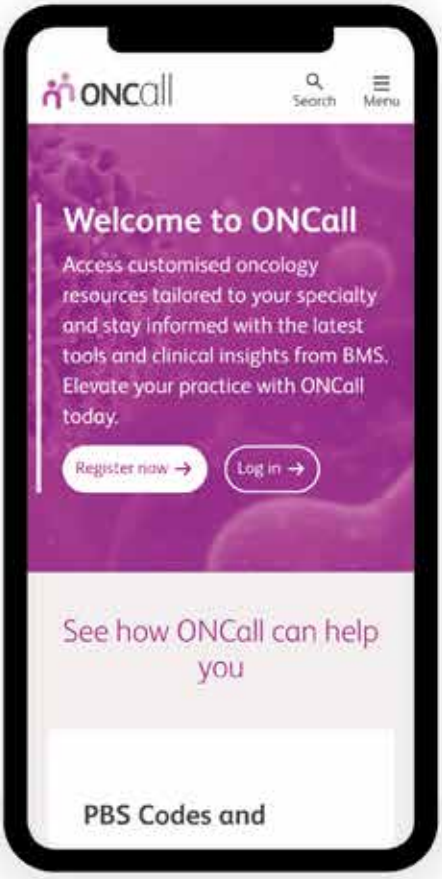
- Customised content based on your field of practice or area of interest



Exclusive content on **genitourinary cancers** now available on **ONCall**

Access a range of resources, including video highlights from international experts, educational case studies and the most recent updates from our key clinical trials in renal cell and muscle-invasive urothelial carcinomas.

How to access

1. Scan the QR code or visit www.bms-oncall.com.au
2. Create an account to verify that you are a healthcare professional
3. Provide your preferences to personalise your experience

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Your login details will remain the same. If you've forgotten your password, click 'Forgot password?' on the login page.

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BMS Medical Information: 1800 067 567. Bristol-Myers Squibb Australia Pty Ltd, ABN 33 04 333 322, 4 Nexus Court, Mulgrave, VIC 3170. 1506-AU-2400196. June 2024. BRMSOY0216.

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Josie Downey,
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SAVE THE DATE

ANZUP 2025 ANNUAL SCIENTIFIC MEETING

20-22 JULY, 2025

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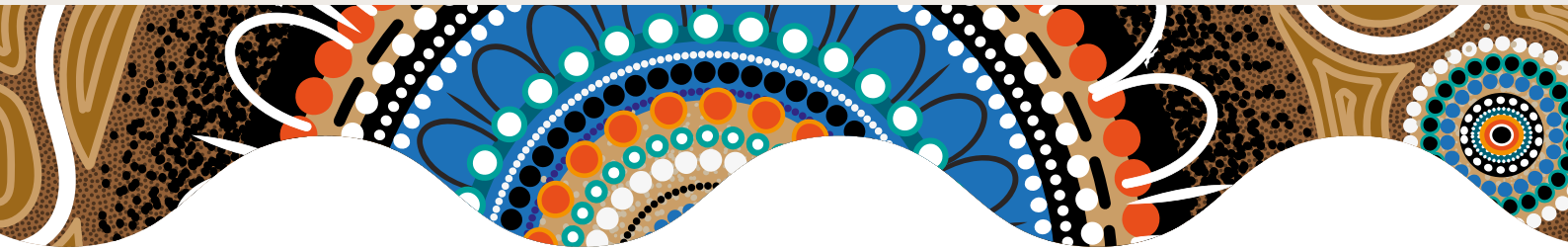

ANNUAL SCIENTIFIC MEETING

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2024 ANZUP ANNUAL SCIENTIFIC MEETING

'M AKINGWAVES'

Contents

ANZUP Chair Welcome


Ian Davis

I wish you a very warm welcome to the 2024 Annual Scientific Meeting (ASM) of ANZUP, the Australian and New Zealand Urogenital and Prostate Cancer Trials Group!

Genitourinary cancers collectively comprise the most common types of cancer affecting our community. However, awareness of these cancers is lower than it should be; and the critical importance of clinical trial research is also under-recognised. We know that the only meaningful outcomes in medical treatment arise from meticulous and carefully designed clinical trials, that identify key clinical questions, understand the scientific landscape, devise experiments to try to improve the situation, interpret the results in the context of what is known when the trial finally completes, and then translates and implements that evidence into practice. That was one long run-on sentence, but the reality is that it reflects many years of work, huge commitment of financial and other resources, and the generous donations of time and expertise by many people, over long periods of time – for each clinical question.

We do this because ANZUP is here to improve the lives of everyone affected by bladder, kidney, testicular, penile, and prostate cancers. Carefully performed and meaningful clinical trials are the best way to generate the evidence we all need to be able to reach that objective. We also need to foster, mentor, and support everyone involved in the process, to ensure that what we are doing now is best practice on global standards, and that we set ourselves up for sustainability in the future.

The ANZUP Annual Scientific Meeting has become one of the world's leading genitourinary cancer conferences. It brings together a diverse group of people, each with their own experience, expectations, expertise, ideas, connections, aspirations, learning needs, and unique contributions; all of which mix together to produce something wonderful every year. It is very unusual to see the level of interdisciplinary communication and collaboration, and the warm and collegial atmosphere that is so characteristic of an ANZUP ASM. I hope you get to experience and enjoy that yourself!

We are still celebrating "Bouncing Back", the 2023 ASM held in Melbourne. It was wonderful to be able to meet again face to face, knowing from bitter recent experience that we cannot take that for granted. Our theme this year is "Making Waves". We are on the Gold Coast, so at least one link to that theme is clear, but it extends much further than that. ANZUP has and should continue to make waves in the genitourinary cancer community. We do work of the highest quality and challenge others to do similarly. We bring ideas not considered by others. We recognise the ups and downs we all experience, as do our patients and their families. We also recognise that being in the surf is a lot more fun than being in a quiet stagnant millpond. My wish for you at this meeting is that you experience the exhilaration of both making and riding waves, as we join together in improving the lives of the people we serve.

We are very grateful to our sponsors and supporters. Our sponsors do not have the huge and expensive displays you might see at other meetings. Instead, they contribute their resources where they might be used more productively by ANZUP and its members. Please take the opportunity to meet and thank our sponsors, draw them out from behind their tables, and engage them in conversation. We all have the same goal! Thanks also go to Cancer Australia for its ongoing support of ANZUP.

Our convening committee, led by Matt Roberts and Aaron Hansen, has been working hard over the last 12 months to put together a stimulating, engaging, educational, and enjoyable program for you. We have a fantastic international faculty: Dr Elena Castro, Dr Paul Nguyen, Prof Ravindran Kanesvaran, Dr Rob Hamilton, Dr Cristiane Bergerot, and Prof Bertrand Tombal. They will be joined by an outstanding group of local presenters. We will include our MDT Masterclass, our nurses and allied health symposium, translational sessions, a theranostics breakfast, and much more. The submitted abstracts are of a very high quality. The programme truly has something for everyone.

I hope you enjoy the 2024 ANZUP ASM and I look forward to catching up with you over the course of the meeting.

Ian Davis
Chair, ANZUP

ANZUP Co-Convenors' Welcome

A/Prof Matt Roberts

A/Prof Aaron Hansen

On behalf of the ASM Convening Committee, we are delighted to welcome you to the #ANZUP24 ASM in Gold Coast, the premier GU cancer conference in the region, themed "Making Waves".

This event will serve as a dynamic platform for discussing and presenting the latest advancements in GU cancer treatment, research, and supportive care. Attendees will also have the opportunity to learn about ongoing and upcoming ANZUP trials.

We will continue to offer several engaging sessions designed to captivate your interest:

The Perfect Pitch session will focus on the art of pitching ideas and fostering their development, potentially leading to fully fledged clinical trials. This session will be valuable for all clinicians, especially budding investigators. If you're a trainee in medical oncology, radiation oncology or urology, make sure you don't miss it!

The ANZUP and PCFA Nurses and Allied Health Symposium will bring together nurses and allied health professionals to discuss, share ideas and get updates on projects within the ANZUP community.

Our MDT Masterclass will feature a distinguished panel of experts addressing real-life clinical challenges, making it another must-attend session for trainees.

We are honoured to host an exceptional international faculty at this year's ASM, including Dr Cristiane Bergerot, Dr Elena Castro, Dr Paul Nguyen, Prof Ravindran Kanesvaran, Dr Rob Hamilton and Prof Bertrand Tombal.

Additionally, our national experts will provide vital updates on GU cancer management, research priorities, ANZUP trials, and the challenges and opportunities in improving access to clinical trials.

We extend our heartfelt gratitude for your attendance and ongoing support of ANZUP. This meeting is made possible by the dedication of our entire ANZUP community. The ASM Convening Committee has demonstrated extraordinary commitment in developing another world-class educational and inspirational program. We also thank the ANZUP subcommittee chairs for their diligent review of abstracts and concepts. Special appreciation goes to the ANZUP management team, particularly CEO A/Prof Samantha Oakes and Chair Prof Ian Davis, as well as everyone at ANZUP who has helped to deliver another successful meeting. Furthermore, we are grateful to our sponsors, including Cancer Australia, whose key infrastructure funding is essential to ANZUP's success.

ANZUP continues to grow stronger, and we encourage all members to actively engage. Your involvement is crucial, whether through attending ASMs, proposing and developing new trials, recruiting for ongoing trials, or participating in subcommittees. Despite our progress, people continue to be diagnosed with genitourinary cancers, so there is more work to be done. With your help, ANZUP can position Australia and New Zealand at the forefront of GU Oncology worldwide.

We hope you enjoy the #ANZUP24 ASM and the city of surfing, waves and sunshine (even in winter).

A/Prof Matt Roberts and A/Prof Aaron Hansen
Co-Convenors, ANZUP Annual Scientific Meeting 2024

ANZUP MDT Masterclass Co-Convenors' Welcome

Dr Carole Harris

Dr Andrisha Inderjeeth

Sponsored by AMGEN Oncology and Movember

Get ready for an incredible experience at the MDT Masterclass, a highlight of our program that promises to be unforgettable.

Join us as we navigate through interesting and thought provoking topics in urological cancer management. Brace yourself for an immersive and dynamic journey as we actively engage with our audience, ensuring an experience that will captivate you until the very end.

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

- Renal Cell - Lewis Au
- BUP - Tania Moujaber
- Germ Cell - Orlaith Heron
- Early Prostate - Bernie Riley
- Advanced Prostate - James Buteau

The aim of the ANZUP MDT Masterclass is to cater to uro-oncology trainees, consultants, nurses, and allied health professionals. These sessions are designed to challenge and inform, addressing relevant topics in urological cancer management.

With a focus on renal cell, bladder, germ cell and prostate, our panels will emphasise multidisciplinary care through a core-based teaching approach. Each panel will tackle both common and controversial management issues across localised and metastatic disease spectrums, with active audience participation encouraged through polling and contributions.

On behalf of ANZUP, we extend a warm welcome to the #ANZUP24 ASM. Get ready to immerse yourself in this exciting experience and be a part of the action in GU cancer!

Dr Carole Harris and Dr Andrisha Inderjeeth
Co-Convenors, MDT Masterclass

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MDT MASTERCLASS

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Andrisha Inderjeeth – Co-Convenor

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Antoinette Fontella – ANZUP Clinical Trials Project Manager

Archana Nair – ANZUP Clinical Trials Project Manager

Alex Paine – ANZUP Clinical Trials Assistant (From October 2023)

Andrisha Inderjeeth – ANZUP Fellow (Until February 2024)

Anthony Uccellini – ANZUP Fellow (From March 2024)

Carole Harris – ANZUP Fellow (From March 2024)

CTC

Martin Stockler – CTC Clinical Lead

Izabella Pokorski – Clinical Trial Operations Lead (Until December 2023)

Alison Zhang – ANZUP /USYD fellow

Danka Zebic – ANZUP /USYD fellow

Karen Bracken – Clinical Trials Program Manager (Until April 2023)

Ailsa Langford – Clinical Trials Operations Lead (Until May 2023)

Minal Dalvi – Clinical Trials Operations Lead (Until Sept 2023)

Lauren Fisher – Clinical Trials Operations Lead

Katrina Diamante – Clinical Trials Operations Lead

Claire Niu – Clinical Trials Operations Lead

Nuria Zamora Solano – Clinical Trials Program Manager (From August 2023)

Martijn Oostendorp – Associate Director (From May 2023)

Anthony Jaworski – Associate Director (From June 2023)

John Simes – Acting CTC Clinical Lead (From March 2024)

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Anthony Uccellini – ANZUP Fellow (From March 2024)

Carole Harris – ANZUP Fellow (From March 2024)

BaCT

Jacqui Cumming – Director BaCT (Periodically attendance)

Maria Farrell – Clinical Operations Manager (Periodically attendance)

Sophie Lee – Clinical Trials Project Manager

Annie Ko – Clinical Trials Project Manager

Ilenia Distefano – Clinical Trials Project Manager (From June to September 2023)

Juliana Di Iulio – Clinical Trials Project Manager (Until July 2023)

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Anthony Uccelini – ANZUP Fellow (From March 2024)

Sophie O'Haire – WEHI GU Research Project Manager

Miku Kuba – Project Officer (From October 2023)

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Andrisha Inderjeeth – ANZUP Fellow (Until February 2024)

Anthony Uccellini – ANZUP Fellow (From March 2024)

Carole Harris – ANZUP Fellow (From March 2024)

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Naomi Knoblauch – Head of Clinical Trial Operations

Nicole Lachapelle – Clinical Trials Project Manager

William Hamilton – Clinical Trial Coordinator (From May 2023)

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Samantha Oakes – ANZUP CEO (From March 2024)

Jennifer Thompson – ANZUP Clinical Trials Operations Manager (From July 2023)

Thomas Cusick – Clinical Senior Trials Project Manager

Antoinette Fontella – Clinical Trials Project Manager

Archana Nair-Clinical Trials Project Manager

Alex Paine – ANZUP Clinical Trials Assistant (From October 2023)

Andrisha Inderjeeth – ANZUP Fellow (Until February 2024)

Anthony Uccellini – ANZUP Fellow (From March 2024)

Carole Harris – ANZUP Fellow (From March 2024)

TGI

Helen Monaghan – Head of Clinical Trial Partnerships

Allison Humphries – Business Development Lead, Academic Project Operations

Baldeep Kaur – Senior Project Manager, Academic Project Operation

CATALYST EVENT SOLUTIONS MEETING MANAGER

Sarah Dixon

Awards and Scholarships

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Jeremy Cheng
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Srilakshmi Srinivasan
Bryce Stewart
Achala Vitharanage
Colin Williams
Dixon Woon
Yong Yeung
Shaoting Zhang

Awards and Scholarships *continued*

2024 ANZUP Trial / Study Coordinator Scholarship sponsored by ANZUP

Endalkachew Alamneh
Leigh Mcintyre
Jade Allan
Harriet Mackenzie
Dragana Apcir
Nandini Makwana
Ashley Baring
Hannah Milne
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Sonya Stephens
Brandon Holt
Monika Tencic
Allison Hyde
Amy Wallace
Jacquie Keller
Georgia Wilson
Gerard Liew
Miku Kuba
Jessica Lewis
Saba Kugashiya
Tom La
Kristina Zlatic

Awards and Scholarships *continued*

2024 Best of the Best Awards sponsored by Astellas Pharmaceuticals

ANZUP would like to thank Astellas Pharmaceuticals 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 make an oral presentation or present a poster at the ASM.

Awards are presented at the ASM, based on the content, degree of innovation, significance and quality of the presentation, and are judged by an independent panel.

There are four awards:

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

Sponsor Acknowledgements

The Australian and New Zealand Urogenital and Prostate Cancer Trials Group gratefully acknowledge the generous support of our 2024 ASM sponsors.

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International Invited Faculty

Cristiane Bergerot

Dr Cristiane Bergerot, Ph.D., is the head of Supportive Care at Oncoclinicas, Brazil. She completed a 3 year research fellowship in the Department of Medical Oncology at the City of Hope Comprehensive Cancer Center in Duarte, California, USA. She has been working with cancer patients for almost 20 years as a clinician and as a researcher. She has received four merit awards from the American Society of Clinical Oncology (ASCO) Conquer Cancer Foundation and was selected for the prestigious SWOG Young Investigator Course. She is past recipient of the Barry Hoeven Memorial Kidney Cancer Research Grant from Kure It in 2020, the Global Oncology Young Investigator Award (GOYIA) from the Conquer Cancer Foundation in 2021, and the Psychosocial Focus Award from the Kidney Cancer Association in 2021. Currently, she is serving as the quality-of-life Chair of two ongoing clinical trial in the US and France. She is committed to bettering the lives of patients with cancer through (1) obtaining a detailed understanding of their quality of life and (2) addressing their quality of life through novel, targeted interventions.

Elena Castro

Dr Elena Castro is a Consultant Medical Oncologist in prostate cancer at Hospital 12 de Octubre in Madrid. Dr Castro studied Medicine and obtained a PhD from the University of Salamanca. After training in Medical Oncology, she completed a fellowship in Cancer Genetics at the Institute of Cancer Research and The Royal Marsden Hospital. In 2013, she moved back to Spain and joined the Prostate Cancer Clinical Research Unit at the Spanish National Cancer Research Center. Dr Castro is a translational clinician-scientist whose research interest span preclinical research to clinical trials. Her work has addressed the clinical implications of genetic and genomic variants in prostate cancer and has been involved in several clinical trials investigating new treatment strategies for patients with advanced prostate cancer. Dr Castro serves on the European Society of Medical Oncology faculty panel for prostate cancer and is an elected member of the translational medicine and precision medicine working group.

Sponsored by: BAYER

Rob Hamilton

Dr. Hamilton is a urologic oncologist at Princess Margaret Cancer Centre and Associate Professor in the Department of Surgery (Urology) at the University of Toronto, Canada. His clinical and research interests are in prostate cancer and testicular cancer. In prostate cancer, he is exploring the role of pharmacogenomics to personalize chemoprevention, with a particular interest in statin medications. He has interest in oligometastatic disease and molecular imaging modalities. In testicular cancer his interests include novel biomarkers and studying means to minimize treatment morbidity. Dr. Hamilton trained at the University of Toronto; completed a Masters of Public Health at The University of North Carolina at Chapel Hill and a research fellowship at Duke University. He completed a fellowship at Memorial Sloan-Kettering Cancer Centre.

Ravindran Kanesvaran

Prof Ravindran Kanesvaran is a Senior Consultant and Chairman of the Division of Medical Oncology of the National Cancer Centre Singapore. He is also an Associate Professor and the SingHealth- Duke NUS Distinguished Professor in Geriatric Oncology at Duke-NUS Medical School. He is actively involved in graduate medical education and is the Past Programme Director of the Medical Oncology Senior Residency Programme. His research interests include genitourinary (GU) oncology and geriatric oncology. He is currently the past President of the Singapore Society of Oncology (SSO) and the Singapore Geriatric Oncology Society. He is the Past President of the International Society of Geriatric Oncology (SIOG) and past council member of ESMO. He has published over 220 peer reviewed manuscripts. He is vice-chairman of the Singapore Cancer Society (SCS). He was recently awarded the Fellow in ESMO award (FESMO).

Paul Nguyen

Dr. Paul Nguyen is an internationally-recognized expert in prostate cancer clinical care and research. He has published over 350 original research articles and has national leadership as Co-Chair of the National Cancer Institute's GU Steering Committee, Chair of the ARS/ACR Appropriateness Criteria Committee for Prostate Cancer, and Chair of the ASTRO Annual Refresher Course. He is the Principal Investigator of the multi-center randomized FORMULA-509 trial and the national NRG Oncology GU-009/PREDICT-RT trial, and Co-Chair of the international randomized ENZARAD trial. His research is supported by an NIH R-01 grant. He serves as the DF/BWCC Genitourinary Clinical Center Director for Radiation Oncology, Vice-Chair for Clinical Research in the Department of Radiation Oncology, Professor at Harvard Medical School, and Baldwin-Politi Distinguished Chair in Oncology at Brigham and Women's Hospital where he is also associate director of the Harvard Radiation Oncology Program residency. He received his AB from Harvard College, MD from Harvard Medical School, MBA from the MIT Sloan School of Management, and completed his residency at the Harvard Radiation Oncology Program where he served as chief resident.

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.

National Speakers

Muhammed Ali
Muhammed Ali is a radiation oncologist at Peter MacCallum Cancer Centre Australia and a PhD candidate at the University of Melbourne. His main areas of interest are genitourinary and head/neck malignancies. His areas of expertise and research include the role of Stereotactic body radiotherapy (SBRT) for primary and metastatic kidney cancer

Jade Allan is a Clinical Trial Coordinator and Team Leader at the Medical Oncology Clinical Trials Unit, Royal Brisbane and Women's Hospital. She has a background in Oncology Nursing and is a passionate patient advocate. Jade has a keen interest in optimising the running of complex clinical trials at a site level through the development of tailored procedures and building strong collaborative relationships between multidisciplinary contributors.

Ray Allen Ray is in his 60's, and has moved on from his working career. He doesn't use the word retired and prefers to describe himself as 'getting on with life'. He spent almost his entire working career in the commercial property industry with the last 20 years in property related investment banking and funds management. He resisted all invitations to 'suit-up' and return to the boardroom. Ray believes there is so much else to be done. He ascribes to a doctrine of enabling. He's a very keen follower of the performing arts, with a particular leaning to opera and classical music. With a personal commitment to engaging youth with opera he assists the students and staff of a regional Conservatorium of Music to stage an annual, full opera production involving young people. A few years back, Ray was diagnosed with prostate cancer and subsequently had a radical prostatectomy. He said it was certainly a life changer and so far so good. He doesn't shy away from talking about the disease, its diagnosis, consequences, and management. His involvement over the past few years with ANZUP has been a great opportunity to channel his experience to help others and to increase community awareness and encourage participation in valuable clinical trials.

Angelyn Anton Angelyn (Arsha) Anton is a medical oncologist at Eastern Health with an interest in genitourinary and breast cancers. She is also currently completing a PhD at the Walter and Eliza Hall Institute focussing on the use of real world registries and the development of pragmatic clinical trials.

Lewis Au Lewis Au is a Medical Oncologist and Postdoctoral Research Fellow (Neeson Lab), with a focus on kidney cancer. He obtained his undergraduate medical degree from The University of Melbourne in 2009, and his Medical Oncology specialist qualification in 2017. From 2017-2022, he worked in London at The Royal Marsden Hospital as a Clinical Research Fellow, and as a Translational Research Scientist at The Francis Crick Institute.

While abroad, Lewis obtained a PhD on Cancer Genomics and Tumour Immunology through the Institute of Cancer Research (ICR). His work focused on predictive biomarkers of immunotherapy treatment response in patients with clear cell renal cell carcinoma (kidney cancer), through in-depth analyses of patient tumour samples obtained from clinical trials.

In 2020, he co-established and conducted the CAPTURE study, which became the largest study globally to prospectively evaluate the immune response to SARS-CoV-2 and COVID-19 vaccines in cancer patients. This research provided insights on

factors leading to higher morbidity and mortality in cancer patients, and reasons for a reduced functional immune response to COVID-19 vaccines particularly against SARS-CoV-2 variants as the pandemic evolved.

His research has led to high-impact co-first author scientific publications including in The Lancet, Nature Medicine, Nature Cancer, and Cancer Cell. His discovery of the link between anti-PD-1 treatment response and intratumoural T cell receptor sequences in kidney cancer was awarded the Best Fundamental Research Prize by the European Association of Urology in 2023.

He is the recipient of the 2019 Cecile and Ken Youner IKCC Scholarship, the 2022 Chairman's Prize for outstanding PhD thesis by the ICR, and the 2023 Discovery Partner Fellowship Award by The Peter MacCallum Cancer Foundation.

He is an ESMO Faculty Member of Translational Research for 2022-2026.

Narjess Ayati (MD, FRACP, FAANMS) is a nuclear medicine specialist currently practicing at St Vincent's Hospital Sydney. She earned her medical degree from Mashhad University of Medical Sciences (Iran) and holds board certifications from the European Association of Nuclear Medicine (EANM, 2012, Italy), the Asian School of Nuclear Medicine (First rank, 2015, South Korea), and the American Society of Nuclear Cardiology (2015). Having relocated to Australia in December 2018 on a Distinguished Talent Visa, she continued her professional journey at Austin Health (Advanced registrar, 2019-2021), Westmead Hospital (2021-2022), Peter MacCallum Cancer Centre (Theranostics fellow, 2022-2023), and currently, St Vincent's Hospital Sydney (Consultant, since Feb 2023). She also holds the position of Conjoint Associate Professor at UNSW.Dr. Ayati specializes in Theranostics, particularly in patients with advanced prostate cancer, and has actively collaborated in numerous clinical trials, including PRIMARY II (as a central reviewer), PRINCE, LuPARP, ENZAp, and EVOLUTION (SPECT analysis, Below the Belt project). She has over 50 peer-reviewed publications in esteemed journals such as European Urology (IF: 24), EJNMMI (IF: 10), and JNM (IF: 11). Notably, she was honored with the "most cited paper award" from the Asia Oceania Journal of Nuclear Medicine in 2019. Dr. Ayati serves as an editorial board member and active peer reviewer for several distinguished medical journals. She is committed to advancing the field of nuclear medicine and theranostics, with a focus on improving patient outcomes and contributing to scientific knowledge in the domain.

Arun Azad is a medical oncologist based at Peter MacCallum Cancer Centre focused on clinical and translational research in prostate cancer. He has past and ongoing leadership positions in numerous prostate cancer clinical trial steering committees. He holds key leadership roles including Translational Chair at ANZUP Cancer Trials Group and Urologic Oncology Chair at Clinical Oncology Society of Australia. He is also the Prostate Track Chair at the ESMO Congress 2024.

Paulo Bergerot, M.D., is a Medical Oncologist and researcher at Oncoclinicas in Brasilia, Brazil, specialising in genitourinary cancers and exercise oncology. He currently serves as the Latin American representative in the International Society of Exercise Oncology (ISEO). Dr. Bergerot completed a 3-year research fellowship in Genitourinary Cancers at the City of Hope Comprehensive Cancer Center in Duarte, California, USA. In 2018, he was selected for the prestigious AACR/ASCO Vail Workshop.

Jasmine Brady has been specialising in oncology for just shy of 20 years and has developed an interest in theranostics. Most recently, Jasmine has been working as a Senior Clinical Trial Coordinator as part of the Medical Oncology Clinical Research Unit at the Royal Brisbane and Women's Hospital since 2018. Jasmine has pioneered the implementation of collaborative theranostics care-planning which has seen greater efficiency and fiscal improvements across the space of clinical trials – a space which she is passionate to continue to work on. Jasmine has an interest in early protocol development and logistical design, supporting staff where appropriate. She is currently is involved in the Imaging and Theranostics subcommittee within ANZUP.

Emerald Brewer, is a Kombumerri-Noonuccal woman / Traditional Custodian of the Gold Coast and North Stradbroke Island. Emerald is the youngest grandchild of (Uncle) Dr Graham Dillon OAM. Emerald lives on country on the Gold Coast with her young family and is a highly regarded member of the community here. Emerald has an undergraduate degree majoring in Psychology and is currently completing her master's in teaching (Secondary). Emerald's passions are in connecting with and educating people about Aboriginal history, community and culture.

Russell Briggs is a registered nurse with 25 years' experience. He has worked in health services both nationally and internationally and has experience in administration and management positions.

Since 2018 Russell has been working in the field of Prostate Cancer initially as a Prostate Cancer Specialist Nurse in a public health service before joining Prostate Cancer Foundation of Australia in the role of General Manager, Nursing program where he helps run a national specialist nursing program.

Russell is currently studying a PhD exploring the unmet need of men undertaking active surveillance within the first 12 months following diagnosis.

Nick Buchan is a Urologist based in Christchurch, New Zealand and works in both public and private practice. Nicks practice focuses on the diagnosis and management of urological cancers. Nick gained his experience in medical trials while on fellowship at the Vancouver Prostate Centre. The Vancouver Prostate Centre is one of the largest research and clinical centres in the world that focuses on translational research into prostatic diseases, prostate cancer in particular. Currently Nick is managing director of the Canterbury Urology Research Trust (CURT). CURT is a trust that conducts urological trials for contract research organisations (CROs) as well as its own investigator lead trials in urological conditions with the main focus being urological oncology. Nick is also a previous director of a privately owned hospital in Christchurch, Forte Health and managing director of a large Urology specialist practice, Urology Associates.

James Buteau completed his nuclear medicine specialisation in Canada, where he practiced for 2 years. Since 2019, he has worked at Peter Mac as a clinical and research fellow in the Prostate Cancer Theranostics and Imaging Centre of Excellence (ProsTIC). Dr Buteau is in the second year of his PhD, under the supervision of Prof Michael Hofman and A/Prof Arun Azad. He published the TheraP trial PET imaging biomarkers analysis in the Lancet Oncology as first author. He is currently investigating the role of PSMA PET/CT for prostate cancer diagnosis in the PRIMARY2 trial, and Terbium-161-PSMA therapy for men with mCRPC in the VIOLET trial.

Lisa Butler is a Cancer Council Principal Research Fellow at the University of Adelaide and heads the Prostate Cancer Research Group at the South Australian Health and Medical Research Institute. 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, and was most recently an ARC Future Fellow (2014-18). Prof Butler's research focuses on novel approaches to target androgen signalling therapeutically in prostate cancer, and on biomarker discovery in drug development. Her specific goals are to develop and commercialise novel diagnostic/prognostic markers and therapies alongside innovative, non-invasive approaches to monitor them in clinical trials. She has established productive translational research programs that leverage her unique preclinical models involving primary clinical samples, prostate biobanking, proof-of-concept clinical trials and international collaborations. Currently, she leads a Movember Revolutionary Team to investigate the androgenic regulation of lipid metabolism in prostate cancer, and the potential for lipids and their regulatory enzymes to be utilised as new biomarkers of disease aggressiveness. The outcomes will enable more precise tailoring of new metabolic therapies to the patients who will benefit from them the most.

Ciara Conduit is a medical oncologist working in the Tasmanian Health Service at the Royal Hobart Hospital. She completed her advanced training at Peter MacCallum Cancer Centre, where she gained specific experience in early drug development, and genitourinary and skin cancer streams. Ciara's research interest spans the scope of genitourinary oncology, and she previously worked with as a Clinical Research Fellow with ANZUP , and as an ongoing position at the Walter and Eliza Hall Institute of Medical Research. She recently submitted her PhD thesis, which focused on testicular cancer.

Elizabeth Connolly is a PhD student, medical oncologist, MRCPUK(2016) FRACP(2020), and clinical senior lecturer with the University of Sydney. She is in the penultimate stage of a proteomics PhD, full time, through the Children's Medical Research Institute and Chris O'Brien Lifehouse, in collaboration with the Garvan Institute. She has established, or contributed, to 20 national and international research collaborations and had 21 recent publications, including 8 multi-centre studies. She represented Australia in the ESMO Young Oncologists Committee

Michelle Cybulski, Bachelor of Nursing, clinical nurse and trial coordinator, team leader at Royal Brisbane & Women's Hospital, Medical Oncology. Previously started out as a trial coordinator in oncology at Toowoomba Hospital in 2004, also assisting with trials in the Gynaecology and Cardiac Units. She then assisted in the setup of the Toowoomba Cancer Research Centre at St Andrews Hospital in Toowoomba acting in the role of a project manager for a prostate trial for Australian sites. She then moved on to the Wesley Medical Research as a clinical research coordinator, conducting trials in Multiple Sclerosis and cluster headaches. She also has coordinated phase 1 trials in a dedicated phase 1 trial unit. Other roles have included blood collection, aliquoting and shipping, regulatory including new trial protocol submissions and amendments. As a Registered Nurse she has worked in medical, surgical, palliative care, paediatrics, and school nursing as a college nurse.

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 has honorary appointments as an Affiliate Professor of Deakin University, adjunct Associate Professor of the University of Melbourne, Associate of the University of Sydney, Honorary Professorial Fellow with The George Institute, and Adjunct Professor of University of New South Wales. 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 chair of the ANZUP Board and of its Scientific Advisory Committee.

Richard De Abreu Lourenço, is a Professor of Health Economics and Deputy Director at the Centre for Health Economics Research and Evaluation (CHERE), University of Technology Sydney. He is an experienced health economist who has a keen interest in applied economic evaluations, patient preference and quality of life and the economics of specialty health areas. Currently, he is the program lead for the Cancer Australia Cancer Research Economics Support Team, and the Senior Evaluator for CHERE's Pharmaceutical Benefits Advisory Committee (PBAC) evaluation group. He is an investigator on a number of cancer clinical studies and studies investigating preferences for health care decision making.

Juliet De Nittis was diagnosed at 50 with a rare aggressive kidney cancer in 2019. After surgery to remove her left kidney, and the tumour that covered it, came the revelation that the cancer had spread to her lungs. That is when the enormity of her situation struck. Rare kidney cancer had no treatment, leading to a short life expectancy with palliative care. Fortunately, hope arrived; an ANZUP clinical trial led by Associate Professor David Pook for rare kidney cancers. Now, incredibly after two years of immunotherapy treatment and another two years treatment free, her cancer continues to be in remission, stable and the latest scan revealed: "lungs clear!". Juliet knows she would not be here without the immunotherapy treatment she received from an ANZUP clinical trial. Juliet is a success story and is profoundly grateful to pay it forward after becoming a member of the ANZUP Consumer Advisory Panel in 2022. Juliet considers it an absolute privilege to be a part of an inspiring team dedicated to improving pathways and outcomes for all patients. Juliet plans to utilise her lived experience to work with the CAP team to raise awareness of access to clinical trials and to facilitate greater patient involvement in treatment choices.

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, University of Sydney. Haryana has more than 25 years' experience in cancer clinical research across a range of investigator-initiated cancer clinical trials. Her research interests are broad encompassing cancer survivorship, health literacy, and interventions for survivorship, symptom management, and psycho-oncology. Haryana Chairs ANZUP's Quality of Life and Supportive Care Subcommittee. Haryana is passionate about rigor in research, practical solutions to tricky problems, and doing what she can to help humans make it to the 22nd century.

Pierre-Antoine Dugué is a Senior Research Fellow in the School of Clinical Sciences at Monash Health, Monash University. He has a background in Statistics and Cancer Epidemiology and has developed expertise in the analysis of -omic data from large-scale datasets since he arrived in Australia (Cancer Council Victoria, 2014). He currently leads the Molecular Epidemiology team (Precision Medicine), which aims to use complex study designs and statistical methods coupled with molecular data to address key epidemiological and clinical questions. Recently, he has obtained two Mid-Career Research Fellowships (Prostate Cancer Foundation of Australia, 2022 and Victorian Cancer Agency, 2023-2027) for research on prostate cancer, applying machine learning methods to genetic / epigenetic data to improve the molecular characterisation of prostate cancer and better predict outcomes.

Rachel Effeney is Australian and joined the EORTC in August 2019 as a Medical Fellow. She holds a Bachelor of Science in biophysics and a Medical Degree from the University of Queensland, and a Master of Medicine (clinical epidemiology) from the University of Sydney. Prior to joining the EORTC, she worked as a Radiation Oncology trainee in Queensland, Australia, and recently completed fellowship examinations with the Royal Australian and New Zealand College of Radiologists. She has a keen interest in improving patient outcomes through quality improvement in radiotherapy. Rachel will work with the EORTC and the European Society for Paediatric Oncology (SIOPE) on the QUARTET project, which is developing a radiotherapy quality assurance programme for paediatric, adolescent and young adult tumours across Europe.

Louise Emmett is the Director of Theranostics and Nuclear medicine at St Vincent's Hospital Sydney, Australia with a specialty interest in the imaging and therapy of prostate Cancer. She undertook her medical undergraduate training in Auckland, New Zealand, prior to completing her specialty training in Nuclear Medicine in Sydney, and a post specialty Nuclear Cardiology fellowship in Toronto, Canada. She commenced work in Nuclear medicine and PET at St Vincent's Hospital, Sydney in 2012, initiating radio-pharmacy production of multiple new imaging and therapy peptides on the St Vincent's campus for clinical and research evaluation. She is principal investigator in multiple phase I-II trials including the PRIMARY trial (PSMA + MRI in prostate diagnosis), PRIMARY2 (randomised phase III imaging trial), LuPIN trial (Phase I/II trial of Lu PSMA+ Idronoxil), ENZA-p (phase II randomised trial of enza vs enza + Lu PSMA), in addition to running multiple phase I imaging trials in new theranostic agents.

Tom Ferguson is a medical oncologist practicing at Fiona Stanley Hospital in Perth, Western Australia.

Liesel FitzGerald is a Principal Research Fellow at the Menzies Institute for Medical Research, UTAS. She has internationally recognised expertise in prostate cancer genetics. Her work with national and international colleagues has led to significant advances in prostate cancer genetics, including seminal publications describing the identification of common and rare risk variants. She is particularly interested in how this knowledge can translate into advances in screening and treatment strategies, leading to better quality-of-life and survival outcomes in patients.

Tracey Gardner Prior to joining us at PCFA, Tracey was Senior Psychologist at Cancer Council Queensland where she led the Counselling Service there in providing evidence-based psychological support to individuals, couples, and families affected by cancer. She has experience providing a broad range of psychological services in a variety of community, hospital, and university-based settings. Tracey has over 18 years in psycho-oncology experience and is now PCFA's psychologist within the Prostate Cancer Counselling Service.

Craig Gedye is a physician/scientist, dual trained as a medical oncologist and cancer researcher. He works for patients with melanoma, brain, kidney, prostate, testis, and bladder cancer at the Icon Cancer Centre Adelaide, and is the Director of Research (Medical Oncology and Haematology) for Icon. He chairs the Renal Cancer Subcommittee for the ANZUP Cancer Trials Group, and lead investigator-led clinical trials in kidney, brain and prostate cancers.

Jeffrey Goh is an experienced Medical Oncologist consulting at Icon Cancer Centre Chermside and Greenslopes Private Hospital. He is actively involved in numerous clinical trials and acted as principal investigator (PI) in a number of phase Ib, II and III gynaecological oncology, urological malignancy and early phase drug trials at RBWH, ICON Research and GPH. He is also a co-investigator in numerous other multi-centre clinical trials in oncology. He maintains an active interest in clinical research and is a member of several leading cancer trial groups including ANZUP, ANZGOG, ASCO and ESMO. He maintains a significant part-time role as Senior Staff Specialist at RBWH and is an Adjunct Professor at the Queensland University of Technology. He is also involved with mentoring advanced trainee registrars in Medical Oncology at RBWH. Additionally, Dr Goh is a member of both the Research Committee and Medical Advisory Committee (MAC) at Icon. His clinical experience covers a broad range of solid tumour malignancies, with specific clinical and research interest in gynaecological and genitourinary cancers, in addition to early phase clinical trials.

Aaron Hansen is a medical oncologist consulting at Icon Cancer Centre Greenslopes. In 2004, he completed his Bachelor of Medicine, Bachelor of Surgery (MBBS) at the University of Queensland. He subsequently undertook specialist medical oncology training at the Princess Alexandra Hospital, followed by a fellowship in drug development at the Princess Margaret (PM) Hospital in Toronto, Canada.

In 2015, A/Prof Hansen was appointed as a staff medical oncologist at the PM and was the medical oncology lead for genitourinary cancers and co-chair of the head and neck disease site at the Canadian Clinical Trials Group. After a decade working in Canada, A/Prof Hansen returned to Brisbane, however he remains an active member of the US National Cancer Institute Recurrent Metastatic Head and Neck Cancer Taskforce.

Alongside his practice at Icon, A/Prof Hansen works as a medical oncologist at Greenslopes Private Hospital and Princess Alexandra Hospital. With a passion for providing education and mentorship to the next generation of medical oncologists and cancer researchers, he is also an associate professor at the University of Queensland's School of Medicine.

A/Prof Hansen has a strong interest in clinical research and trials, with the aim of transforming care for cancer patients by increasing survival or improving quality of life. He has led multiple clinical trials across all phases, launched several investigator-initiated trials and has over 170 publications with many papers in peer-reviewed journals. A/Prof Hansen has also received various research awards, including the National Cancer Institute of Canada (NCIC) Phase II Program Team Award in 2016, Phase III Program Team Award and University of Toronto's Young Investigator Award in 2021.

His clinical experience covers a broad range of solid tumour malignancies and he is recognised internationally as an expert in drug development, genitourinary cancer and head and neck cancer.

Carole Harris is medical oncologist with a special interest in genitourinary and breast cancers and cancer survivorship. Dr Harris graduated from medicine from the University of Sydney with honours in 2002 and received her fellowship in Medical Oncology from the Royal Australian College of Physicians in 2009. She went on to complete a Master of Medicine by Research at UNSW. This research focused on targeted cancer therapies in breast cancer.

Dr Harris is a staff specialist at St George Public Hospital and Sutherland Hospital and a VMO at St George Private Hospital. She is a Senior Research Fellow with The George Institute (TGI) and Australian and New Zealand Urogenital and Prostate Cancer Trials Group (ANZUP). Dr Harris is principal investigator on several clinical trials and involved in all levels of clinical trial development through her work with TGI and ANZUP. She is a Conjoint Senior Lecturer at the University of New South Wales and an Associate Fellow of the Higher Education Academy where she oversees the oncology teaching programme to undergraduate students at St George and Sutherland Hospitals and helped establish the St George Hospital Survivorship Clinic.

Cynthia Hawks has worked as a Uro-oncology Clinical Nurse, Trial Coordinator and Research Nurse since 2007. Cynthia successfully completed her PhD in 2023 where her thesis reported on aspects of the One Stop Prostate Clinic – a same day prostate cancer assessment and diagnostic clinic for rural men in WA. Cynthia continues to support the research activities of the Urology unit, with a particular focus on bladder cancer.

Dickon Hayne is a urologic surgeon who leads urological research and education in urology, at the University of Western Australia. He is Head of Urology for the South Metropolitan Health Service in WA. Dickon Chairs the Bladder Urothelial and Penile (BUP) Cancer Sub-committee of ANZUP, is a SAC member, leads the BCG+MM, ZipUp and SUBDUE trials and is widely engaged in ANZUP's other subcommittees, trials and activities. His major clinical and research interests are urological cancer, in particular bladder cancer.

Peter Heathcote is a Urologic Surgeon with a special interest in Cancer of the Prostate, and Medico-Legal practice. Having completed Urology Speciality training in Queensland Peter spent further time in Cardiff, United Kingdom and in Toronto, Canada developing Reconstructive and Radical Prostatectomy skills. Peter is an Adjunct Professor at the Australian Prostate Cancer Research facility at QUT/PAH and Adjunct Clinical Professor Monash University Dept of Epidemiology. He is Co-chair of the Steering Committee of the Review of the Guidelines for the Early detection of Prostate Cancer in Australia. Current appointments include Member of General Medical Assessment Tribunal – Workers Compensation Services Qld., Member of External Panel of Experts in Urology - Avant Medical Insurance, Panel Member Professional Services Review Australian Government, Medical Board of Australia performance assessor. He is a member of the Board of Directors of the Prostate Cancer Foundation Australia and Australasian Urological Foundation. Past appointments include Senior Visiting Urologist Princess Alexandra Hospital and Senior Examiner - Royal Australasian College of Surgeons. Peter also holds professional memberships with the Australian Medical Association, Urological Society of Australia and New Zealand, European Association of Urology, Urological Association of Urology, American Urologic Association, The Society of Robotic Surgeons, The

Australasian Brachytherapy Group, Australia and New Zealand Cancer trials group (ANZUP), Société Internationale De Urologique and Member Academy of Surgical Educators RACS. He was elected a Fellow of the Urological Society of Australia and New Zealand in 2024 having served as President and on the board of directors.

Nicole Heneka leads a translational program of prostate cancer survivorship research through the University of Southern Queensland and Prostate Cancer Foundation of Australia research collaboration. Her research focuses on the implementation of evidence-based prostate cancer survivorship interventions into clinical care using participatory research methods.

Orlaith Heron is a Medical Oncologist in the Southern district of Te Waipounamu, New Zealand. She has subspeciality interests in genitourinary, gynaecological and breast cancers. Alongside her clinical role, Orlaith is principal investigator on a number of trials and sits on the NZ Advanced Training sub-committee for Medical Oncology. In her spare time, she can be found in mountainous and backcountry terrain either trail running or mountain biking.

Tuan Hoang is an engineer by training, that led to a 35-year IT career partly overseas (Bangladesh, Nepal, Thailand, Malaysia, Singapore, Vietnam and Fiji) and partly within the Australian Telco industry. Diagnosed with prostate cancer in 2018, Tuan has been going through systemic treatments ever since. He is enthusiastic in raising awareness among the growing high-risk group of 50-plus men - utilising knowledge that will serve to alleviate the cancer burden and saving life with early detection. Tuan is now semi-retired, he has worked as a consultant to complete a new Care-Manager Portal for Sequel Home Care Management in Heidelberg. Besides that, Tuan is busy volunteering in the Scouts Movement (ex District Commissioner) and is a freelance IT service provider for the Vietnamese community 50-Up.

Michael Hofman is a Nuclear Medicine Physician and leads the Prostate Cancer Theranostics and Imaging Centre of Excellence (ProsTIC) at Melbourne's Peter MacCallum Cancer Centre. His groundbreaking research in PSMA PET and PSMA radioligand therapy has revolutionised prostate cancer imaging and treatment, resulting in FDA approval, Australian MBS funding, and a significant investment by Novartis.

Brett Hollier Brett Hollier's research investigates the mechanisms that mediate cancer metastasis, in particular, the Insulin-like Growth Factor (IGF) family and the epithelial-to-mesenchymal transition (EMT) program. His research focus is to better define the EMT program operating in cancer and its relevance to metastasis in order to identify novel biomarkers and therapeutic targets of EMT to better prognosticate and treat aggressive forms of cancer.

Dr Hollier was awarded a PhD in April 2008, in which he described for the first time the critical signalling events and transcriptional networks responsible for cancer cell migration induced by novel growth factor complexes. He conducted postdoctoral training at the M.D. Anderson Cancer Center (Houston, TX, USA) investigating the role of embryonic transcription factors in EMT, cancer stem cells and metastasis. He returned to Australia in late 2010 where he initiated an independent research laboratory at QUT. In 2012, he joined the APCRC-Q where he leads the Invasion and Metastasis laboratory.

Dr Hollier was awarded a 3 year Queensland Smart Futures Fund Fellowship (2012-2015) to design

smarter targeted therapies for cancer progression and is excited about the future opportunities to extend his research in these fields. In recognition of his research and his rapidly emerging national and international profile in the fields of Insulin-like growth factor (IGF) biology and mechanisms of cancer metastasis, particularly the EMT program, he has been invited and presented his findings at both national and international conferences as well as external research institutes.

Lisa Horvath is the Director of Research at Chris O'Brien Lifehouse. She completed medical school at the University of Sydney and trained in medical oncology at Royal Prince Alfred Hospital, where she was appointed to the senior staff in 2003. She completed her PhD in translational research at the Garvan Institute of Medical Research in 2004. Lisa's research interest is predominantly in the field of prostate cancer in particular biomarkers, prostate cancer biology and clinical trials.

Lisa holds academic appointments at both the University of Sydney and the University of New South Wales and is the Head of Advanced Prostate Cancer research group at The Kinghorn Cancer Centre/ Garvan Institute of Medical Research. She is the Conjoint Chair of Medical Oncology (Genitourinary Cancers) at Lifehouse. She has published more than 140 original research papers in peer-reviewed journals in the last 20 years. She has presented extensively at national and international meetings both peer-reviewed and invited presentations. Lisa is an ANZUP Board Director, a member of the ANZUP Scientific Advisory Committee and is Chair of the ANZUP Prostate Cancer Subcommittee.

Michael Huo is a radiation oncologist at the Princess Alexandra Hospital in Brisbane who specialises in radiotherapy for urological cancers. He is a senior lecturer at the University of Queensland and is a member of the Australian and New Zealand Urogenital and Prostate Cancer Trials Group (ANZUP), The Royal Australian and New Zealand College of Radiologists (RANZCR) and the International Stereotactic Radiosurgery Society (ISRS).

Kym Hyam is a Registered Nurse with over 37 years of experience. Her expertise bridges Implementation Science, Patient Safety, and Quality Improvement.

Kim is committed to improving population health outcomes and supporting the healthcare workforce in developing their capacity to undertake innovative service improvements. She actively promotes the use of implementation and improvement theories, frameworks, and methodology to achieve successful and sustainable implementation.

Andrisha Inderjeeth is a medical oncologist working at Sir Charles Gairdner Hospital in Perth, Western Australia and a current WEHI genitourinary research fellow. After completing her training in WA she relocated to the Peter MacCallum Cancer Centre in Melbourne to complete a fellowship in genitourinary cancers and melanoma. She held the ANZUP research fellow position in 2023 and worked as a medical oncologist at PMCC prior to relocating to Perth.

Jim Jackson is an experienced, supportive radiation oncologist who is committed to delivering prompt, personalised cancer treatment for those in his care. He is passionate about cutting-edge radiation therapy and maintains an active involvement in clinical research to deliver the best possible outcome for his patients.

Belinda Jago has been the Chair of the ANZUP Consumer Advisory Panel (CAP) since 2013. Belinda professionally has worked in human resources in a variety of operational and strategic HR 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 since 2012 has provided an opportunity for Belinda to share the knowledge and skills she has acquired during her family's experience and to pursue her passion for assisting cancer patients, their carers and families, with a particular interest in kidney and Adolescent and Young Adults (AYA) cancers and clinical trial research.

Evon Jude is a Research Fellow at the Olivia Newton John Cancer Research Institute and Austin Health, having completed her basic physician training at Austin Hospital, with a keen interest in research focusing on kidney and breast cancer. She has gained experience working in the Clinical Trials setting at Monash University's School of Public Health and Preventive Medicine and received a Summer Research Scholarship at The University of Auckland.

Brian Kelly (University of Newcastle) is Chair of the Psycho-Oncology Cooperative Trials Group, a national clinical trial group of Cancer Australia. He is a psychiatrist with longstanding clinical and research interests in the psychosocial aspects of cancer and palliative care, and experience in rural and regional health care. He is Co-Editor in Chief of the Journal of Psychosocial Oncology Research and Practice, official journal of the International Psycho-Oncology Society

Liz Kenny is a senior Radiation Oncologist at the Royal Brisbane and Women's Hospital, Metro North Hospital and Health Service, and a Professor within the School of Medicine, University of Queensland. Liz has held the Presidencies of the Clinical Oncological Society of Australia, and the Royal Australian and New Zealand College of Radiologists. She has advised nationally and internationally on cancer care infrastructure, quality assurance and accreditation systems and is currently the chair of the National Quality Management Committee of BreastScreen Australia. In her clinical life, Liz cares for people affected by breast cancer, head and neck cancer and highly complex skin cancer. Liz is a keen researcher and collaborator. Her h-index is 39, and she has over 150 publications. Liz's work has been recognised with honours by most major international radiological organisations. In 2017, Liz was made an Officer of the Order of Australia. She loves to cook for friends and family and travel the world.

Lawrence Kim is a uro-oncologist at candidate at the University of Sydney. He is regularly invited to various national and international meetings. He has participated in several trials as a primary and sub-investigators and is a Site Investigator for the PCOR-NSW (Westmead hospital).

Kevin M. Koo is a NHMRC Investigator Fellow at The University of Queensland Centre for Clinical Research (UQCCR). Dr Koo's prostate cancer research encompasses multi-disciplinary fields of molecular biomarker and nanobiosensor development, translation, and commercialization for precision disease management applications. Dr Koo was a recipient of a Queensland Young Tall Poppy Science Award (2023) and a Prostate Cancer Foundation of Australia (PCFA) Future Leader Award (2024).

Laurence Krieger returned to Sydney as the Director of Clinical Trials for the Riverina Cancer Care Centre before becoming the lead clinician and Principal Investigator for numerous studies in urogenital malignancies at Genesis Care, Sydney. He is a Clinical Lecturer with the University of Sydney, Northern Medical School and a Consultant General Physician and undergraduate trainee supervisor for the Royal College of Physicians at Royal North Shore Hospital, Sydney. He is an active member of the bladder, testicular, renal and prostate cancer subcommittees for the ANZUP trials group and a member of the EVIQ urogenital committee. He serves on multiple national and international advisory boards.

Louise Kostos is a consultant Medical Oncologist at the Peter MacCallum Cancer Centre and PhD candidate. She has a particular interest in prostate cancer and early-phase clinical trial development. Her PhD aims to optimise outcomes for patients who are treated with radioligand therapy for advanced prostate cancer primarily through combination therapy, and has developed two phase I/II clinical trials. Her research also aims to identify potential biomarkers of response or resistance to optimise patient selection for treatment through analysis of circulating DNA samples.

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-ray 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.

Mitchell Lawrence is a Laboratory Head at Biomedicine Discovery Institute, Monash University with appointments at the Peter MacCallum Cancer Centre and Cabrini Health. He has expertise in using patient-derived models of prostate cancer for preclinical testing in collaboration with clinicians, pharma and patient advocates.

Nicky Lawrence is a Medical Oncologist at Te Toka Tumai Auckland with an interest in genitourinary cancers and clinical trial methodology, and is Deputy Director of Cancer Trials New Zealand at Waipapa Taumata Rau, The University of Auckland. Nicky completed her medical oncology training in Auckland, and her fellowship at The University of Sydney where she was awarded her PhD evaluating the design of cancer clinical trials in the era of targeted and immunological therapies, and worked as a clinical research fellow on ANZUP clinical trials. She is co-lead of the Aotearoa New Zealand decentralised clinical trial steering committee. She is passionate about educational opportunities and convened the inaugural NZ concept development workshop in 2016, and is a member of the international steering committee for the ACORD protocol writing workshop.

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.

Rhea Liang is a general and breast surgeon on the Gold Coast, medical educator, Clinical Sub Dean at Bond University, and systems change leader. She researches, advocates and consults in diversity and equity issues. She is the past Chair of the RACS Operate With Respect Education committee, current Chair of the Commonwealth A Better Culture Curriculum Design group, and in 2023 became the first Australian woman awarded RCSEng(Hon) for contributions to surgical education and diversity over two decades. She is still not sure that she is a good 'fit' for surgery. She tweets at @LiangRhea.

Fiona Maclean Although Fiona Maclean enjoys all organs in the urogenital system, she particularly loves a good kidney tumour, as they are like a puzzle to be solved!. She has authored more than 100 peer reviewed papers, as well as chapters of premier textbooks in the fields of pathology and histology. She has recently participated as a chair and/or committee member in international consensus meetings covering classification of bladder and testis tumours and shortly one on pre-neoplastic conditions. Assoc. Prof. Maclean is the immediate Past President of the Australasian Division of the International Academy of Pathology (IAP). For more than two years, she has additionally spent half of her week working in artificial intelligence (AI), partnering with Franklin.ai, to develop tools to assist pathologists, and welcomes our computer overlords.

Raewyn Manssen lives in Auckland and works as a Life and Disability insurance adviser. Raewyn's company is a mutual society that was started by doctors 100 years ago to provide insurance and investment solutions to doctors, dentists and vets. The mission is to inspire a healthier New Zealand and the company has a charitable foundation that focuses on this. Raewyn joined the company 3 years ago as she felt it aligned perfectly with her values. She says the employees are supported to volunteer our time to assist also. Raewyn is a mum to 2 children who are now young adults and starting out in their careers. Apart from their births Raewyn had no hospital stays prior to being diagnosed with bladder cancer in July 2021. The treatment she was offered is the gold standard and, she believes, has been the same for the last 40 years. Raewyn was invited to join a clinical trial. She was assigned to the 'control' group, but was very happy that she had a complete response to the chemo and subsequent surgery. However, the prospect of contributing to a better treatment regime or outcome for future sufferers piqued her interest in medical research. When she was diagnosed, Raewyn joined

a Facebook group for Women with Bladder Cancer. These are women around the world and for some the diagnosis was delayed due to either them or their health providers not seeing their symptoms as potential cancer. Hearing these women's stories, Raewyn has realised the importance of raising awareness and empowering patients to advocate for themselves.

Andrew Martin is inaugural Professor of Innovative Clinical Trials and leads the University of Queensland's cLinical Trials cApability (ULTRA) program. Was previously Professor of biostatistics at the NHMRC Clinical Trials Centre University of Sydney. Prior to academia, Andrew held senior biostatistics roles within research-based pharmaceutical organisations (Pfizer and Roche). Has made original, innovative, and distinguished contributions to methodological research, as well as the design, conduct, analysis, interpretation, and dissemination of clinical research that has had an impact at an international level policy, practice, and subsequent research programs.

Jarad Martin practices as a Radiation Oncologist in Newcastle, Australia, 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.

Tania Moujaber is a Staff Specialist Medical Oncologist at Westmead and Blacktown hospitals and subspecialises in the management of urogenital malignancies. Dr Moujaber is active in translational and clinical research and has been a principal or sub-investigator on more than 40 clinical trials. She is a Senior Clinical lecturer with the University of Sydney and is Medical Oncology lead for the Westmead Clinical School.

Declan Murphy is Consultant Urologist, Director of Genitourinary (GU) Oncology, and Director of Robotic Surgery at the Peter MacCallum Cancer Centre and Professorial Fellow at the University of Melbourne. He is a member of the invitation-only Advanced Prostate Cancer Consensus Conference, a bi-annual gathering of the world's top prostate cancer experts and is also a member of the exclusive Association of Academic European Urologists, an invitation-only association of the world's top academic urologists. He is a Founding Director of Cancer Specialists, a specialist multidisciplinary cancer practice comprising top specialists from Peter Mac. He 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.

Samantha (Sam) Oakes PhD FRSN AAICD brings over 20 years of experience in the Health and Medical Research and Not for Profit sectors to the role of Chief Executive Officer, ANZUP Cancer Trials Group Ltd. With an established career in medical research, Sam's research has led to important discoveries including new therapeutic and anti-metastatic strategies for hard-to-treat breast cancers and other cancers including pancreatic adenocarcinoma. In 2019-2020, Sam established and

led the Long-Term Clinical Follow Up Unit in the Australian Genomic Cancer Medicine Centre (AGCMC), now known as OMICO, one of Australia's largest precision medicine programs. As Director, Research Investment, and member of the Senior Executive Leadership Team at the National Breast Cancer Foundation 2021-2024, Sam has led and overseen the distribution of over $45 million dollars in investment in world class breast cancer research, the development and implementation of the 2023-2028 NBCF Pink Horizon Research Strategy and contributed to organisation-wide change and growth. Sam is a passionate advocate and communicator of Health and Medical Research that will ultimately save lives, alleviate suffering, and improve quality of life and is committed to helping ANZUP continue to deliver on its mission of improving the lives of those diagnosed with Below the Belt cancers through practice-changing multidisciplinary collaborative clinical trials.

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 Pattison underwent dual specialty training in both Endocrinology and Nuclear Medicine at Royal Melbourne Hospital, Austin Hospital and Peter MacCallum Cancer Centre in Melbourne. He was appointed a staff specialist at Peter MacCallum Cancer Centre at the completion of his training and moved to Royal Brisbane & Women's Hospital in 2016 where he is currently the Deputy Director of Department of Nuclear Medicine & Specialised PET Services, nuclear medicine lead for the RBWH radionuclide therapy service and supervises postgraduate students at University of Queensland.

His research interests are at the intersection of nuclear medicine & endocrinology - neuroendocrine tumours & thyroid cancer - and prostate cancer theranostics.

He has been a chief investigator on several large competitive grants for theranostics, including redifferentiation of radioactive iodine refractory thyroid cancer (I-FIRST $2.7 million MRFF 2021), prostate cancer (UpFrontPSMA $4 million Movember/Cancer Australia 2019) and merkel cell cancer (GoTHAM $1.8 million MRFF 2018).

Ruth Pidsley is an NHMRC Investigator Fellow, Group Leader of the DNA Methylation Biomarkers group at the Garvan Institute of Medical Research and Conjoint Lecturer at UNSW Sydney. She graduated with a degree in Human Sciences from Oxford University, before studying for an MSc/PhD in epigenetics at King's College London. In 2013 she transitioned to cancer research at Garvan, establishing her own research group in 2018. The group's research focuses on the role of epigenetics in the prostate tumour microenvironment. Their goal is to use epigenetics to improve cancer diagnosis and prognosis, so patients can receive the correct treatment.

Laura Porter is an Early Career Research Fellow at Monash University in the Prostate Cancer Research Group, which has a strong translational focus that is applicable to urology and oncology clinical practice. Dr Porter's expertise is in the use of patient-derived models of prostate cancer for studying tumour pathology and preclinical therapeutic testing, including CAR T cell immunotherapy and PSMA radioligand therapy.

Andrew Redfern Andy Redfern is Associate Professor of Medical Oncology at the University of Western Australia, Associate Director for Clinical Strategy at Harry Perkins Institute of Medical Research, and a Consultant Medical Oncologist in Perth, treating breast and urological cancers. He has a range of translational research interests which centre around treatment resistance in cancer, cholesterol biosynthesis in cancer, predicting optimum hormonal treatment choices in breast cancer and immunotherapy in bladder and other cancers.

Cameron Redfern is an early career scientist currently working with the Translational Oncology Group of the Cancer Program at the Harry Perkins Institute of Medical Research in Western Australia. He is currently working on a broad portfolio of projects inclusive of; predictive immune profiles in non-muscle invasive bladder cancer, mechanisms of endocrine resistance in breast cancer and Aboriginal lung cancer biology and treatment. He interests also extend to the genetic basis of malignant and non-malignant disease and the use of gene editing and other genetic manipulation technologies in therapy.

Bernie Riley is a registered nurse with 20 years' experience. He has worked across regional and metropolitan, private and public health services. Since 2018 Bernie has been working in the field of Prostate Cancer initially as a Prostate Cancer Specialist Nurse in a private not for profit health service before joining Prostate Cancer Foundation of Australia in the role of Head of Telenursing and Supportive Care Programs. Bernie leads a national telephone-based nursing and counselling service handling enquiries from men and families affected by prostate cancer. Since its launch on 2021, the Telenursing Service has handled over 12000 cases and in 2022 PCFA added a counselling service which has since delivered over 2000 sessions of prostate cancer specific counselling. Bernie has a passion for ensuring men and families are provided the information and support they need to manage their prostate cancer wherever they are.

Matthew Roberts is a Urologist consulting and operating at St Vincent's Private Hospital Northside. He grew up in Brisbane and is a medical graduate from the University of Queensland. He undertook Urology specialty training in Queensland and New South Wales and gained his fellowship from the Royal Australasian College of Surgeons (RACS) in 2020. He undertook dedicated training in robotic surgery at Nepean Hospital, NSW and was certified as a robotic surgeon from the European Association of Urology Robotic Urology Section (ERUS).

A/Prof Roberts has thrived on surgical innovation in urology, introducing new surgical techniques and patient care pathways backed by clinically-relevant world-class research to improve cancer outcomes and patient experience. His clinical and research interests include urologic oncology (surgery and other treatments, imaging, and biomarkers), endourology and urological infections.

A/Prof Roberts was awarded a highly competitive Metro North Clinician Research Fellowship and works as a surgeon-scientist as Associate Professor and Group Leader of the Prostate Theranostics and Urological Diseases Research Group at The University of Queensland Centre for Clinical Research (UQCCR). Matthew has authored more than 120 peer-reviewed manuscripts in international journals, as well as presentation at international conferences. He has been Acting Director of Urology at the RBWH in 2021-2022 and currently is Deputy Clinical Director of Surgery at Surgical Treatment and Rehabilitation Service (STARS).

Natasha Roberts, is a Specialist Nurse. She became a registered nurse in 1994 after graduating from her Bachelor of Nursing Degree, later receiving her Honours degree in 2001 and her PhD in 2021. Her PhD focused on implementing patient reported outcomes in a medical oncology setting. Natasha has extensive clinical experience in prostate cancer nursing and in ICU, and has supported clinical research since her time as a graduate nurse, across roles including cancer care co-ordination, nurse researcher CNC, and clinical trial co-ordinator. She has also served on the UQ Research Ethics Committee. As a clinician researcher, Natasha's research includes multidisciplinary care interventions using co-design and PROMs including in areas such as genitourinary cancer, precision medicine in cancer and infection, as well as consumer involvement in research, qualitative research, mixed methods research, systematic and scoping reviews, and implementation science.

Shahneen Sandhu is a Consultant Medical Oncologist and researcher in the Melanoma and Uro-oncology units at the Peter MacCallum Cancer Centre. She is the Research Lead for the Melanoma Medical Oncology Service. She sits on multiple international advisory panels and has been principal investigator on multiple investigator-initiated and practise changing registration studies in melanoma and prostate cancer. She leads clinical, translational and laboratory research in skin cancers and prostate cancer with a major focus on designing and conducting biologically driven clinical trials to translate laboratory findings into new clinical treatments and studying biomarkers of response and resistance to treatment.

Sally Sara Sally is an experienced nurse leader with a broad range of expertise in both clinical and management roles. Sally established the Prostate Cancer Specialist Nursing Service in the Southern Adelaide Health Care Network in 2014 and has a passion for ensuring quality care and support is provided for men living with prostate cancer and their families.

Tahlia Scheinberg is a medical oncologist and clinician scientist at Chris O'Brien Lifehouse. Her research interest focuses on optimising outcomes for patients with prostate cancer through precision therapies, including metabolic therapies.

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 an expertise in managing sexual dysfunction in oncology/urology patients. She has a Master in Nursing Science and postgraduate qualifications in oncology, urology and continence, nursing. She is currently enrolled in her PhD. Her affiliations are: President of Australian & New Zealand Urology Nurses (2019-2022); Scientific Advisory Committee of Australian and New Zealand Urogenital & Prostate Cancer trials Group (ANZUP); Board member of Victorian Urological Nurses Society.

Andrew Scott is Director, Department of Molecular Imaging and Therapy, Austin Health; leads the Tumour Targeting Program at the Olivia Newton-John Cancer Research Institute; and Professor, University of Melbourne, La Trobe University, and Monash University. His clinical and research interests are focused on molecular imaging particularly oncology applications of PET in cancer and developing innovative strategies for targeted therapy of cancer with monoclonal antibodies, as well as global advocacy of Nuclear Medicine. His laboratory has been involved in the preclinical development and first-in-man trials of numerous recombinant antibodies in cancer patients, and seven antibodies developed in his laboratory have been licenced to Biotech and Pharma companies. He is an Executive Council member of the World Federation of Nuclear Medicine and Biology, is Research Translation and Commercialisation Lead of the VCCC, is a member of the Scientific Committee of ARTnet, and a Federal Council member of the Australian and New Zealand Society of Nuclear Medicine.

Samantha Shekar is a final year Medical Oncology trainee currently undertaking the Cunningham Fellowship in Genitourinary Cancer at The Kinghorn Cancer Centre, St Vincent's Hospital.

Vinod Subhash, PhD is a biomedical scientist with over 10 years of experience in cancer research, specifically focusing on solid tumors. At ANZUP, Vinod leads the Translational Research Operations, bringing a unique combination of academic research expertise and operational insights to cancer clinical trials. Prior to joining ANZUP, Vinod's post-doctoral research focused on biomarker studies for early detection and response monitoring in cancers.

Christopher Sweeney is the inaugural Director of the South Australian immunoGENomics Cancer Institute (SAiGENCI), and a Professor of Medicine at the University of Adelaide. Prof. Sweeney completed his medical education at the University of Adelaide before accomplishing his internship at Royal Adelaide Hospital in Australia. He completed his residency training in internal medicine at Gundersen Lutheran Medical Center in Wisconsin, and his fellowship in hematology and oncology at Indiana University School of Medicine. He then spent 7 years on faculty at Indiana and was appointed Associate Director for Clinical Research for the Simon Cancer Center. Prof. Sweeney joined the Lank Center for Genitourinary Oncology at Dana-Farber Cancer and Harvard Medical School in 2009 and promoted to full Professor of Medicine at Harvard Medical School in 2018.

Alvin Tan is a consultant medical oncologist at Waikato Hospital, Hamilton, New Zealand.

He is the current Head of Department for Medical Oncology at Waikato Hospital, and previous Chair of the Aotearoa New Zealand Advanced Training Subcommittee for Medical Oncology for the Royal Australasian College of Physicians.

He completed his Bachelor of Medicine and Surgery (2006) at the University of Otago, Dunedin. He achieved Fellowship of the Royal Australasian College of Physicians (FRACP) in 2014, having trained in medical oncology at Auckland City Hospital where he developed particular interest in genitourinary cancers and participation in oncology clinical trials.

He is the primary site investigator for a number of collaborative oncology trials being conducted at Waikato Hospital, and has previously participated in the 2016 Australia & Asia Pacific Clinical Oncology Research Development (ACORD) Workshop. He is a graduate of the 2019 ESMO Leaders Generation

Programme Asia and now serves as a member of the ESMO Practising Oncologist Working Group Committee (2021-present). He is a past Executive Committee member for the New Zealand Society of Oncology.

Renea Taylor is an Associate Dean, Centres and Institutes, in the Faculty of Medicine, Nursing and Health Sciences, Monash University. She the Co-Head of the Cancer Program in the Monash Biomedicine Discovery Institute and co-leads the Prostate Cancer Research Group in the Department of Physiology. Prof Taylor performed inter-disciplinary training in stem cell and prostate biology through prestigious post-doctoral and mid-career training fellowships from National Health and Medical Research Council, U.S. Army Department of Defense, Prostate Cancer Foundation of Australia and Victorian Cancer Agency. This training led to her developing an independent research career built around a translational research program that is directly applicable to urology and oncology clinical practice.

In her academic role as a Teaching and Research Fellow at Monash University, she is committed to training the future research scientists in both undergraduate and postgraduate courses in Endocrinology and Cancer Biology and is a particular advocate for young women.

Prof Taylor leads the Monash University Research Prostate Cancer Support Group within the PCFA Network. Renea actively engages with consumer representatives and seeks their input into research design and implementation, as well as dissemination of research outcomes and advances in the field. She plays a key role in science communication and dedicates significant time to the promotion of prostate cancer awareness in the community. Her team have a proud and longstanding relationship with the EJ Whitten Foundation (now RULE Prostate Cancer), working together towards research and advocacy for prostate cancer.

Niluja Thiruthaneeswaran (B.Sc., MBBS, FRANZCR, MPH, PhD) is a Radiation Oncologist and holds a Conjoint Senior Lecturer position at The University of Sydney. She completed her medical studies at The University of Queensland and speciality training in Australia before undertaking the Windeyer Brachytherapy Fellowship at Mount Vernon Cancer Centre, UK. Following this she completed her PhD with the Translational Radiobiology group at The University of Manchester on hypoxia gene expression signatures in prostate cancer. She has a Master of Public Health from The University of Sydney. Her research interests primarily focus on radiation response biomarkers, with a particular emphasis on their application in genitourinary and gynaecological cancers.

Jonathan Tomszewski Jonathan trained in radiation oncology at the Peter MacCallum Cancer Centre in Melbourne. In 2014, he joined the team at the Ballarat Austin Radiation Oncology Centre (BAROC) as a generalist Radiation Oncologist, with a special interest in the management of urological malignancies. He served as co-chair and chair of the eviQ Radiation Oncology Reference Committee from 2017-2021. He has been a lecturer in radiation and cancer biology for the Victorian/Tasmanian Radiation Oncology Training Network and convened the ESTRO Basic Clinical Radiobiology course in 2018. He has recently been involved in updating the FROGG guidelines for postprostatectomy radiotherapy. Jonathan's focus is on providing world-class, evidence-based care for regional cancer patients close to home.

Ben Tran is an Associate Professor within the Sir Peter MacCallum Department of Oncology at The University of Melbourne and a Medical Oncologist at Peter MacCallum Cancer Centre. He also holds a Clinician Scientist appointment at the Walter and Eliza Hall Institute. His clinical focus lies entirely within the genitourinary (GU) tumour stream, in particular, testicular cancers. Following his medical oncology training in Australia, Ben completed an overseas Fellowship in Drug Development and Urological cancers at Princess Margaret Cancer Centre in Toronto, Canada. There he gained extensive experience in treating GU cancers, conducting Phase I clinical trials, implementing a large scale molecular profiling program and managing large multi-centre databases containing real world patient data. These experiences have allowed him to establish himself as a leader in GU cancers, Early Drug Development and RWD. Ben currently leads the GU clinical trials program at Peter MacCallum Cancer Centre and is Chair of the GU Tumour Group within Cancer Trials Australia, and Chair of the ANZUP Germ Cell Subcommittee.

Haitham Tuffaha is the Interim Director at The University of Queensland's Centre for the Business and Economics of Health (CBEH). He also lead Health Technology Assessment for the Centre, which involves evaluating submissions made to the Australian Government to reimburse new medicines and medical devices through the Pharmaceutical Benefits Scheme (PBS) and the Medicare Benefits Schedule (MBS). His research is focused on the economic evaluation of health interventions to inform decision making and promote value-based health care. He has pioneered the application of Value of Information (Research) analysis to enhance the efficiency of clinical trials and maximise the return on investment from medical research.

Anthony Uccellini is a distinguished Medical Oncologist with a focus on genito-urinary cancers, gastrointestinal cancers, and neuro-oncology. Graduating from Deakin University Medical School in 2013, Dr. Uccellini became a Fellow of the Royal Australian College of Physicians in 2023. His proficiency in clinical trials is underscored by his ongoing roles at the esteemed Walter Eliza Hall Institute and the ANZUP organization.

Ian Vela is an early career clinician scientist at the APCRC-Q and Consultant Urologist at the Princess Alexandra Hospital with subspecialty training in Urologic Oncology.

He has a molecular and cellular biology research background and was awarded his PhD from the University of Queensland in 2010, identifying a novel Wnt pathway associated gene (PITX2) in metastatic prostate cancer (publication submitted to Journal of Experimental Metastasis).

During his PhD, Dr Vela secured several grants/ scholarships including a Smart State PhD scholarship (2007), Australasian Urologic Foundation scholarship (2006) and a University of Queensland Pathfinder grant (2009).

During this time, he collaborated with Team Leaders Prof Clements and Prof Nelson, being co-authors on publications, abstracts and international and national podium and poster presentations. Dr Vela was also an associate supervisor for two PhD students together with Profs Clements and Nelson.

Dr Vela has completed his training in Urology being awarded FRACS Urology in 2012 and was then selected for a two year Society of Urologic Oncology (SUO) Fellowship at the prestigious Memorial Sloan-Kettering Cancer Center in New York, where he, together with Dr Charles Sawyers, Dr Brett Carver, Dr Yu Chen, and Dr Howard Scher (Memorial Sloan-Kettering Cancer Center), and Dr Hans

Clevers (Hubrecht Institute in the Netherlands), was instrumental in developing cutting edge "organoid" culture technology.

This technology allows in vitro culture of metastatic prostate cancer tissue and circulating prostate cancer tumour cells (CTCs), and has lead to the development of multiple new metastatic prostate cancer cell lines (publication currently pending).

The fellowship also provided Dr Vela with extensive clinical training in advanced open, minimally invasive, endoscopic and robotic Urologic Oncology.

Andrew Weickhardt is a medical oncologistat 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.

Elizabeth Williams, BSc (Hons), PhD, has worked in the field of cancer metastases, focussing on prostate and bladder cancer, since completing her PhD in pharmacology in 1997. She joined APCRC-Q in 2013 to lead the tumour models stream and extend her prostate cancer research program.

Prior to joining APCRC-Q, Dr Williams was the Metastasis Research Group Leader at Monash Institute of Medical Research's Centre for Cancer Research (2006-2012), an Associate Senior Fellow at the Department of Surgery, University of Melbourne and a Research Fellow (Prostate Cancer Group Leader) at the Bernard O'Brien Institute of Microsurgery (2002-2006).

Dr Williams and her team have established a panel of systems to study the interaction of prostate cancer cells within the endothelial cells of the prostatic lymphatic vessels, with the aim of identifying key molecules involved in the process. They are also investigating the molecular basis of prostate cancer cells that survive castration. Her current research project utilises transplantable human prostate cancer xenografts, including one that her team derived from a bone metastasis in 2001.

Trent Williams is the current NSW Nurse of the year establishing the nations first nurse led Cardio Oncology service. He has 20 years as a Cardiology CNC receiving multiple awards for Cardiology systems of care.

He was awarded his PhD at the University of Newcastle in 2019 and a previous holder of a 3 year fellowship.

Henry Woo is a urological surgeon who subspecialises in prostate disease. He is the Director of Uro-Oncology and Head of Robotic Cancer Surgery at the Chris O'Brien Lifehouse. He is also an Honorary Professor at the College of Health and Medicine of the Australian National University and Conjoint Professor in the Blacktown Mount Druitt Clinical School of Western Sydney University. Additionally, he is the Head of the Department of Urology, at Blacktown Hospital in the Western Sydney Local Health District. He has published widely in major urological journals. He is an Associate Editor of the Société Internationale d'Urologie Journal and serves on the journal editorial boards of World Journal of Urology, Prostate Cancer and Prostatic Diseases, Prostate International, Asian Journal of Urology and World Journal of Men's Health. He is a Fellowship elected Councillor (Board Director) of the Royal Australasian College of Surgeons and has recently been appointed Chair of the Professional Standards Committee. He also serves on the board of the charitable Australian Urological Foundation (AUF).

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.

Paul Zawa is currently a Principal Lawyer at Phi Finney McDonald (PFM), which he joined in August 2018. His personal experience with cancer began with his mother, who died of lymphoma at the age of 71. His brother, 10 years his senior, was diagnosed with prostate cancer at 48 and had a radical prostatectomy. Consequently, Paul has been monitoring his PSA since the age of 38. Despite his family history, his health was reasonably good, so it came as a shock to be diagnosed with stage 2 testicular cancer at the end of 2018 at the age of 61, an unusual age for that disease. He was at stage 2 because a tumour had been located in his chest cavity. Following an orchiectomy (right), he commenced chemotherapy at the Peter MacCallum Cancer Centre in the first calendar quarter of 2019. Unfortunately, the chemotherapy did not shrink the tumour enough, and he underwent a retroperitoneal lymph node dissection in June of 2019 to remove the tumour and confirm the cancer had not spread. The tumour was completely dead tissue, and the cancer did not appear to have spread to any lymph nodes. To quote one of his doctors, 'he was 99.9% cured'. During one of Paul's recent check-ups with his oncologist, Dr Ben Tran, he was discussing what a positive emotional experience he had at Peter MacCallum as a result of the amazing support of the staff there. He told Ben that he has always believed in "putting something back" to the community and was curious about what avenues there might be at Peter MacCallum, or elsewhere, to assist with cancer patients and treatment. As a result of that conversation, Ben put Paul in touch with ANZUP, suggesting a role on the Consumer Advisory Panel, based on his experience.

Alison Zhang is a Medical Oncologist at Macquarie University Hospital, Chris O'Brien Lifehouse and an Adjunct Senior Lecturer at Macquarie University Hospital. She focuses on treating Genitourinary (bladder/ urothelial, kidney, prostate, testicular and penile) malignancies and is the Bladder Cancer Lead at Macquarie University Hospital and the Bladder/ Kidney Cancer Lead at the Chris O'Brien Lifehouse.

She has completed a translational cancer PhD (Garvan Institute, Sydney), focusing on delineating biomarkers in prostate cancer and a Master of Clinical Epidemiology (focusing on statistical methods and clinical trial design). She is currently a Senior Oncology Research Fellow at the NHMRC Clinical Trials Unit, as part of the University of Sydney, where she is comprehensively involved in trial design, conduct and analysis of academic genitourinary trials. She is the Macquarie University and Chris O'Brien Lifehouse principal investigator on more than 15 Phase I-III studies.

Her research has been published in peer-reviewed, high impact factor journals, including the New England Journal of Medicine, Lancet, Lancet Oncology, Journal of Clinical Oncology and Annals of Oncology. She also sits on several ANZUP trial management committees and is an active member of the European Society of Medical Oncology (ESMO), American Society of Clinical Oncology (ASCO), Medical Oncology Group of Australia (MOGA), and Australia and New Zealand Urogenital and Prostate Cancer Trials Group (ANZUP).

ANZUP Scientific Program and Pre-Conference Meetings 2024 *'Making Waves'*

SUNDAY 21 JULY 2024

0730 - 0755		**ANZUP PCFA Nurses & Allied Health Symposium Breakfast** ***Foyer 5, 6 & 7***
0830 - 1030	**The Perfect Pitch** ***Hall 1*** **Co-Chairs:** Andrisha Inderjeeth and Arun Azad	**ANZUP PCFA Nurses & Allied Health Symposium** ***Rooms 5, 6 & 7*** *Sponsored by:* astellas ONCOLOGY Prostate Cancer Foundation of Australia **Co-Chairs:** Kath Schubach and Sally Sara - Welcome - Sponsors Welcome - Astellas
	Introduction to Session - Andrisha Inderjeeth and Arun Azad	Rapid Access Nurse Led Cardio-Oncology Clinics: Management and impact for Prostate Cancer Patients - Trent Williams
	Small to medium grant opportunities - Andrew Redfern	**RESEARCH UPDATES** Development, implementation, and evaluation of a nurse-led survivorship intervention for men with prostate cancer receiving Androgen Deprivation Therapy (ADT) - Sally Sara
	Translational funding opportunities - Ian Vela	Identifying the Supportive Care Needs of People Affected by Non-Muscle Invasive Bladder Cancer: An Integrative Systematic Review - Kath Schubach
	Industry sponsored research - Arun Azad	Identifying the lived experience of Active Surveillance for Prostate Cancer - understanding and supporting the unmet survivorship care needs of men within the first 12 months following diagnosis - Russell Briggs
	Health Economics 101 - Richard De Abreu Lourenco	The Journey of Growth (not the erectile kind) - Michelle Cybulski and Jade Allen
		Clinician Researcher Fellowships - Natasha Roberts
	The consumer role and engagement in grant - Belinda Jago	Combination gemcitabine/docetaxel for BCG refractory high-risk non-muscle invasive bladder cancer - Cynthia Hawks
		ANZUP Nurses Project - Natasha Roberts and Jasmine Brady
	Q&A	**RESEARCH 101** How to write an abstract - Nicole Heneka
1030 - 1100	**Morning Tea** ***Trade Hall - Hall 2***	**Morning Tea** **Foyer of Meeting *Rooms 5, 6 & 7***

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

Continued over

ANZUP Scientific Program and Pre-Conference Meetings 2024 *'Making Waves'*

SUNDAY 21 JULY 2024 *continued*

1100 - 1230	**Translational Highlights Session** ***Hall 1*** **Co-Chairs:** Renea Taylor and Brett Hollier	**ANZUP PCFA Nurses & Allied Health Symposium continues...** ***Rooms 5, 6 & 7*** *Sponsored by:* astellas ONCOLOGY, Prostate Cancer Foundation of Australia
	Characterization of prostate tumors with germline BRCA2 mutations - Elena Castro *Sponsored by:* BAYER	**RESEARCH 101 continues...** Overview of research Methodologies - Nicole Haneka
	DNA methylation markers of prostate cancer aggressiveness - Pierre-Antoine Dugue	Clinical Trials can be for everyone - Craig Gedye
	Personalising precision medicine approaches for bladder cancer treatment and monitoring - Elizabeth Williams	
	Immunomodulatory effects of anti-VEGF TKI – results from the Phase II APREDICT study - Lewis Au	An Introduction to Implementation - Kym Hyam
	Gene Fusion Diagnostics for Prostate Cancer Liquid Biopsies: Suppressing Noise & Enhancing Sensitivity - Kevin Koo	
1230 - 1330	**Lunch**	***Trade Hall - Hall 2***
1330-1500	**ANZUP Masterclass** ***Hall 1*** *Sponsored by:* AMGEN, MOVEMBER **Co-Chairs:** Carole Harris and Andrisha Inderjeeth Welcome by Sponsor - Mun Hin Yong, Amgen	
	Renal Cell	**Chair:** Lewis Au
	BUP	**Chair:** Tania Moujaber
	Germ Cell	**Chair:** Orlaith Heron
1515 - 1545	**Afternoon Tea**	***Trade Hall - Hall 2***
1545 - 1700	**ANZUP Masterclass continues** ***Hall 1*** *Sponsored by:* AMGEN, MOVEMBER **Co-Chairs:** Carole Harris and Andrisha Inderjeeth Welcome by Sponsor - Sarah Weller, Movember	
	Early prostate	**Chair:** Bernie Riley
	Advanced prostate	**Chair:** James Buteau

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Continued over

ANZUP Scientific Program and Pre-Conference Meetings 2024 *'Making Waves'*

SUNDAY 21 JULY 2024 *continued*

1700 - 1830	**ANZUP Welcome Reception**	***Hall 2***
1815 and 1845	**Coach transfer from the Gold Coast Convention Centre TO Southport Yacht Club** First two buses depart 1815, second two buses depart 1845	
1915 - 2200	**ANZUP Evening Symposium – *AI: Judgement Day or a Research Revolution*** ***Southport Yacht Club, 1 Macarthur Parade, Main Beach*** **Chair:** Ben Tran **Welcome by:** Michael Eisbacher, Johnson and Johnson – Impact of AI on clinicians, researchers, and society - benefits and pitfalls - Paul Nguyen – Real Intelligence - Fiona McLean Followed by a panel discussion: Paul Nguyen, Fiona Maclean and Ray Allen	*Sponsored by:* Johnson&Johnson

MONDAY 22 JULY 2024

0715 - 0815	**ANZUP sponsored Translational Science Breakfast** ***- Translational Rapid-Fire updates*** ***Hall 1*** *Sponsored by:* ANZUP Cancer Trials Group Limited **Co-Chairs:** Lisa Butler and Tuan Hoang	**Supportive Care Breakfast** ***Patient reported outcomes measured or missed?*** ***Rooms 5, 6 & 7*** *Sponsored by:* Prostate Cancer Foundation of Australia *This session will explore the use of PROMs and whether the measures we have are 'fit for purpose', and what is coming in the next wave of PROMs.* **Chair:** Haryana Dhillon
	prelim GEP and germline and tumor exome data from CHAARTED and STAMPEDE that will inform what we are doing in ENZAMET – Chris Sweeney	At the pointy end of PROMS: Q&A with two ANZUP CAP members - Juliette de Nittis and Ray Allen
	TheraP imaging biomarkers / Tb-161 dosimetry – James Buteau	Gaps in measurement: Understanding patient perspective on current PROMs – Cristiane Bergerot
	Germ Cell Update – Ben Tran	Putting the health back into health economic analyses: the role of PROMs – Richard De Abreu Lourenco
	Bladder Update – Andrew Redfern	
	Prostate Update – Lisa Horvath	Panel discussion and Q&A
0830 - 0900	**Opening Session** ***Hall 1*** - Welcome and introduction - Ian Davis - Welcome to Country - Emerald Brewer, proud Kombumerri woman and Traditional Custodian - Co-Convenors - Matt Roberts and Aaron Hansen - ANZUP CEO - Samantha Oakes - Sponsor address: PCFA - Steve Callister - Sponsor address: AstraZeneca - Daniel Cleary	*Sponsored by:* AstraZeneca
0900 - 1030	**Keynote Session – What's making waves in GU in 2024** ***Hall 1*** **Co-Chairs:** Aaron Hansen and Niluja Thiru – Updates in Bladder Cancer: Ushering the Era of Precision Oncology - Ravindran Kanesvaran – New advances in testis cancer care - Rob Hamilton – Rocking the boat in kidney cancer: latest updates - Niara Oliviera – What are the next-gen mHSPC clinical trials? - Chris Sweeney – Making Waves: Psycho-Oncology and the changing tide of "Supportive Care" - Brian Kelly Q&A	*Sponsored by:* MERCK

Continued over

ANZUP Scientific Program and Pre-Conference Meetings 2024 *'Making Waves'*

MONDAY 22 JULY 2024 *continued*

1030 - 1100	**Morning tea**	***Trade Hall - Hall 2***	*Sponsored by:* IPSEN Innovation for patient care
1100 - 1225	**Translational Plenary**	***Hall 1***	*Sponsored by:* AstraZeneca

Co-Chairs: Mitchell Lawrence and Tahlia Scheinberg
- Impact of HRR alterations in metastatic castration resistant prostate cancer - Elena Castro sponsored by: Bayer
- RNA expression and AI-driven digital pathology to personalize therapy in high risk prostate cancer - Paul Nguyen
- Epigenetics in the prostate tumour microenvironment - Ruth Pidsley
- Discovery of rare risk variants to advance clinical testing in prostate cancer - Liesel FitzGerald

1225 - 1245	**Debate - Should we be waiting for OS to apply adjuvant therapy treatments**	***Hall 1***	*Sponsored by:* Bristol Myers Squibb

Co-Chairs: Melissa Le Mesurier and and Handoo Rhee
Affirmative: Alison Zhang
Negative: Jarad Martin

1245 - 1345	**Lunch**	***Trade Hall - Hall 2***	
1345 - 1510	**Best of the Best Oral Abstracts Session**	***Hall 1***	*Best of the Best Awards sponsored by:* astellas ONCOLOGY

Co-Chairs: Tom Ferguson and Rachel Effeney
- Prognostic and Predictive Immune-Based Biomarkers to Assess the Benefit of Adding mitomycin to Bacillus Calmette-Guérin as intravesical therapy for high-risk, non-muscle-invasive urothelial bladder cancer - Cameron Redfern
- Can proteomics predict metastatic relapse in prostate cancer? Development of a 6 protein prognostic signature in a >250 sample proteomic study including a validation cohort - Elizabeth Connolly
- Registry-Based Randomised Study of Enzalutamide vs Abiraterone Assessing Cognitive Function in ELderly Patients with Metastatic Castration-Resistant Prostate Cancer (REAL-Pro) - Angelyn Anton
- Radiobiological responses to Lutetium-PSMA-I&T: the impact of underlying tumour biology on treatment response - Laura Porter
- Analysis of combination immunotherapy availability in Australia and time to treatment commencement in metastatic clear cell renal cancer - Evon Jude
- Bipolar androgen therapy in combination with carboplatin chemotherapy retains activity in late line metastatic castrate- resistant prostate cancer. An interim analysis of the Phase II HIGH-TeCH study - Samantha Shekar
- A novel targeted therapy for treatment-emergent anaplastic forms of castration-resistant prostate cancer - Brett Hollier
- A novel, two-staelnage approach to the treatment of renal cell carcinoma with intra-cardiac tumour extension and hepatic vein involvement: a case series - Dixon Woon

1510 - 1540	**Afternoon tea**	***Trade Hall - Hall 2***	*Sponsored by:* Bayer
1540 - 1700	**Wave of Inclusivity**	***Hall 1***	*Sponsored by:* MSD

Co-Chairs: Raewyn Manssen and Nick Buchan
- Remote Physical Activity Program for Patients with Metastatic Renal Cell Carcinoma Undergoing Immunotherapy - Paulo Bergerot
- Empowered by mentorship: creating networks to improve cancer care in Brazil - Cristiane Bergerot
- Inequities in prostate cancer care for Māori in Aotearoa New Zealand - Jared White
- One of these things is not like the other: Sexual identity & Gender orientation & clinical trials - Haryana Dhillon

Q&A

1700 - 1730	**ANZUP AGM** (Members Only)	***Hall 1***	
1730 - 1830	**Poster Walkaround**	***Hall 2***	*Best of the Best Awards sponsored by:* astellas ONCOLOGY

Poster discussants: Group 1: Henry Woo, Ciara Conduit and Anthony Uccellini
Group 2: Laurence Krieger, Nicky Lawrence and Richard de Abreu Lourenco
Group 3: Chris Sweeney, Niara Oliveri and Natasha Roberts

1900 - 2300	**ANZUP Conference Dinner**	***Hall 4***

Includes address by Education Fellowship Sponsor - Charini Jayasinghe, Ipsen

Continued over

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ANZUP Scientific Program and Pre-Conference Meetings 2024 *'Making Waves'*

TUESDAY 23 JULY 2024

0715 - 0815	**Breakfast Session – *Theranostics*** *Sponsored by:* Prostate Cancer Foundation of Australia **Rooms 5, 6 & 7** **Co-Chairs:** Louise Emmett and David Pattison – Combination Treatments - Louise Emmett – Alpha Therapies - David Pattison – SPECT - Narjess Ayati – Early Phase Trials - Michael Hofman	
0830 - 1000	**Plenary – *Surf's up - Value in GU Oncology*** ***Hall 1*** **Co-Chairs:** Les Land and Cynthia Hawks – Exploring app-based mindfulness among patients with metastatic kidney cancer - Cristiane Bergerot – Bang for the Buck in GU Oncology - Paul Nguyen – New drugs, do we pay more for less? Let's speak about value - Bertrand Tombal sponsored by: astellas ONCOLOGY – What is value for consumers? - Leonie Young – Translating to public policy and other health economics consideration - Haitham Tuffaha – Population testing/PCFA update - Peter Heathcote Q&A	
1000 - 1030	**Riding the Career Wave** ***Hall 1*** **Co-Chairs:** Declan Murphy and Carole Harris – Learning to Surf - Fiona Maclean – Opportunities and talking about mentorship - Liz Kenny – When is the right time for change? Advice to an older self - Rhea Liang Q&A	
1030 - 1100	**Morning tea** ***Trade Hall - Hall 2***	*Sponsored by:* Johnson&Johnson
1100 - 1230	**Plenary – GU Oncology in 2034** ***Hall 1*** **Co-Chairs:** Rachel Effeney and Paul Zawa – Testis cancer care in the year 2034 - Rob Hamilton – Theranostics assimilation into medical oncology - Louise Kostos – Experimental therapies in GU Oncology - Shahneen Sandu – Innovation in Clinical Trial Design - Andrew Martin – Closing the Cancer Care Gap in Asia Pacific by 2034 - Ravindran Kanesvaran Q&A	
1230 - 1230	**Lunch** ***Trade Hall - Hall 2***	
1330 - 1500	**2024 – ANZUP Trials in Action** ***Hall 1*** *Sponsored by:* astellas ONCOLOGY **Co-Chairs:** Niara Oliveira and Jim Jackson – Translational: Vinod Subhash – BUP: Dickon Haynes and Andrew Weickhardt – Germ Cell: Ben Tran – Imaging and Theranostics: Andrew Scott and Narjess – Prostate: Lisa Horvath and Jarad Martin – Renal: Craig Gedye – Quality of Life: Haryana Dhillon and Natasha Roberts	
1500 - 1530	**ANZUP Awards and ASM close** **Chairs:** Ian Davis, Matt Roberts and Aaron Hansen Closing comments: PCFA - Peter Heathcote Announcing ANZUP ASM 2025	
1530	End of ASM	
1545	**Coaches depart to Brisbane and Gold Coast Airports.** *Please collect your bags and head quickly to the main entrance of the GCCEC to alight the coaches.*	

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The Best of the Best Oral Abstracts

Registry-Based Randomised Study of Enzalutamide vs Abiraterone Assessing Cognitive Function in ELderly Patients with Metastatic Castration-Resistant Prostate Cancer (REAL-Pro)

Angelyn Anton

Remote Physical Activity Program for Patients with Metastatic Renal Cell Carcinoma Undergoing Immunotherapy

Paulo Bergerot

Can proteomics predict metastatic relapse in prostate cancer? Development of a 6 protein prognostic signature in a >250 sample proteomic study including a validation cohort

Elizabeth Connolly

A novel targeted therapy for treatment-emergent anaplastic forms of castration-resistant prostate cancer

Brett Hollier

Analysis of combination immunotherapy availability in Australia and time to treatment commencement in metastatic clear cell renal cancer

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Radiobiological responses to Lutetium-PSMA-I&T: the impact of underlying tumour biology on treatment response

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Prognostic and Predictive Immune-Based Biomarkers to Assess the Benefit of Adding mitomycin to Bacillus Calmette-Guérin as intravesical therapy for high-risk, non-muscle-invasive urothelial bladder cancer

Cameron Redfern

Bipolar androgen therapy in combination with carboplatin chemotherapy retains activity in late line metastatic castrate-resistant prostate cancer. An interim analysis of the Phase II HIGH-TeCH study

Samantha Shekar

Rapid Access Nurse Led Cardio-Oncology Clinics: Management & impact for Prostate Cancer Patients -

Trent Williams

A novel, two-stage approach to the treatment of renal cell carcinoma with intra-cardiac tumour extension and hepatic vein involvement: a case series

Dixon Woon

List of Poster Abstracts

68Ga-Prostate Specific Membrane Antigen Positron Emission Tomography/Computed Tomography (PSMA PET/CT) Maximum Standardised Uptake Values and Total Lesion PSMA Predict PSA Levels and PSA Density in Localised Prostate Cancer #abs1

Dr Jeremy Cheng, Dr Tho Pham, Dr David P Nadebaum, Ms Ashley Baring, A/Prof Martin Cherk, A/Prof Jeremy P Grummet

A novel targeted therapeutic approach against advanced treatment resistant prostate cancer #abs2

Dr Lisa Philp, Ms Sophie Napier, Dr Charles Bidgood, Dr Anja Rockstroh, Dr Qiuhua Hu, Mr Yuhin Tang, Ms Namrata Bhattacharya, Ms Tanisha Ngo, Dr Melanie Lehman, A/Prof Elizabeth Williams, Dr Jennifer Gunter, Prof Erik Thompson, Dr Philip Rowell, Prof John Wade, Prof Laszlo Otvos Jr, Prof Colleen Nelson

A novel targeted therapy for treatment-emergent anaplastic forms of castration-resistant prostate cancer #abs3

Dr Brett Hollier, Mr Momin Rahman, Ms Sayuri Mudiyanselage, Dr Nataly Stylianou, Dr Melanie Lehman, Dr Anja Rockstroh, Dr Charles Bidgood, A/Prof Himisha Beltran, Prof Yuzhuo Wang, Prof Martin Gleave, Prof Eva Corey, A/Prof Arun Azad, Dr Jennifer Gunter, Prof Colleen Nelson

A novel, two-stage approach to the treatment of renal cell carcinoma with intra-cardiac tumour extension and hepatic vein involvement: a case series #abs4

Jayapadman Bhaskar, Dixon Woon, Marcos V. Perini, Joseph Ischia, Sara Qi, Graham Starkey, David Wetherell, Dr Louise Ellard, Peter McCall, Lachlan Miles

A Systematic Review on Prostate-Specific Membrane Antigen Positron Emission Tomography (PSMA PET) Evaluating Localized Low- to Intermediate-Risk Prostate Cancer: A Tool to Improve Risk Stratification for Active Surveillance? #abs5

Dr Jordan Santucci, Dr Jianliang Liu, Dr Dixon Woon, Dr Rick Catterwell, Dr Marlon Perera, Professor Declan Murphy, Professor Nathan Lawrentschuk

Active surveillance in ISUP 1 prostate cancer and PI-RADS 4/5 lesion #abs6

Mr Shaoting Zhang, Dr Kylie Yen-Yi Lim, Mr Harrison Liu, Dr Jeffery Jiang, Dr Eldo Paul, Dr Steuart Rorke, Prof. Beena Kumar, Dr Sean Lim, Dr Matthew Harper, Dr Kevin Chu, Dr James Huang, Dr Neiroshan Rajarubendra, Dr Paul Manohar, Dr Trung Pham, Mr Gideon Blecher, Dr Scott Donnellan, A/Prof Weranja Ranasinghe

Active surveillance versus radical treatment for high-volume low-risk prostate cancer: a tertiary centre experience #abs7

Mr Shaoting Zhang, Dr Kylie Yen-Yi Lim, Mr Harrison Liu, Dr Jeffery Jiang, Dr Eldo Paul, Dr Steuart Rorke, Prof. Beena Kumar, Dr Sean Lim, Dr Matthew Harper, Dr Kevin Chu, Dr James Huang, Dr Neiroshan Rajarubendra, Dr Paul Manohar, Dr Trung Pham, Dr Gideon Blecher, Dr Scott Donnellan, A/Prof. Weranja Ranasinghe

AKT inhibition synergizes with docetaxel in neuroendocrine prostate tumours with high phospho-AKT protein expression #abs8

Ms Hipacia Gomes, Natalie Lister, Birunthi Niranjan, Michelle Richards, Renea Taylor, Gail Risbridger

Analysis of combination immunotherapy availability in Australia and time to treatment commencement in metastatic clear cell renal cancer #abs9

Dr Evon Jude, Dr Elizabeth Liow, Dr Jeremy Shapiro, Dr Arun Azad, Dr Megan Crumbaker, Dr Annabel Smith, Dr Ganes Pranavan, Dr Christopher Hocking, Dr Felicia Roncolato, Dr Shirley Wong, Dr Angelyn Anton, Julie Johns, Dr Peter Gibbs, Dr Ben Tran, Dr Andrew Weickhardt

Assessment of Patient and Clinician Perspectives on Clinically Meaningful Extension of Progression-Free Survival in Prostate Cancer #abs10

Dr Ek Leone Oh, Dr Wade Huish, Dr Sara El-Gamil, Mr Tim Benson, Dr Thomas Ferguson

Association between perceived cognitive impairment, psychosocial factors and occupational functioning in prostate cancer survivors: An exploratory cross-sectional analysis #abs11

Mrs Lorna Pembroke, Prof Kerry Sherman, A/Prof Haryana Dhillon, A/Prof Heather Francis, Prof Howard Gurney, Prof David Gillatt

Avelumab first-line (1L) maintenance for advanced urothelial carcinoma (aUC): long-term outcomes from the JAVELIN Bladder 100 trial in patients with high body mass index (BMI) #abs12

Jeanny B. Aragon-Ching, Daniel P. Petrylak, Srikala S. Sridhar, Shilpa Gupta, Petros Grivas, Thomas Powles, Howard Gurney, Tommy Liu, Natalia Jacob, Karin Tyroller, Silke Guenther, Joaquim Bellmunt

Avelumab first-line maintenance (1LM) for advanced urothelial carcinoma (aUC): long-term outcomes from JAVELIN Bladder 100 in patients with low tumor burden #abs13

Joaquim Bellmunt, Thomas Powles, Se Hoon Park, Eric Voog, Begona P. Valderrama, Howard Gurney, Anders Ullén, Yohann Loriot, Srikala S. Sridhar, Norihiko Tsuchiya, Cora N. Sternberg, Jeanny B. Aragon-Ching, Daniel P. Petrylak, Miguel A. Climent Duran, Tommy Liu, Karin Tyroller, Jason Hoffman, Natalia Jacob, Petros Grivas, Shilpa Gupta

Avelumab first-line maintenance (1LM) for advanced urothelial carcinoma (aUC): long-term patient-reported outcomes (PROs) in the phase 3 JAVELIN Bladder 100 trial #abs14

Petros Grivas, Jeanny B. Aragon-Ching, Joaquim Bellmunt, Yohann Loriot, Srikala S. Sridhar, Po-Jung Su, Se Hoon Park, Yoshiaki Yamamoto, David Pook, Natalia Jacob, Jason Hoffman, Mairead Kearney, Michael Schlichting, Thomas Powles

Bacillus Calmette-Guérin with or without pembrolizumab for high-risk non–muscle-invasive bladder cancer that persists/recurs after bacillus Calmette-Guérin induction: cohort A of the phase 3 KEYNOTE-676 study #abs15

Dr Hiroyuki Nishiyama, Prof. Dr. Shahrokh F. Shariat, Dr. Gary Steinberg, Dr. Ashish M. Kamat, Dr. Shaheen Riadh Alanee, Dr. Noah M. Hahn, Dr. Kijoeng Nam, Dr. Kentaro Imai, Dr. Ekta Kapadia, Dr. Neal D. Shore

Barriers and enablers for prostate cancer screening in men from culturally and linguistically diverse backgrounds #abs16

Dr Norma Bulamu, Dr Lemlem Gebremichael, Dr Joshua Trigg, Mr Mwangi Nduati, Associate Professor Michael O'Callaghaan, Associate Professor Billingsley Kaambwa, Dr Daile Rung

BCG therapy and clinical management of bladder cancer in a rural Australian cohort: A small-scale retrospective review #abs17

Dr Sunil Rai, Dr Elke Vermeulen, Dr Alexandra Smith

Bipolar androgen therapy in combination with carboplatin chemotherapy retains activity in late line metastatic castrate-resistant prostate cancer. An interim analysis of the Phase II HIGH-TeCH study #abs18

Dr Samantha Shekar, Professor Anthony Joshua, Dr Mitchell Lawrence, Leonard Goldstein, Dr Andrew Yam, Dr Teesha Downton, Nicole Araiza, Jacob Yousif, Lalith Ratnayake, Professor Emmanuel Antonarakis, Professor Sam Denmeade, Dr Megan Crumbaker

Bladder preservation treatment opportunities for patients with non-metastatic muscle invasive bladder cancer: a qualitative exploration of a single-centre experience #abs19

Dr Savisha Fernando, Prof Farshad Foroudi, Mr Mark Tacey, Dr Gregory Jack, A/Prof. Andrew Weickhardt

Blazing a New Trail: How Neutrophil Extracellular Traps Might Be Driving Bladder Cancer #abs20

Ms Raquel Herranz, Patricia Ibiza-Guijarro, Julia Oto, Patricia Verger, Emma Plana, Santiago Bonanad, Pau Martínez-Rodríguez, César D Vera-Donoso, Manuel Martínez-Sarmiento, Dr. Elizabeth D Williams, Dr. Pilar Medina

Can proteomics predict metastatic relapse in prostate cancer? Development of a 6 protein prognostic signature in a >250 sample proteomic study including a validation cohort #abs21

Dr Elizabeth Connolly, Dr Simon Cai, Dr Daniel Bucio-Noble, Dr Zainab Noor, Dr Jennifer Koh, Professor James Kench, Dr Adel Aref, Anne-Maree Haynes, Dr Peter Hains, Professor Phillip Stricker, Professor Phillip Robinson, A/Prof Qing Zhong, A/Prof Peter Grimison, Professor Roger Reddel, Professor Lisa Horvath

Changing landscape of real-world upfront treatment of metastatic hormone-sensitive prostate cancer (mHSPC) #abs22

Dr Andrisha - Jade Inderjeeth, Dr Richard Kelly, Dr Angelyn Anton, Prof Peter Gibbs, Ms Julie Johns, Dr Elizabeth Liow, Dr Annabel Smith, Prof Phillip Parente, Dr Stephen Brown, Prof Jeremy Shapiro, Prof Anthony Joshua, Prof Arun Azad, Dr Shirley Wong, Prof Andrew Weickhardt, Prof Ben Tran

Coformulations of favezelimab/pembrolizumab and vibostolimab/pembrolizumab in patients with bacillus Calmette-Guérin–unresponsive high-risk non–muscle-invasive bladder cancer: cohort C of the phase 2 KEYNOTE-057 trial #abs23

Dr. Ashish Kamat, Dr. Girish Kulkarni, Dr. Shilpa Gupta, Prof. Andrea Necchi, Dr. Hema Dave, Dr. Ekta Kapadia, Dr. Qing Zhao, Dr. Neal D. Shore

Diagnostic performance of contrast-enhanced ultrasound (CEUS) in evaluation of renal masses #abs24

Dr Mohammadmehdi Adhami, Ms Anuradha Narayan, Dr Jonathan O'Brien, Ms Jane Keating, Dr Wayland Wang, Dr Kenneth Sim, Dr Paul Simkin, Dr Robert Gibson, Prof Nathan Lawrentschuk

Dissecting the meaning of obesity in metastatic castration resistant prostate cancer: size or metabolism? #abs25

Dr Rhiannon Mellor, Dr Charlotte Kench, Dr Hui-Ming Lin, Dr Blossom Mak, Dr Tahlia Scheinberg, A/Prof Kate Mahon, Ms Lisa Graham, A/Prof Arun Azad, Prof Anthony Joshua, Prof Martin Stockler, Prof Gavin Marx, Dr Karen Briscoe, Prof Peter Meikle, A/Prof Andrew Hoy, Prof Katherine Samaras, Prof Lisa Horvath

Emerging recruitment patterns from a national randomised controlled trial of a survivorship care intervention for men with prostate cancer on androgen deprivation therapy (PCEssentials Hormone Therapy Study) #abs26

Mrs Catherine Riley, Professor Robert U Newton, Professor Suzanne K Chambers, Associate Professor David P Smith, Professor Haitham Tuffaha, Professor Daniel A Galvão, Adjunct Professor Peter Heathcote, Professor Manish I Patel, Professor David Christie, Mr Sam Egger, Ms Sally AM Sara, Associate Professor Nicole Heneka, Professor Jeff Dunn

Erectile dysfunction in focal low-dose-rate brachytherapy – early results from Australia's LIBERATE Registry #abs27

Dr Mohammadmehdi Adhami, Dr Elliot Anderson, Dr Lloyd Smyth, Dr Richard O'Sullivan, Dr Andrew Ryan, Prof Nathan Lawrentschuk, Dr Andrew See, A/Prof Jeremy Grummet

Exploring the Clinical Outcomes and Role of Magnetic Resonance Imaging for Patients Diagnosed with Atypical Small Acinar Proliferation #abs28

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Poster Abstracts

#abs1 | 68Ga-Prostate Specific Membrane Antigen Positron Emission Tomography/ Computed Tomography (PSMA PET/CT) Maximum Standardised Uptake Values and Total Lesion PSMA Predict PSA Levels and PSA Density in Localised Prostate Cancer

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INTRODUCTION AND OBJECTIVES: 68Ga-prostate specific membrane antigen positron emission tomography/computed tomography (PSMA PET/CT) is widely used in staging/re-staging of prostate cancer (PC). Maximum standardised uptake values (SUVmax) have been shown to correlate with PSMA histological uptake1. We aimed to determine if SUVmax and total lesion PSMA (PSMATL) could be used similarly to predict PSA.

METHODS: We retrospectively analysed 200 patients with primary/treatment naive biopsy proven PC who underwent 68Ga-PSMA PET/CT demonstrating disease localised to prostate only. SUV¬¬max was quantitatively measured by mapping regions of interest at the primary lesion. PSMATL was defined as the product of PSMA tumour volume and SUVmean.

RESULTS: Median PSA was 9.54ng/mL (interquartile range 6.60-13.00). A statistically significant weak correlation with SUVmax was demonstrated by both PSA and PSA density (Spearman p=0.343, p<0.001 and p=0.303, p<0.001 respectively). There was a weak correlation between PSA and PSMATL (p=0.359, p<0.001).

SUVmax and PSMATL values were both greater as PSA subgroup (≤10 vs 10-20 vs ≥20) increased (p<0.001, Kruskal-Wallis test). There was a significant difference in mean SUVmax and PSMATL across groups (p<0.001, oneway ANOVA): ≤10 (11.43 ± 7.98) vs 10-20 (14.61 ± 12.07) vs ≥20 (20.86 ± 12.17) and ≤10 (33.44 ± 28.30) vs 10-20 (40.40 ± 30.29) vs ≥20 (70.26 ± 55.45) respectively. SUVmax demonstrated a weak correlation with Gleason score in the radical prostatectomy subgroup based on final histopathology (p=0.355, p<0.001).

CONCLUSIONS: We demonstrated that both 68Ga-PSMA PET/CT SUVmax and PSMATL can predict PSA levels and PSA density, and that SUVmax correlates with Gleason score. PSMATL is an additional PSMA PET/CT parameter that could be used in the risk stratification of PC. Further exploration of the relationship between PSMATL, Gleason score and long-term clinical outcomes is required.

1. Woythal N, Arsenic R, Kempkensteffen C, Miller K, Janssen JC, Huang K, Makowski MR, Brenner W, Prasad V. Immunohistochemical Validation of PSMA Expression Measured by 68Ga-PSMA PET/CT in Primary Prostate Cancer. J Nucl Med. 2018 Feb;59(2):238-243. doi: 10.2967/jnumed.117.195172. Epub 2017 Aug 3. PMID: 28775203.

#abs2 | A novel targeted therapeutic approach against advanced treatment resistant prostate cancer

Dr Lisa Philp[1,2], Ms Sophie Napier[1,2], Dr Charles Bidgood[1,2], Dr Anja Rockstroh[1,2], Dr Qiuhua Hu[1,2], Mr Yuhin Tang[1,2], Ms Namrata Bhattacharya[1,2], Ms Tanisha Ngo[1,2], Dr Melanie Lehman[1,2], A/Prof Elizabeth Williams[1,2], Dr Jennifer Gunter[1,2], Prof Erik Thompson[2], Dr Philip Rowell[3], Prof John Wade[4], Prof Laszlo Otvos Jr[5], Prof Colleen Nelson[1,2]

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OBJECTIVES: Targeting the androgen receptor (AR) axis has remained the backbone strategy against localised and advanced prostate cancer (PC), but

inevitable treatment failure leads to the development of aggressive metastatic castration resistant PC (mCRPC). Prolonged AR pathway inhibitor (ARPI) use drives the molecular rewiring of PC, causing the outgrowth of aggressive 'androgen-indifferent' tumour cells. Understanding the adaptive response to ARPI and the key rewiring events that underpin the transition from androgen-sensitive to -indifferent is critical for developing new therapeutics against mCRPC. In studying the adaptive response, we uncovered a profound rapid and sustained increase in circulating leptin, a hormone secreted by adipose tissue and master regulator of cellular energy balance. This coincides with an elevated tumour expression of leptin's receptor (LEPR) that escalates with treatment resistance and correlates with disease progression. We therefore devised an innovative therapeutic strategy, targeted the leptin axis, and hypothesised that our safe and potent LEPR antagonist Allo-aca would exhibit marked anti-tumour efficacy against mCRPC

METHODS: Patient-derived xenografts (PDX) and patient bone metastases representing mCRPC were grown in vivo (NSG mice) and ex vivo (patient-derived organoids (PDOs)). The impact of daily Allo-aca administration, compared to vehicle and standard-of-care treatments was assessed in vivo through thrice weekly tumour volume measurement and ex vivo using staining and ATP-based viability assays. Results: Allo-aca showed exceptional anti-tumour potency, inhibiting the growth of 4 distinct mCRPC PDX models in vivo, extended 'survival' and demonstrated superior efficacy to Enzalutamide. Similarly, potent growth reduction by Allo-aca was observed in fresh bone mCRPC PDOs from 3 consented patients, with similar or superior reduction in PDO viability to standard-of-care chemotherapy and Enzalutamide.

CONCLUSION: Our work has uncovered a novel therapeutic strategy against mCRPC, targeting leptin axis dysregulation. Marked anti-tumour response and tolerance across all patient-derived mCRPC models tested highlights the translational potential of therapeutic Allo-aca.

#abs3 | A novel targeted therapy for treatment-emergent anaplastic forms of castration-resistant prostate cancer

Dr Brett Hollier[1], Mr Momin Rahman[1], Ms Sayuri Mudiyanselage[1], Dr Nataly Stylianou[1], Dr Melanie Lehman[1], Dr Anja Rockstroh[1], Dr Charles Bidgood[1], A/Prof Himisha Beltran[2], Prof Yuzhuo Wang[3], Prof Martin Gleave[3], Prof Eva Corey[4], A/Prof Arun Azad[5], Dr Jennifer Gunter[1], Prof Colleen Nelson[1]

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INTRODUCTION & OBJECTIVES: Approximately 25-30% of mCRPC patients harbour metastases that have undergone cellular reprogramming acquiring a continuum of de-differentiation, collectively termed herein as treatment-emergent anaplastic PCa, with transdifferentiation to Neuroendocrine PCa (tNEPC) at the terminal end of this spectrum. These anaplastic tumours, particularly NEPC, often have low expression of prostate-specific membrane antigen (PSMA). While a number of new molecular targeted agents have shown promise in preclinical studies, none have yet been approved for clinical application in treating NEPC. Our team has recently identified the FAcilitates Chromatin Transcription complex (FACT) to be a novel therapeutic target in tNEPC, which inversely correlates with PSMA expression. Pilot testing of the FACT-inhibitor, CBL0137, has provided compelling preclinical data for this small molecule to be a novel molecular targeted agent for treatment of tNEPC. The objective of this study was to extend the preclinical testing of CBL0137's anti-tumour efficacy in an expanded cohort of NEPC PDX models, both in vivo and ex vivo PDX organoid cultures (PDXOs).

METHODS: Anti-tumour effects of CBL0137 treatment (60mg/kg/weekly, i.v. injection) was assessed in 5 NEPC PDX models from both the LTL and LuCaP PDX series developed by collaborators, Prof YZ Wang (UBC) and Prof Eva Corey (UW). Ex vivo PDXOs were established from fresh PDX tumour

tissue and their growth and cell viability in response to CBL0137 monotherapy and in combination with cisplatin chemotherapy assessed.

RESULTS: We have observed CBL0137 monotherapy in vivo to significantly reduce the growth of all NEPC PDX models tested to date. Similar results are observed in PDXOs with additional benefits on the responses to cisplatin observed in vitro.

CONCLUSIONS: Our studies have provided first-in-field data on the significant anti-tumour efficacy of CBL0137 as a potential mono- or combination therapy for anaplastic phenotypes including tNEPC.

#abs4 | A novel, two-stage approach to the treatment of renal cell carcinoma with intra-cardiac tumour extension and hepatic vein involvement: a case series

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INTRODUCTION & OBJECTIVES: Budd Chiari syndrome (BCS) is a rare and severe complication of renal cell carcinoma (RCC). It occurs as a consequence of hepatic vein obstruction by inferior vena caval (IVC) tumour thrombus. This greatly increases peri-operative risk and complicates the operative approach. We present a novel, multidisciplinary approach to this phenomenon using a two-staged operation.

METHODS: Austin Health is a quaternary centre in Melbourne, Australia with liver transplant and cardiac bypass services. We describe the first five patients to undergo a novel, two-stage resection of renal cell carcinoma with intravascular spread into the inferior vena cava and right atrium, complicated by hepatic vein involvement and secondary Budd- Chiari syndrome. The first stage involves transdiaphragmatic debulking of the right heart, inferior vena cava and hepatic veins via median sternotomy and deep hypothermic circulatory arrest. The second stage is performed separately and involves en bloc resection of the affected kidney and inferior vena cava and vascular reconstruction via an abdominal incision.

RESULTS: Three of the five patients presented with clinical BCS; two had radiological features only. While all five patients successfully completed both operative stages, one patient died 22 days after the second stage. Of the remaining four, all survive with no disease recurrence. While we continue to compile longer-term data for a larger follow-up series, these preliminary findings show the feasibility of this technique and support the development of this.

CONCLUSIONS: Our two-staged operative approach successfully resolves BCS and allows for delayed nephrectomy and IVC reconstruction once the patient is medically stable. Long-term oncological outcomes are yet to be explored.

#abs5 | A Systematic Review on Prostate-Specific Membrane Antigen Positron Emission Tomography (PSMA PET) Evaluating Localized Low- to Intermediate-Risk Prostate Cancer: A Tool to Improve Risk Stratification for Active Surveillance?

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INTRODUCTION & OBJECTIVES: Active surveillance remains a treatment option for low- to intermediate-risk prostate cancer (PCa) patients. Prostate-specific membrane antigen positron emission tomography and computed tomography (PSMA PET/CT) has emerged as a useful modality to assess intraprostatic lesions.

METHODS: This systematic review aims to evaluate PSMA PET/CT in localized low- to intermediate-risk PCa to determine its role in active surveillance. Following PRISMA guidelines, a search was

performed on Medline, Embase, and Scopus. Only studies evaluating PSMA PET/CT in localized low-tointermediate-risk PCa were included. Studies were excluded if patients received previous treatment, or if they included high-risk PCa.

RESULTS: The search yielded 335 articles, of which only four publications were suitable for inclusion. One prospective study demonstrated that PSMA PET/CT-targeted biopsy has superior diagnostic accuracy when compared to mpMRI. One prospective and one retrospective study demonstrated MRI occult lesions in 12.3–29% of patients, of which up to 10% may harbor underlying unfavorable pathology. The last retrospective study demonstrated the ability of PSMA PET/CT to predict the volume of Gleason pattern 4 disease.

CONCLUSIONS: Early evidence demonstrated the utility of PSMA PET/CT as a tool in making AS safer by detecting MRI occult lesions and patients at risk of upgrading of disease.

#abs6 | Active surveillance in ISUP 1 prostate cancer and PI-RADS 4/5 lesion

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INTRODUCTION: According to EAU guidelines, active surveillance (AS) is the standard of care for patients with ISUP Grade Group (GG) 1 disease. However, there are some concerns with AS in GG1 patients with a PI-RADS 4/5 lesion on multiparametric MRI (mpMRI). The aim of this study was to evaluate disease upgrading in men with ISUP GG1 and PIRADS 4-5 lesions.

METHODS: ISUP GG1 patients who underwent AS at a tertiary institution between 2016 and 2023 with MRI were identified. Demographic, biopsy, and MRI information were collated. All patients were assessed in accordance with the PI-RADS version 2.1 guidelines. Cox regression was used to determine the association between PI-RADS 1-3 and 4-5 cohort and their disease upgradation.

RESULTS: Two hundred and twenty-eight men with ISUP 1 disease were included. Of these, one hundred and thirty-five (57.6%) patients had a PI-RADS 4-5 lesion, while nighty-three (42.4%) patients had PIRADS 1-3 lesions. There was a significant difference in the maximum length of positive cores (p-value=0.039), biopsy upgrading (p-value=0.017) and subsequent radical prostatectomy (p-value= 0.02) between study cohorts

On repeat biopsy, twenty-three (40.4%) men with PIRADS 1-3 and forty-nine men (58.3%) with PIRADS 4-5 were upgraded to clinically significant prostate cancer (p-value=0.04), with a significantly shorter time to disease upgrading (p-value=0.001). Among patients who underwent radical prostatectomy post reclassification, 15.4% (2/13) with PIRADS 1-3 had ≥pT3 disease, while 47.7% (20/42) patients with PIRADS 4-5 lesion had ≥pT3 disease (p-value=0.09). Additionally, four deaths were reported in each cohort. Among those, one patient with PI-RADS 4/5 lesion experienced a metastatic disease and died from the disease.

CONCLUSION: PI-RADS 4-5 patients showed a higher likelihood of biopsy upgrading and a significantly shorter time to disease progression. This suggests that ISUP GG1 disease with PI-RADS 4/5 lesion on MRI warrants careful AS.

#abs7 | Active surveillance versus radical treatment for high-volume low-risk prostate cancer: a tertiary centre experience

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INTRODUCTION: Active Surveillance (AS) is the standard approach for ISUP grade group (GG1) prostate cancer (PCa). However, some clinicians and patients may prefer upfront active intervention. We aim to examine the oncological outcomes of AS versus radical treatment for high-volume ISUP1 PCa.

METHODS: Men diagnosed with high-volume (five or more positive biopsy cores) ISUP GG 1 PCa at a tertiary institution reviewed retrospectively. All patients were engaged in a shared decision-making model and counselled on AS and radical prostatectomy (RP) at the discretion of the reviewing clinician. Cox regression was used to assess the association between study cohorts.

RESULTS: Out of 84 men with high-volume ISUP GG1 disease, 56 (66.7%) patients underwent AS, while 17 (20.2%) opted for RP. There were significant differences in median age (63.5 vs 66.8, p=0.04) and PSA density (0.17 vs 0.265, p-value=0.03) between two cohorts. Among 16 (28.6%) patients who were initially placed on AS and later underwent RP, twelve patients (75.0%) had upgraded pathology to clinically significant PCa at re-biopsy, with a median time of 74 months. In contrast, among seven patients who underwent upfront RP, six (85.7%) showed upgraded pathology to clinically significant PCa, of those, five (83.3%) had detectable MRI lesions (PI-RADS 4/5).

There was no statistical difference was observed in ≥pT3 disease (0 vs 6 in the AS program, p=0.06), with one patient had a positive surgical margin.

There were two (3.57%) deaths in the AS cohort and one death in the upfront RP – all unrelated to PCa.

CONCLUSION: While our results demonstrate that AS in high-volume ISUP GG1 is safe; over 50% of patients are likely to have disease upgradation. Additionally, patients undergoing AS with high volume ISUP GG1 PCa with visible lesions on MRI scans should be carefully monitored, as they exhibited a higher likelihood of disease upstaging.

#abs8 | AKT inhibition synergizes with docetaxel in neuroendocrine prostate tumours with high phospho-AKT protein expression

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INTRODUCTION AND OBJECTIVES: A recent trial showed that the combination of the AKT inhibitor capivasertib with chemotherapeutic docetaxel prolongs the overall survival of patients with metastatic castration-resistant prostate cancer compared to chemotherapy alone. In contrast to preclinical studies, the trial failed to show any differences in treatment response according to PTEN status. Notably, patients with neuroendocrine tumour were excluded from the study, even though AKT upregulation is associated with neuroendocrine differentiation. This study aimed to identify tumours most likely to benefit from the combination of AKT inhibitors with docetaxel and determine the relevant biomarkers associated with an effective response.

METHODS: We performed DNA target sequencing and immunostaining for PTEN and phospho-AKT(Ser473), a marker of AKT full activation, in 41 prostate cancer patient-derived xenografts (PDXs), including adenocarcinoma and neuroendocrine tumour types. The effects of combining capivasertib with docetaxel were tested in vitro on six different PDX-derived organoids, along with AKT1 knockdown experiments using lentivirus.

RESULTS: Phospho-AKT protein expression was highly variable in PDXs and did not correlate with PTEN/PI3K/AKT mutations or PTEN protein levels. Neuroendocrine tumours exhibited higher phospho-AKT expression than adenocarcinoma. Subsequent

functional experiments in organoids with elevated phospho-AKT showed an increased sensitivity to docetaxel after AKT1 knockdown. In three of the six organoids tested, the combination of capivasertib with docetaxel resulted in greater growth reduction than either agent alone, as confirmed by the HSA synergy score. These responders exhibited a neuroendocrine phenotype and high phospho-AKT expression, consistent with a predicted response.

CONCLUSIONS: Our preclinical findings support the exploration of AKT inhibitors in conjunction with docetaxel in neuroendocrine prostate cancer. We demonstrated that the combination can enhance antitumor efficacy in a subset of individuals whose tumours produce more p-AKT protein. These findings will help the selection of patients for future clinical trials.

#abs9 | Analysis of combination immunotherapy availability in Australia and time to treatment commencement in metastatic clear cell renal cancer

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INTRODUCTION AND OBJECTIVES: Some patients with metastatic clear cell kidney cancer (mccRCC) can safely delay treatment due to indolent disease (1). Combination immunotherapy (IO/IO) was approved in 2019 but limited to IMDC intermediate or poor-risk patients, likely leading to a decreased tendency to delay treatment beyond 12 months in patients with indolent disease, which would classify them as favourable IMDC risk and prevent access to the IO/IO regimen. This study investigates the impact of IO/IO approval in 2019 on treatment initiation and outcomes.

METHODS: The Australian Kidney Cancer Database (KRAB) identified patients >18 years old with mccRCC who received systemic therapy. The patient demographics, IMDC risk category, time to systemic therapy (TTST), and outcomes were compared before and after January 2019 in patients receiving 1st line therapy.

RESULTS: The KRAB database identified 472 patients with mccRCC who received systemic therapy. Since 2019, the proportion of patients with a time to systemic treatment >= 12 months (TTST>=12m) decreased (27% to 7%), and an increased proportion treated within 12 months (TTST<12m) of diagnosis were IMDC score = 1 (38% compared to 24%). There is a significant difference in the mean TTST before and after 2019 (14 and 4 months, $p < 0.05$). In those with de-novo metastatic disease, the proportion of patients with a TTST>=12m decreased from 17.5% to 4% after 2019. Despite this, Progression Free Survival (PFS) and Overall Survival (OS) were not significantly different before and after 2019; OS 31.8 and 30.7 months, PFS 21.7 and 20.5 months.

CONCLUSION: Since approval of combination IO/IO in 2019, more patients with mccRCC commenced treatment within 12 months of diagnosis, and a higher proportion of these had IMDC score = 1 without a significant impact on PFS or OS to date.

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#abs10 | Assessment of Patient and Clinician Perspectives on Clinically Meaningful Extension of Progression-Free Survival in Prostate Cancer

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INTRODUCTION AND OBJECTIVES: It is widely accepted the value of treatments for incurable metastatic cancer depends on their ability to improve overall survival (OS), quality of life (QOL), or both.

Progression-free survival (PFS) frequently acts as the primary endpoint because accurately assessing OS and QOL1,2 is challenging due to factors like underpowering, practical limitations, and treatment imbalances after disease progression. The perceived value of extending PFS when there is uncertainty regarding the benefit to OS/QOL may vary between clinicians and patients. This study aimed to measure patient and clinician perspectives on what defines a clinically meaningful PFS benefit. Understanding differences may provide insights for optimal shared-care treatment discussions.

METHODS: We conducted an observational study using a self-administered questionnaire. Participants included patients with advanced prostate cancer (PP) and medical oncology clinicians (CP) treating patients with prostate cancer. The questionnaire presented a hypothetical scenario of metastatic castrate-resistant prostate cancer (mCRPC). Participants were asked about their willingness to undergo/prescribe treatment offering PFS benefits despite uncertain OS outcomes. Participants specified the minimum acceptable extension of PFS, surpassing the estimated 18-month duration outlined in the scenario while considering varying levels of toxicity. Additional questions assessed various perspectives, disease status, and demographic characteristics.

RESULTS: Between April and May 2024, 49 PP and 27 CP responses were received. 47/49 (95.9%) PP and 22/27(81.5%) CP expressed willingness for a prospective treatment associated with longer PFS but uncertain OS benefit. For treatment with no/mild toxicity, the minimum duration of PFS-extension to accept treatment was 0-3/3-6/6-9/9-12/>12 months in 14.3%/12.2%/4.1%/8.2%/57.1% for PP and 11.1%/33.3%/33.3%/3.7%/0% for CP. For treatment with severe toxicity, 36.7%/51.9% of PP/CP would not accept treatment and the minimum duration of PFS extension to accept treatment was 0-3/3-6/6-9/9-12/>12 months in 14.3%/20.4%/4.1%/8.2%/16.3% for PP and 0%/0%/3.7%/18.5%/25.9% for CP. Most PP (61.2%) ranked radiological and/or PSA response over OS as "more important" while 48.1% of CP considered this "less important".

CONCLUSIONS: Most patients and clinicians are open to mCRPC treatment based on PFS benefits despite OS uncertainty. Patients needed longer PFS-extension to justify treatment but were more accepting of side-effects and placed greater importance on PSA/radiological response compared to clinicians.

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#abs11 | Association between perceived cognitive impairment, psychosocial factors and occupational functioning in prostate cancer survivors: An exploratory cross-sectional analysis

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OBJECTIVE: Perceived cancer-related cognitive impairments (CRCIs) have been reported in prostate cancer survivors (PCS). However, their associations with occupational functioning and modifiable psychosocial factors are not well understood. We aimed to investigate these associations.

METHODS: Adult PCS, either undergoing hormonal treatments (e.g., ADT) or on 'watchful waiting'/ 'active surveillance' participated in a cross-sectional survey. Perceived cognitive functioning was measured using 'Yes/No' responses to noticing changes in thinking (e.g., memory, attention, etc.) as a treatment side-effect and the Perceived Cognitive Impairments (PCI20) subscale from the FACT-Cog. PCS reported 'Yes/No' to changes to work ability, performance,

hours and whether treatment side-effects led to early retirement. Fisher's exact tests and logistic regressions examined the relationship between CRCI and occupational functioning. Pearson's correlation explored the association between PCI20 and psychosocial factors (psychological distress, interpersonal functioning, functional wellbeing, self-compassion & intellectual engagement). Significant variables were included as predictors in a hierarchical regression, examining the relationship with PCI20 and related psychosocial factors, controlling for demographic, biomedical, and lifestyle factors.

RESULTS: Among 96 PCS recruited, a third reported low cognitive function on PCI20. In a regression analysis with cancer treatment, depression, physical and functional wellbeing as predictors, only functional wellbeing was a significant predictor of PCI20. Cognitive changes were significantly associated with perceived changes in work ability, work performance and decreased work hours; 35% of PCS working during treatment endorsed experiencing cognitive side-effects, and 15% of retired PCS endorsed both cognitive changes and an early retirement due to treatment side-effects. Endorsing cognitive side-effects was significantly associated with poorer scores on the PCI20.

CONCLUSION: Perceived cognitive functioning was associated with quality of life and the ability to participate in day-to-day activities including work and enjoyment. Considering CRCI is crucial when planning return-to-work post-treatment. A 'Yes/No' question of CRCI may serve as a valuable screening tool.

#abs12 | Avelumab first-line (1L) maintenance for advanced urothelial carcinoma (aUC): long-term outcomes from the JAVELIN Bladder 100 trial in patients with high body mass index (BMI)

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INTRODUCTION AND OBJECTIVES: Avelumab 1L maintenance + best supportive care (BSC) significantly prolonged overall survival (OS) and progression-free survival (PFS) vs BSC alone in patients with aUC without progression with 1L platinum-based chemotherapy (PBC) in the JAVELIN Bladder 100 phase 3 trial (NCT02603432). The long-term safety of avelumab 1L maintenance was also demonstrated. High BMI is a risk factor for bladder cancer. We report exploratory analyses of long-term outcomes from the trial in patients with high BMI (≥30) at baseline.

METHODS: Eligible patients with unresectable locally advanced or metastatic UC without progression after 1L PBC were randomized 1:1 to receive avelumab 10 mg/kg every 2 week + BSC (n=350) or BSC alone (n=350). The primary endpoint was OS; secondary endpoints included PFS and safety.

RESULTS: At data cutoff (June 4, 2021), median follow-up was ≥38 months in both arms. In the avelumab + BSC and BSC alone arms, 67 and 55 patients had high BMI, respectively. In these patients, median OS (95% CI) was 20.8 months (16.9-34.4) with avelumab + BSC vs 12.7 months (8.1-26.6) with BSC alone (HR, 0.77 [95% CI, 0.49-1.21]); 2-year OS rates were 47.8% vs 37.6%, respectively. Median PFS by investigator (95% CI) was 5.6 months (3.7-7.5) with avelumab + BSC vs 2.1 months (1.9-4.0) with BSC alone (HR, 0.64 [95% CI, 0.42-0.97]); 2-year PFS rates were 23.5% vs 11.3%, respectively. Long-term safety in patients with high BMI was generally consistent with the overall safety population.

CONCLUSIONS: This exploratory analysis shows the long-term efficacy and tolerability of avelumab 1L maintenance in patients with high BMI in JAVELIN Bladder 100, with no new safety concerns identified. These results further support the use of avelumab 1L maintenance as a standard of care in patients with aUC without progression after 1L PBC, including patients with high BMI.

FUNDING STATEMENT: This trial was sponsored by Pfizer and was previously conducted under an alliance between Merck (CrossRef Funder ID: 10.13039/100009945) and Pfizer. This analysis was sponsored by Merck. Medical writing support was provided by Amy Davidson of Nucleus Global and was funded by Merck.

#abs13 | Avelumab first-line maintenance (1LM) for advanced urothelial carcinoma (aUC): long-term outcomes from JAVELIN Bladder 100 in patients with low tumor burden

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INTRODUCTION AND OBJECTIVES: In the JAVELIN Bladder 100 phase 3 trial (NCT02603432), avelumab 1LM + best supportive care (BSC) significantly prolonged overall survival (OS) and progression-free survival (PFS) vs BSC alone in patients with aUC without progression after 1L platinum-based chemotherapy (PBC). Low tumor burden (eg, nonvisceral metastases or lymph node [LN]-only disease) has been associated with better outcomes in patients with aUC receiving immune checkpoint inhibitors. We report exploratory analyses of efficacy and safety in patients with low tumor burden from JAVELIN Bladder 100.

METHODS: Patients with unresectable locally advanced or metastatic UC without progression after 1L PBC were randomized 1:1 to receive avelumab + BSC or BSC alone. The primary endpoint was OS; secondary endpoints included PFS and safety. Nonvisceral metastases included locally advanced disease or only nonvisceral disease, including bone metastasis, at randomization.

RESULTS: In the avelumab + BSC and BSC alone arms, 159 patients each had nonvisceral metastases and 51 patients each had LN-only disease, of whom 42 and 35 patients had pelvic/retroperitoneal LN-only disease. At the efficacy data cutoff (June 4, 2021), median follow-up was ≥38 months in both arms. In patients with nonvisceral metastases, LN-only disease, or pelvic/retroperitoneal LN-only disease, median OS with avelumab + BSC vs BSC alone was 31.4 vs 17.1 months, 31.9 vs 22.7 months, and 31.2 vs 20.2 months, respectively. PFS was also prolonged with avelumab + BSC vs BSC alone in all subgroups. Incidences of treatment-related adverse events

were similar across subgroups. In the avelumab + BSC and BSC alone arms, subsequent anticancer drug treatment was received by 56.6% vs 74.8% with nonvisceral metastases, 52.9% vs 76.5% with LN-only disease, and 52.4% vs 77.1% with pelvic/retroperitoneal LN-only disease.

CONCLUSIONS: Exploratory analyses suggest avelumab 1LM has pronounced efficacy and manageable toxicity in patients with aUC with a low tumor burden.

FUNDING STATEMENT: This trial was sponsored by Pfizer and was previously conducted under an alliance between Merck (CrossRef Funder ID: 10.13039/100009945) and Pfizer. This analysis was sponsored by Merck. Medical writing support was provided by Sophie Saunders of Nucleus Global and was funded by Merck.

#abs14 | Avelumab first-line maintenance (1LM) for advanced urothelial carcinoma (aUC): long-term patient-reported outcomes (PROs) in the phase 3 JAVELIN Bladder 100 trial

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INTRODUCTION AND OBJECTIVES: In the JAVELIN Bladder 100 trial (NCT02603432), avelumab 1LM + best supportive care (BSC) significantly prolonged overall survival vs BSC alone in patients with aUC without progression after 1L platinum-based chemotherapy, and health-related quality of life was maintained. We report long-term exploratory PRO analyses in the overall avelumab + BSC arm (any treatment duration) and in the subgroup with ≥12 months of avelumab treatment.

METHODS: PROs (secondary endpoint) were assessed at baseline, day 1 of each 4-week cycle, and end of treatment/withdrawal, and up to 90 days post treatment. PRO instruments were National Comprehensive Cancer Network/Functional Assessment of Cancer Therapy Bladder Symptom Index-18 (FBlSI-18) and EuroQol 5 Dimensions 5 Levels (EQ-5D-5L). Data were not evaluated in the BSC alone arm because few patients remained on study treatment at later time points.

RESULTS: At data cutoff (June 4, 2021), median follow-up was 38.0 months and median duration of treatment was 5.8 months. In patients treated for ≥12 months (n=118/350 [33.7%]), baseline characteristics were similar to those in the overall avelumab arm, except for a higher proportion with ECOG performance status of 0 (70.3% vs 60.9%) and lower proportion with visceral metastases (47.5% vs 54.6%). In both populations, completion rates for both PRO instruments among evaluable patients were >80% at all time points during treatment. On average, PRO scores remained stable throughout treatment, and no clinically relevant changes from baseline were reported. Among evaluable patients treated for ≥12 months, ≈75% reported no change or a decrease in being bothered by treatment side effects throughout 24 months of treatment.

CONCLUSIONS: Prolonged avelumab 1LM treatment (≥12 months) was associated with stable PROs, indicating preservation in quality of life, further supporting the use of avelumab 1LM until progression or unacceptable toxicity in patients with aUC who are progression-free after platinum-based chemotherapy.

FUNDING STATEMENT: This study was sponsored by Pfizer and was previously conducted under an alliance between Merck (CrossRef Funder ID: 10.13039/100009945) and Pfizer. This analysis was

sponsored by Merck. Medical writing support was provided by Sophie Saunders of Nucleus Global and was funded by Merck.

#abs15 | Bacillus Calmette-Guérin with or without pembrolizumab for high-risk non–muscle-invasive bladder cancer that persists/recurs after bacillus Calmette-Guérin induction: cohort A of the phase 3 KEYNOTE-676 study

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Trial registry name and registration number: Clinicaltrials.gov, NCT03711032

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BACKGROUND: In KEYNOTE-057, pembrolizumab monotherapy demonstrated antitumor activity in patients with bacillus Calmette-Guérin (BCG)¬-unresponsive high-risk (HR) non–muscle-invasive bladder cancer (NMIBC) with carcinoma in situ (CIS) ± papillary tumors. Cohort A of the phase 3 KEYNOTE-676 trial (NCT03711032) will evaluate BCG ± pembrolizumab in patients with persistent/recurrent HR NMIBC after first BCG induction.

METHODS: Approximately 430 patients will be enrolled who have confirmed HR NMIBC (T1, high-grade Ta, and/or CIS) that persists/recurs following 1 adequate course of BCG induction therapy, have no concurrent extravesical disease or history of extravesical disease that recurred within <2 years, and have undergone cystoscopy/transurethral resection of bladder tumor ≤12 weeks before randomization. Patients will be randomly assigned 1:1 to receive pembrolizumab 200 mg intravenously every 3 weeks plus BCG induction or BCG induction alone. Intravesical instillation of BCG (50 mg) will be administered once weekly for 6 weeks and then as maintenance therapy once weekly for 3 weeks at weeks 13 and 25, and every 24 weeks thereafter. Treatment will continue for approximately 2 years (pembrolizumab) or 3 years (BCG) or until confirmed persistent/recurrent HR NMIBC or disease progression to MIBC or metastatic bladder cancer, unacceptable toxicity, or withdrawal of consent. Primary end point is complete response rate in patients with CIS. Secondary end points include duration of complete response in complete responders with CIS, event-free survival, recurrence-free survival, time to cystectomy, overall survival, disease-specific survival, and safety.

RESULTS: Recruitment is ongoing in Asia, Australia, Europe, North America, and South America.

CONCLUSIONS: Results from cohort A of KEYNOTE-676 will demonstrate efficacy and safety of pembrolizumab plus BCG in patients with HR NMIBC that persists/recurs following BCG induction.

#abs16 | Barriers and enablers for prostate cancer screening in men from culturally and linguistically diverse backgrounds

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INTRODUCTION: Compared to Australian-born individuals, men from culturally and linguistically diverse (CALD) communities have up to 32% less likelihood of undergoing prostate cancer screening. We aimed to understand the barriers and enablers of prostate cancer screening among men from CALD backgrounds.

METHODS: Participants were recruited through the Multicultural Community of South Australia. Respondents to the call outs attended an information session and were assessed for eligibility. Participants were included if aged 45-50 years regardless of history of prostate cancer screening or diagnosis. Focus group discussions (FGD) were conducted following a semi-structured interview guide, co-designed with the community facilitators. Discussions were audio-recorded, transcribed verbatim, and data analysed thematically using reflexive framework analysis.

RESULTS: Six FGDs, each comprised of five men (n=30), were conducted in three multicultural communities, two in each community. Participants were mostly from Africa (70%), aged between 45-59 (63%), had a university degree (80%), were very comfortable communicating in English (73%) and worked full time (50%). Most men migrated to Australia between 1996 and 2006 with 43% arriving on a humanitarian visa and 20% on student visa.

Participants identified the following as potential enablers to support CALD men's uptake of cancer screening services: increased awareness of prostate cancer screening services, being informed of the test by their general practitioner, mobilisation through community groups, targeted messages with concise instructions, government incentives for participation and de-stigmatisation of prostate health in the community. Potential barriers to participation in screening included the fear of the unknown, language barriers, cultural norms that made testing and talking about prostate cancer taboo and the stigma associated with it.

CONCLUSION: The findings from this exploratory study suggests that men from CALD backgrounds may lack access to knowledge and awareness of prostate cancer and that culturally informed and sensitive communications of available screening services may be of particular benefit to improving the health literacy and uptake of services. As such, this study suggests the uptake of screening is likely to be improved by culturally appropriate initiatives to address the lack of information with targeted messages for specific communities and addressing cultural norms in relation to sexual health and death.

#abs17 | BCG therapy and clinical management of bladder cancer in a rural Australian cohort: A small-scale retrospective review

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INTRODUCTION: Despite changing treatment paradigms, outcomes for bladder cancer have ostensibly remained consistent in Australia since the mid-1990s [1-3]. Historically, NMIBC has been treated in urological settings and is available primarily to urban patients; BCG availability for rural patients is limited. Providing BCG treatment in rural/regional cancer centres can bridge such deficits, hence our study examining this rurally-based cohort's characteristics, clinical pathways, and outcomes.

OBJECTIVES: Our primary aim was to understand sociodemographic and clinical characteristics of a rurally-located NIMBC patient cohort. Secondarily, we aimed to identify options for enhancing clinical pathways for patients receiving BCG treatment in a cancer centre, under supervision of medical oncologists rather than in a urological setting.

METHODS: We undertook a small-scale retrospective facility-based cross-sectional review of medical records, for patients aged >18yrs diagnosed with NMIBC and referred for BCG treatment at a rural NSW cancer centre, between 2010-2022. Sociodemographic and treatment-related factors were summarized as frequencies with percentages, or mean with SD. Distribution of treatment- and survival-related outcomes was analyzed using regression analysis and one-way ANOVA.

RESULTS: A majority of the total study population (n=23) were male (n=18, 78%) and >65 years (n=16, 70%). A weakly positive but not-significant relationship was identified between: age and RFS; total BCG doses administered and both RFS and OS. No correlation was observed between age and OS, nor sex and OS.

CONCLUSIONS: Results showed general congruence with national/global trends, however the sample size posed limitations to further conclusions. This

conceptually formative study nonetheless highlights the value of further research incorporating larger rural/regional samples, and cross-centre comparative studies. It also indicates imperatives including better understanding BCG's use and potential within medical oncology settings; and ensuring referral/management pathways that facilitate early use of BCG as a known means of reducing risk of cystectomy. Further work to improve and increase data collection for research use (now underway at this centre), and opportunities to embed bladder cancer clinical pathways within cancer centres, are also highlighted.

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#abs18 | Bipolar androgen therapy in combination with carboplatin chemotherapy retains activity in late line metastatic castrate-resistant prostate cancer. An interim analysis of the Phase II HIGH-TeCH study

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BACKGROUND: Bipolar androgen therapy (BAT) uses intramuscular testosterone stimulating a periodic oscillation between castrate and supraphysiologic testosterone levels, preventing androgen–expressing prostate cancer cells from adapting to a low androgen environment and proliferating. Preclinical data suggests supraphysiologic androgens interrupt DNA relicensing and increase double–stranded DNA breaks, complementing carboplatin [1]. We assessed concomitant treatments from Arm B of the HIGH – TeCH trial.

METHODS: Men with refractory metastatic castrate resistant prostate cancer (mCRPC) after at least one line of taxane based chemotherapy and androgen signalling inhibitor received four weekly testosterone enanthate (500mg IM) with Carboplatin (AUC 5) and androgen deprivation therapy. An initial sample size of 21 patients was planned with expansion of the study if at least three PSA50 responses achieved based on a MinMax two–stage optimum design.

RESULTS: Median follow up was 13.9 months for the first 21 patients as of 26th January 2024. Median age 71; median prior lines of treatment 4; 15 (71%) received Lu-PSMA. 19 patients discontinued treatment for disease progression, 1 patient discontinued due to a serious adverse event (CVA) and 1 patient remains on trial. Median of 6 cycles of BAT/carboplatin were administered. Five (24%) patients had a PSA response ≥ 50%. Median progression-free survival was 165 days (95% CI, 123.99-206.02). Median overall survival not reached. Seventeen (81%) patients experienced treatment–related adverse events (TRAEs); 93% were grade 1 – 2. Highest rates of TRAEs were fatigue (71%), nausea (59%) and musculoskeletal pain (41%). There were no grade 4 TRAEs or deaths.

CONCLUSION: BAT with carboplatin has an acceptable safety profile and retains activity in late line mCRPC. This study meets its endpoint for further clinical expansion. Translational studies to identify predictive biomarkers and quality of life analyses are underway.

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#abs19 | Bladder preservation treatment opportunities for patients with non-metastatic muscle invasive bladder cancer: a qualitative exploration of a single-centre experience

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INTRODUCTION AND OBJECTIVES: Patients with non-metastatic muscle invasive bladder cancer (MIBC) can be treated by radical cystectomy or chemoradiation. Outcomes for both modalities in matched case series appear equivalent[1]. We aimed to assess whether patients with non-metastatic MIBC suited to either radical cystectomy or chemoradiation were offered a choice of options.

METHODS: Patients with non-metastatic MIBC treated at Austin Health from January 2016 – December 2023 were identified using radiation oncology and urology databases. Patients were categorized as being suitable for both modalities, or unsuitable for radiation or surgery based on expert clinician review and criteria. Data points of diagnosis, documented offer of bladder-preservation treatment, management and outcomes were analysed.

RESULTS: 61 patients were identified, with 36 (59%) deemed suitable for a choice between either surgery or chemoradiation, 4 (7%) suitable for only surgical management, and 21 (34%) deemed suited to chemoradiation alone. The majority of patients suitable for either modality underwent cystectomy (22/36, 61%), of which only 36% (8/22) had a documented discussion about chemoradiation. 9% (2/22) were referred to a radiation oncologist for this. The cumulative incidence of distant metastatic disease at 2-year follow-up was 19.3% (95%CI: 7.7%-43.7%) in patients undergoing surgery and 18.5% (95%CI: 4.9%-56.5%) for chemoradiation. Adjusting for age and ECOG status, there was a non-statistically significant improvement in overall survival in patients receiving chemoradiation compared to patients undergoing surgery (HR 0.26, 95%CI: 0.04-1.94, p=0.191).

CONCLUSIONS: Only 59% of patients with non-metastatic MIBC were deemed suitable for a choice of either cystectomy or chemoradiation due to lack of surgical fitness or factors precluding radiation. The slight majority of these patients underwent surgery, but very few surgical patients engaged in discussion with a radiation oncologist. There were no differences in outcomes between the different treatment modalities.

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#abs20 | Blazing a New Trail: How Neutrophil Extracellular Traps Might Be Driving Bladder Cancer

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INTRODUCTION AND OBJECTIVES: Neutrophil extracellular traps (NETs) are extracellular networks composed by DNA, histones and other proteins that are released from neutrophils in response to inflammatory stimuli (NETosis). Cancer induces a systemic environment that primes neutrophils to release NETs. We found elevated levels of NETs in

bladder cancer (BC) patients systemically and in the tumor microenvironment [1]. While these NETs seem to be linked to increased tumor growth and spread, the exact mechanisms are unclear. This study aims to evaluate whether NETs affect BC hallmarks and if there's a difference between NETs from BC patients and healthy individuals.

METHODS: Neutrophils were purified from blood anticoagulated with EDTA from 4 BC patients and 4 healthy controls and forced to NETosis by addition of phorbol 12-myristate 13-acetate. Those NETs were then used to treat two BC cell lines (muscle invasive BC cells T24 and non-muscle invasive BC cells 5637) in increasing concentrations to evaluate differences in BC hallmarks: cell proliferation (sodium phosphatase cell viability assay), migration (scratch assay), extracellular matrix invasion (transwell assay) and anoikis resistance (ability to resist cell death when detached from the surrounding matrix).

RESULTS: Treatment with high concentrations of NETs (500 ng/ml) significantly increased proliferation and extracellular matrix invasion of the more aggressive T24 bladder cancer cells. Notably, these effects were more pronounced with NETs isolated from bladder cancer patients compared to those from healthy controls. Interestingly, NETs also inhibited T24 cell migration. By contrast, NETs did not appear to affect the behaviour of the less aggressive 5637 cells.

CONCLUSION: NETs affect the behaviour of high-grade BC cells by increasing proliferation and invasion and reducing migration, which may promote cancer progression and metastasis implantation. This effect is more significant with BC patient-derived NETs. ISCIII-FEDER (PI20/00075, FI21/00171, MV23/00096, PI23/00449) and SETH.

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#abs21 | Can proteomics predict metastatic relapse in prostate cancer? Development of a 6 protein prognostic signature in a >250 sample proteomic study including a validation cohort

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INTRODUCTION AND OBJECTIVES: Biomarkers to predict metastatic relapse (MR) in prostate cancer (PCa) are needed to improve risk stratification. Recent advances in proteomic technologies, combined with machine learning (ML), may offer novel cancer insights.

METHODS: With the primary aim of identifying a protein signature of MR, high throughput quantitative (HTQ) proteomic analysis, using data independent acquisition mass spectrometry, was undertaken in two cohorts: discovery cohort PCA1, and validation cohort PCA2, which included 146 and 108 formalin-fixed paraffin-embedded (FFPE) prostatectomy samples, respectively. 6101 proteins were quantified. For the protein signature (PS), to avoid misclassification, only patients without relapse with minimum followup (FU) of 12.5 years were included (PCA1 n=123; PCA2 n=71).

A novel bioinformatic and ML method was developed to identify prognostic proteins and construct a risk score-based signature for metastatic free survival (MFS). Bioinformatic methods included feature selection with data partitioning, differential expression analysis, Cox and LASSO regression analysis, and cross validation.

RESULTS: Median FU was 15 and 13 years for PCA1 and PCA2, respectively. Regarding MR events, there were 61/123 and 25/71 MR events, in PCA1 and PCA2.

In PCA1, a 6-PS was developed and highly significant in a multivariate analysis (MVA) with European Association of Urology (EAU) clinical risk group classification (MFS HR 4.7, 95% CI 2.5-8.5, p<0.0001). It showed robust predictive performance combined with EAU risk group classification (ROC AUC 0.81).

In PCA2, the 6-PS was significant in MVA (HR 3.4, 95% CI 1.2-9.5, p 0.02) and showed robust predictive performance combined with EAU risk group classification (ROC AUC 0.78).

CONCLUSIONS: HTQ proteomics can define prognostic signatures of MR in PCa that are significant in independent cohorts and MVA. A 6-PS showed good predictive performance when combined with EAU-risk, paving the way for development of targeted proteomic panels that may offer enhanced precision and clinical utility.

#abs22 | Changing landscape of real-world upfront treatment of metastatic hormone-sensitive prostate cancer (mHSPC)

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INTRODUCTION AND OBJECTIVES: mHSPC treatment has evolved from Androgen Deprivation Therapy (ADT) alone, to combination with Docetaxel, to current standard combinations with Androgen Receptor Pathway Inhibitors (ARPI) or ARPI and docetaxel (triplet). Analysis of real-world data can ensure appropriate uptake of new standards of care, along with assessing safety and efficacy in this setting.

METHODS: We interrogated the electronic Prostate Cancer Australian Database (ePAD), a multi-national registry recording demographic, diagnostic, treatment and outcome data in advanced prostate cancer. We identified Australian mHSPC patients starting ADT after June 2015, and described the evolution in treatment following improved widespread access to ARPI (January 2023).

RESULTS: We identified 1266 eligible patients; 1091 prior to and 127 after January 2023. Comparing cohorts there were no differences in age (median 68 vs 69 years, p=0.695), proportion with visceral metastases (7% vs 8%, p=0.705) or median PSA level at ADT initiation (32 vs 48, p=0.815). Higher grade histology (Gleason score 8-10: 54% vs 65% p=0.021) and synchronous metastatic disease (48% vs 70%, p=<0.001) were less common in the early cohort.

After January 2023, 56% received ADT with ARPI vs 6% prior, compared to 21% vs 62% receiving ADT alone, 4% vs 31% received ADT with Docetaxel. Following improved ARPI access 17% received triplet. Compared to ADT with ARPI, there were no factors significantly associated with triplet therapy, although synchronous metastases (81% 69%, p=0.286) and visceral metastases (5% vs 7%, p=0.710) were numerically more common; Similarly, differences in age (median 73 vs 70 years, p=0.695) and performance status (ECOG 2+ 15% vs 3%, p=0.8) in the ADT alone group were not statistically significant.

CONCLUSIONS: Following improved ARPI access, the majority of Australian mHSPC patients receive combination therapy. With increased accrual, ePAD may identify factors that influence treatment selection, while longer follow up will allow comparisons of outcomes.

#abs23 | Coformulations of favezelimab/pembrolizumab and vibostolimab/pembrolizumab in patients with bacillus Calmette-Guérin–unresponsive high-risk non–muscle-invasive bladder cancer: cohort C of the phase 2 KEYNOTE-057 trial

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Trial registry name and registration number: Clinicaltrials.gov, NCT02625961

Funding: This study was supported by Merck Sharp & Dohme LLC, a subsidiary of Merck & Co., Inc., Rahway, NJ, USA.

BACKGROUND: In the phase 2 KEYNOTE-057 study (NCT02625961), pembrolizumab demonstrated antitumor activity in patients with bacillus Calmette-Guérin (BCG)–unresponsive high-risk (HR) non–muscle-invasive bladder cancer (NMIBC) with carcinoma in situ (CIS) ± papillary tumors who are ineligible for or declined radical cystectomy (RC). Cohort C of KEYNOTE-057 will evaluate efficacy and safety of coformulations of favezelimab or vibostolimab and pembrolizumab in patients with BCG-unresponsive HR NMIBC with CIS ± papillary tumors.

METHODS: Eligible adult patients have histologically confirmed HR NMIBC (CIS ± high-grade Ta or T1 at baseline) that is BCG-unresponsive (persistent or recurrent CIS ± Ta/T1 ≤12 months of completing adequate BCG therapy) and are ineligible for or declined RC. Approximately 60 patients will be randomly assigned 1:1 to receive coformulations of vibostolimab 200 mg and pembrolizumab 200 mg or favezelimab 800 mg and pembrolizumab 200 mg intravenously every 3 weeks for ≤35 cycles or until central pathology–confirmed ≥T1 at any time point, persistent or recurrent CIS or high-grade Ta at 24-week efficacy review or thereafter, or other discontinuation criteria are met. Primary end point is 12-month complete response rate of HR NMIBC by cystoscopy, cytology, biopsy, and radiologic imaging (central pathology and radiology review). Secondary end points include duration of response of HR NMIBC; overall, 3-month, and 6-month complete response rates; progression-free survival (PFS) to worsening of grade, stage, or death; PFS to muscle-invasive or metastatic disease or death; and overall survival.

RESULTS: Recruitment is ongoing in Asia, Australia, Europe, North America, and South America.

CONCLUSIONS: Results from cohort C of KEYNOTE-057 will determine efficacy and safety of vibostolimab or favezelimab and pembrolizumab in patients with BCG-unresponsive HR NMIBC.

#abs24 | Diagnostic performance of contrast-enhanced ultrasound (CEUS) in evaluation of renal masses

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INTRODUCTION & OBJECTIVES: Contrast-enhanced computed tomography (CECT) and contrast-enhanced magnetic resonance (CEMR) are the current mainstay imaging modalities for investigation of renal masses. However, they have several limitations including risk of anaphylaxis, nephrotoxicity, radiation exposure, and high costs. Recently, contrast-enhanced ultrasound (CEUS) has emerged as a promising tool. This study aimed to evaluate the diagnostic accuracy of CEUS and its influence on patient management.

MATERIALS & METHODS: Data was collected from electronic medical records for patients who underwent CEUS at the Royal Melbourne Hospital over the past three years. Data collected included prior imaging, CEUS results, tissue diagnosis and management details. Sensitivities and specificities were calculated to assess

diagnostic accuracy, and Fischer's exact test was utilised to analyse the significance of categorical data.

RESULTS: A total of 81 patients underwent CEUS, 34 (42.0%) had malignant, 41 (50.6%) benign, and 6 (7.4%) indeterminate lesions based on combined histopathology and follow-up. CEUS had a sensitivity of 91.2%, specificity of 100.0%, PPV of 100.0%, and NPV of 93.2%. CEUS showed greater diagnostic accuracy than CECT, US and CEMR collectively (p <0.0001). The qualitative diagnosis obtained from CEUS examination amended patient management in 46.9%, resulted in no change in 46.9%, and had an unclear effect in 6.2% of cases.

CONCLUSIONS: CEUS performs at least as well as or better than CECT or CEMR in the evaluation of renal masses. Its higher diagnostic accuracy may result in more reliable data to inform the decision for intervention when conventional imaging is inconclusive or contraindicated. Further research is needed to validate our findings.

#abs25 | Dissecting the meaning of obesity in metastatic castration resistant prostate cancer: size or metabolism?

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BACKGROUND: Obesity defined by Body Mass Index (BMI) is associated with longer overall survival (OS) in metastatic castration-resistant prostate cancer (mCRPC). However, the underlying mechanisms in relation to lipid metabolism are not well understood. Circulating lipid profiles are associated with OS in mCRPC, indicating that aberrant lipid metabolism contributes to clinical outcomes. Our validated biomarker PCPro can identify patients with mCRPC and a poor prognostic lipid profile.

OBJECTIVE: To define the metabolic characteristics underlying the obesity phenotype in mCRPC and evaluate their impact on OS.

METHODS: Seventy-two patients with mCRPC were enrolled from six Australian Cancer Centres. DEXA body composition scans assessed the distribution of muscle and fat within the body. Plasma lipids were analysed to determine PCPro biomarker status. Primary endpoint was OS. Associations between DEXA parameters, PCPro and OS were assessed via Cox regression.

RESULTS: Increasing BMI was associated with longer OS (HR=0.92 per 1 unit difference in BMI, 95%CI=0.86-0.99, p=0.030), as was increasing fat mass (p=0.024) and fat mass index (FMI, p=0.038). Sixty-eight patients had plasma available for PCPro assessment. Patients who were PCPro positive (indicative of poor prognosis, 22%) had a shorter OS (HR=3.12, 95%CI=1.51-6.42, p=0.002). PCPro expression was an independent prognostic variable when modelled against BMI, fat mass or FMI.

CONCLUSIONS: Obesity and higher body fat are associated with longer OS in mCRPC. However, a PCPro positive plasma lipid profile is associated with shorter OS after adjusting for these. Therefore, underlying lipid metabolism is more relevant to clinical outcomes than BMI or distribution of fat alone.

#abs26 | Emerging recruitment patterns from a national randomised controlled trial of a survivorship care intervention for men with prostate cancer on androgen deprivation therapy (PCEssentials Hormone Therapy Study)

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INTRODUCTION AND OBJECTIVES: The PCEssentials Hormone Therapy Study is an ongoing randomised trial of tele-based nurse-led survivorship care with prostate cancer (PCa) survivors undergoing androgen deprivation therapy (ADT) to: 1) Determine effectiveness of a survivorship care intervention (PCEssentials), relative to usual care, for improving health-related quality of life; 2) Evaluate PCEssentials implementation strategies and outcomes. Forty-two percent of the recruitment target is currently met (N=100/236). We analysed sources of referral and reasons why men have declined to participate to-date.

METHODS: Recruitment occurs through urology and PCa treatment centres, and study promotion via the Prostate Cancer Foundation of Australia. Potential participants self-refer or are referred by a clinician through a verbal consent-to-contact process and screened for eligibility. Recruited men i) will be commencing, or within 3 months of having commenced ADT, and expected to be on ADT for a minimum continuous period of 12 months; ii) are able to read and speak English; iii) have no previous history of head injury, dementia, or psychiatric illness; and iv) have no other concurrent cancer.

RESULTS: Two hundred and twelve referrals have been received; the majority being clinician-referred (82% v self-referral 18%). Referrals fall into all Modified Monash Model1 geographical categories – MM1 (65.5%), MM2 (12.9%), MM3 (7.7%), MM4 (1.6%), MM5 (10.8%), MM6 (1.0%) and MM7 (0.5%). Of referrals that did not proceed, 29.7% were ineligible, 11.9% unable to be contacted for screening, and 58.4% declined participation. Forty-six referrals who declined participation provided a reason. The top four reasons included not being interested (27.4%), time poor (21.6%), full-time carer responsibilities (11.8%), and reluctance to participate in telephone-based research (9.8%).

CONCLUSION: Exploring recruitment patterns of trials involving PCa survivors is important to informing the design of future PCa trials. The clinician verbal consent-to-contact process has been a successful method of referral to-date.

Reference: 1. Department of Health (2019) Modified Monash Model. Australian Government, Canberra.

#abs27 | Erectile dysfunction in focal low-dose-rate brachytherapy – early results from Australia's LIBERATE Registry

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INTRODUCTION & OBJECTIVES:

Focal therapy is an emerging modality aimed at reducing treatment-related toxicity. This study describes the initial patient-reported outcome measures and clinician-reported adverse events relating to erectile dysfunction following focal low-dose-rate (LDR) brachytherapy for low-intermediate risk prostate cancer.

MATERIALS & METHODS: Patients enrolled in a prospective, multi-centre clinical registry of focal LDR brachytherapy for low-intermediate risk prostate cancer from September 2019 (LIBERATE Clinical

Registry), with a minimum of 6 months of follow-up, were included in this study. Clinician and patient-reported assessments for erectile dysfunction were conducted at 6 weeks following implant, and 3 monthly thereafter utilising the validated International Index of Erectile Function [IIEF-5] questionnaire and Common Terminology Criteria for Adverse Events [CTCAE] guidelines. The minimal clinically important difference (MID) for the IIEF-5 score was ±4 points.

RESULTS: Of 77 patients, 54 (70.1%) responded to the IIEF-5 questionnaire with a median follow-up of 18 months. A median IIEF-5 score of 19 (IQR 12.5-23) was observed at baseline, 8 (IQR 2-20.5) at 6 weeks, 14 (IQR 4.3-21) at 6 months, and 15.5 (IQR 5-21) at last follow-up post implant. In the 32 (59%) men who reported no or mild erectile dysfunction at baseline, 10 (31.2%) had a worse MID IIEF-5 score at last follow-up. Of the 52 men classified as having normal erectile function at baseline, grade 3 toxicity (medical treatment unhelpful) was experienced by 7 (13.5%) men at any time after implant and 1 (2%) patient at last follow-up.

CONCLUSION: Focal LDR brachytherapy in low-intermediate risk prostate cancer was found to be associated with an early detrimental effect on erectile function that improves over time and by 6 months only has a mild negative impact in most men, although some men will experience persistent impairment.

#abs28 | Exploring the Clinical Outcomes and Role of Magnetic Resonance Imaging for Patients Diagnosed with Atypical Small Acinar Proliferation

Dr Tran Ngoc An Huynh[1], Mr Titus Chng[1,2], Dr Steuart Rorke[3], Dr Beena Kumar[3], A/Professor Weranja Ranasinghe[1,2]

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INTRODUCTION & OBJECTIVES: Atypical small acinar proliferation (ASAP) in prostate biopsies poses as a diagnostic challenge due to the uncertain risk of clinically significant prostate cancer. This study aims to investigate the rates of developing clinically significant prostate cancer (Grade Group 2 or higher) in patients with 1) ASAP alone, 2) ASAP and concurrent Grade Group 1 (GG1) prostate cancer, evaluate the role of MRI in determining upgrading of disease.

MATERIALS & METHODS: A single-institution retrospective review of patients diagnosed with ASAP between 2010 to 2023 was performed. Data extraction included patient demographics, ASAP diagnosis specifics, MRI details, and follow-up periods.

RESULTS: 118 patients with ASAP were identified (median age 63 years, median follow-up 31 months).

67 were diagnosed ASAP alone, and 40 underwent a subsequent biopsy. 25% progressed to clinically significant prostate cancer (median time 24 months).

28 patients were diagnosed with ASAP and concurrent GG1 prostate cancer, and 19 underwent subsequent biopsy. 47.4% progressed to clinically significant disease (median time 25 months).

33 patients with ASAP or ASAP and concurrent GG1 prostate cancer had a second biopsy with MRI prior. Out of the 16 patients with PIRADS score ≤3, 25.0% progressed to clinically significant disease. Out of the 17 patients with PIRADS score >3, 52.9% progressed to clinically significant prostate cancer.

CONCLUSION: Our study highlights ASAP's predictive value for subsequent clinically significant prostate cancer patients in isolated ASAP cases and low-risk prostate cancer patients on active surveillance. While MRI with PIRADS 4 or 5 scores can effectively identify upgraded tumors, our findings caution that 25% of patients with clinically significant disease may exhibit inconspicuous MRI findings. Close surveillance is imperative for patients diagnosed with ASAP to ensure timely intervention.

#abs29 | Extended follow-up of the phase 2 KEYNOTE-B61 study: pembrolizumab plus lenvatinib as first-line treatment for patients with non–clear cell renal carcinoma

Dr Craig Gedye[1], Dr Martin Voss, Dr Howard Gurney, Dr Vagif Atduev, Dr Cristina Suarez, Dr David Pook, Dr Miguel A. Climent, Dr Piotr Tomczak, Dr Philippe Barthelemy, Dr Jae Lyun Lee, Dr Taron Nalbandian, Dr Viktor Stus, Dr Thomas Ferguson, Dr Pawel Wiechno, Dr Erhan Gokmen, Dr Louis Lacombe, Dr Joseph E. Burgents, Dr Manish Sharma, Dr Jerry Cornell, Dr Laurence Albiges

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INTRODUCTION AND OBJECTIVES: Initial results of the phase 2 KEYNOTE-B61 (NCT04704219) study showed antitumor activity with first-line pembrolizumab + lenvatinib for non–clear cell renal cell carcinoma. Updated results from KEYNOTE-B61, with an additional 8 months of follow-up, are presented.

METHODS: Adults with previously untreated, advanced non–clear cell renal cell carcinoma and measurable disease per RECIST v1.1 received pembrolizumab 400 mg IV every 6 weeks for up to 18 cycles + lenvatinib 20 mg orally once daily until intolerable toxicity, progressive disease, or patient withdrawal. The primary end point was objective response rate (ORR) per RECIST v1.1 by blinded independent central review (BICR). Secondary end points included disease control rate (DCR; complete response + partial response + stable disease of any duration), duration of response (DOR), and progression-free survival (PFS) per RECIST v1.1 by BICR; overall survival (OS); and safety.

RESULTS: Overall, 158 patients were enrolled and received study treatment. Median (range) follow-up was 22.8 months (16.6-27.6). ORR was 51% (95% CI, 43-59; 13 complete responses; 67 partial responses) and DCR was 82% (95% CI, 75-88). Median (range) DOR was 19.5 months (15.3-not reached [NR]); an estimated 51% of responders remained in response ≥18 months. Responses were observed across histological subtypes. Median (95% CI) PFS and OS were 17.9 months (15.1-22.1) and NR (NR-NR), respectively. Grade 3 or 4 treatment-related adverse events occurred in 92 patients (58%), most commonly hypertension (25%). No treatment-related deaths were reported.

CONCLUSIONS: Pembrolizumab + lenvatinib had durable antitumor activity and a manageable safety profile for advanced non–clear cell renal cell carcinoma. These results continue to support pembrolizumab + lenvatinib as a first-line option for this population. This abstract was accepted and previously presented at the 2024 ASCO Genitourinary Cancers Symposium.

#abs30 | External Validity of the American College of Surgeons Surgical Risk Calculator in Cystectomy for Urothelial Malignancy: An Australian Single Centre Analysis

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INTRODUCTION AND OBJECTIVES: The American College of Surgeons (ACS) Surgical Risk Calculator (SRC) was developed with numerically robust surgical interactions to guide patient-specific risk. Its intended use is to guide patient and clinician decision-making for surgical management. Previous analysis suggest the ACS SRC underestimates the post-operative risk. This study analyses the ACS calculator's assessment of risk compared with actual outcomes in a single centre in Western Australia over eight years. The aim of this study was to assess the validity of the ACS Risk Calculator within a high-volume Australian Institution.

METHODS: Patients who underwent radical cystectomy and ileal conduit formation at Fiona Stanley Hospital (FSH) between January 2016 and March 2024 for urothelial malignancy were included. Females who underwent concurrent anterior exenteration were included, however patients who underwent other concurrent procedures (e.g. total pelvic exenteration, urethrectomy, nephroureterectomy or a neo-bladder urinary diversion) were excluded. Twenty patient predictors that contribute to the ACS Risk Calculator were collected for our patients. Output from the Risk Calculator, including average and patient-estimated risk as reported by ACS NSQIP database, and the observed outcomes of the 141-patient cohort at this institution were tabled. Using R software version 4.3.2, Spearman's test was used to analyse the correlation between average, estimated and observed complication, using a p-value of less than 0.05 for significance. A p-value adjustment was performed using Hommel's method to allow for multiple variables within each risk assessment method. Average calculated serious complications of the FSH cohort were compared against Clavien-Dindo Classification scores using Chi-Squared test of proportions; Clavien-Dindo Score of three, four or five representing equivalence to 'serious complication'.

RESULTS: Of the 141 participants, 113 (80%) were males and 28 (20%) females. The average age was 68 and the average BMI 27.4. There were no deaths within 30 days of the operation. The null hypothesis, variables are not correlated, was excluded (true Rho = 0). Accepting the alternate hypothesis, correlation exists between the FSH cohort calculated risk and the observed outcome (Z = 3.076, P-value 0.002). Correlation also exists between ACS cohort average risk and observed outcome (Z = 3.076, P-value 0.002) as well as FSH cohort calculated risk and ACS average risk (Z = 3.464, P-value 0.0005). After p-value adjustment using Hommel's method, the p-values remain significant (<0.05). Using the Clavien-Dindo Classification as an alternate method of identifying 'serious complication', the observed outcome is 9.9%. A test of proportions between different methods of classifying serious risk is significant (Chi squared value 13.383, P-value 0.002).

CONCLUSION: Prior literature assessing the validity of the ACS SRC is varied but favours underestimation of 30-day post operation surgical risk. Although not tailored to operation-specific complications, we have shown it can be an accurate tool for guiding clinicians and patients on post-operative risks after radical cystectomy in our institution. The criteria for serious complications in the ACS SRC are broad and non-specific and may exaggerate serious complication risk when comparing against the Clavien-Dindo classification.

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#abs31 | Genitourinary toxicity in patients receiving TURP prior to hypofractionated radiotherapy for clinically localised prostate cancer. A Scoping Review of The Key Surgical, Radiation and Patient Factors to consider

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BACKGROUND: When compared with conventional external beam radiotherapy, hypofractionated radiotherapy has led to less treatment sessions and improved quality of life without compromising oncological outcomes for men with prostate cancer. Evidence has shown transurethral prostatic resection prior to brachytherapy and external beam radiotherapy is associated with worsening genitourinary toxicity. However, there is no review of genitourinary toxicity when TURP occurs prior to definitive hypofractionated radiotherapy. In this review, we seek to illustrate the genitourinary outcomes for men with localised prostate cancer who underwent transurethral resection of the prostate prior to receiving definitive hypofractionated radiotherapy. Genitourinary outcomes are explored, and any predictive risk factors for increased genitourinary toxicity are described.

METHODS: PubMed, Medline (Ovid), EMBASE and Cochrane Library were all searched for relevant articles published in English within the last 25 years. This scoping review identified a total of 579 articles.

Following screening by authors, 11 articles were included for analysis.

RESULTS: Five studies reported on acute and late toxicity. One article reported only acute toxicity while five documented late toxicity only. While most articles found no increased risk of acute toxicity, the risk of late toxicity, particularly haematuria was noted to be significant. Risk factors including poor baseline urinary function, prostate volume, number of prior transurethral prostatic resections, timing of radiotherapy following transurethral prostatic resection, volume of the intraprostatic resection cavity and mean dose delivered to the cavity were all found to influence genitourinary outcomes.

CONCLUSION: For those who have undergone prior TURP hypofractionated radiotherapy may increase the risk of late urinary toxicity, particularly haematuria. Those with persisting bladder dysfunction following TURP are at greatest risk and careful management of these men is required. Close collaboration between urologists and radiation oncologists is recommended to discuss the management of patients with residual baseline bladder dysfunction prior to commencing hypofractionated radiotherapy.

#abs32 | Identification of a Micropeptide Linked to Cancer Stem Cell Regulation and Chemoresistance

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The emergence of short open reading frames (sORFs) encoding micropeptides (miPEPs) has sparked significant interest due to their regulatory roles in various biological processes. However, their involvement in cancer progression has remained largely unexplored. Recently, we identified a novel miPEP, IRX4_PEP1, encoded by a sORF within the Iroquois (IRX) gene cluster. Genome-wide association studies have identified an association of IRX gene clusters with multiple cancer risks using comprehensive bioinformatic tools, highlighting their importance in cancer. IRX4_PEP1 is a 78-amino acid micropeptide with a high coding potential (91%), suggesting its functional significance.

Research indicates that IRX4_PEP1 plays a pivotal role in promoting prostate cancer (PCa) progression. It facilitates PCa cell proliferation, migration, and invasion by interacting with heterogeneous nuclear ribonucleoprotein K (hnRNPK) and inducing metabolic reprogramming. Moreover, overexpression of IRX4_PEP1 disrupts the Wnt signaling pathway by interacting with Catenin beta-1 (CTNB1), leading to the upregulation of PCa stem cell markers and subsequent resistance to docetaxel, a chemotherapy drug commonly used in PCa treatment.

Notably, IRX4_PEP1 expression is significantly elevated in PCa tissues compared to normal tissues, and its levels positively correlate with disease aggressiveness. Additionally, the expression of CTNB1 and hnRNPK, which interact with IRX4_PEP1, also correlates positively with IRX4_PEP1 expression in PCa tissues.

These findings underscore the critical role of IRX4_PEP1 in regulating PCa stemness and chemoresistance, suggesting its potential as both a therapeutic target and a diagnostic/prognostic biomarker for PCa. Further exploration of IRX4_PEP1 and its interactions may provide valuable insights into PCa biology and aid in the development of targeted therapies for this disease.

#abs33 | Immune predictors of Bacillus Calmette–Guérin (BCG) response in patients with non-muscle invasive bladder cancer

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INTRODUCTION: Intravesical- Bacillus Calmette–Guérin (BCG) is the gold standard therapy for non-muscle invasive bladder cancer (NMIBC). However, up to 70% of patients fail BCG therapy.[1]

We aimed to identify the immune markers associated with BCG response.

METHODS: Patients with NMIBC who underwent intravesical BCG at a tertiary institution between 2018-2022 were identified. Twelve BCG-responders and thirteen non-responders were matched for patient and tumour factors. Formalin-fixed paraffin-embedded specimens before and after BCG therapy were retrieved. Immune cell subsets were measured using monoclonal antibodies; CD4, CD8, T-Bet, GATA-3 and PD-1. GATA-3 and T-Bet stains were used as surrogates for Th-2 and Th-1 cells, respectively.[2-4] Stained specimens were scored at ×40 magnification equivalent with figures stated as per 5-high power field (5/hpf). Paired and unpaired T-tests were used to assess biomarker counts.

RESULTS: Ten BCG-responders and six BCG non-responders had adequate tissue for immunostaining. There were no differences in absolute CD4 or CD8 values in both groups. However, prior to BCG, responders had a lower CD4:CD8 ratio (1.71 vs 2.94, p=0.0003) and a lower Th-2/Th-1 (GATA/T-Bet) ratio (2.97 vs. 5.95, p=0.0026) compared to non-responders. The Th-2/Th-1 ratio was increased post-BCG in responders (mean difference 0.9323, p=0.0228), demonstrating both humoral and adaptive responses to BCG.[2-4] In contrast, the BCG-non-responders had no changes to the CD4:CD8 or Th-2/Th-1 ratios with BCG.

BCG-responders also had a higher mean PD-1 expression compared to non-responders (74.09/5hpf vs 29.17/5hpf, p=0.0008) which decreased in response to BCG (MD -25.5/5hpf, p=0.0121). In contrast, there was a 78% increase in the PD-1 expression in non-responders post-BCG (MD 20.83/5hpf, p=0.016), indicating T cell exhaustion.[5]

CONCLUSIONS: NMIBC environment with low CD4:CD8 and low Th-2/Th-1 (GATA/TBET) ratios can promote both humoral and adaptive responses to BCG and could be used as immune markers for BCG response.

#abs34 | Impact of exposure on outcomes with enfortumab vedotin in patients with locally advanced or metastatic urothelial cancer

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BACKGROUND: Enfortumab vedotin (EV), approved as monotherapy and plus pembrolizumab (EV+P) for patients with locally advanced or metastatic urothelial cancer (la/mUC), improved overall survival (OS) with manageable safety profiles in patients with previously treated or untreated la/mUC. Dose modifications are recommended to manage EV-related AEs. Here we evaluated associations between plasma exposure following EV monotherapy and safety and efficacy outcomes.

METHODS: Patients in EV-101 (NCT02091999; EV 0.75, 1.0, and 1.25 mg/kg on days 1, 8, 15 of 28-day cycles [3Q4W]), EV-201 (NCT03219333; EV 1.25 mg/kg 3Q4W), and EV-301 (NCT03474107; EV 1.25 mg/kg 3Q4W) were characterized for dose- and exposure-response for efficacy and exposure-response for safety outcomes. Pharmacokinetics included multiple samples in cycles 1–2 and pre-dose samples in subsequent cycles.

RESULTS: Dose modifications were common, including reductions to 1.0 mg/kg (EV-201 42.1%; EV-301 35.1%) and 0.75 mg/kg (EV-201 13.6%; EV-301 11.1%). EV improved progression free survival (PFS) and OS versus chemotherapy across exposure quartiles in EV-301: median PFS (95% CI) was 5.65 (5.32–7.23) months for highest EV exposure [Q4] and 4.44 (3.75–6.77) months for lowest exposure [Q1], versus 3.71 (3.52–3.94) months for chemotherapy. Median OS (95% CI) was 12.6 (9.79–not evaluable) months at Q4 and 11.0 (7.89–15.2) months at Q1, versus 8.97 (8.05–10.74) months for chemotherapy. Greater initial EV exposure at cycles 1–2 was associated with higher objective response rates (0.75 mg/kg 21.4% [n=14]; 1.0 mg/kg 18.5% [n=27]; 1.25 mg/kg 40–51.1% across studies [n=613]). Lower EV exposure was associated with fewer EV-related grade ≥3 rash/skin reactions and hyperglycemia and grade ≥2 peripheral neuropathy (all P<0.0001).

CONCLUSIONS: EV improved survival versus chemotherapy in patients with la/mUC across exposure quartiles. Starting doses of 1.25 mg/kg 3Q4W resulted in EV exposure that maximized likelihood of response. Dose modifications are effective for managing EV-related AEs and should be used as clinically indicated.

#abs35 | Impact of intraluminal metastases on renal cancer patients outcome

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INTRODUCTION AND OBJECTIVES: While metastasis to well-recognised sites such as the lungs, liver, brain, bones, and lymph nodes has been extensively studied, the occurrence of renal metastasis to the upper gastrointestinal tract remains a less-explored but clinically relevant phenomenon. These intra luminal metastases typically present with unusual symptoms such as bleeding or hollow viscous perforation and are often missed on the routine scans. We describe a case series of metastatic renal cell cancer (mRCC) patients presenting with intraluminal metastases to the upper gastrointestinal tract.

METHODS: We have reviewed the cases of metastatic renal cancer seen at the Canberra Hospital presenting with intestinal bleeding, perforation or obstruction. We have identified 4 patients between 2013 to 2023.

RESULTS: Four patients were identified, showcasing diverse presentations:

1. A 69-year-old male with clear cell carcinoma experienced haematemesis and melaena, with endoscopic findings confirming duodenal metastasis managed with endoscopic mucosal resection and radiotherapy.

2. A 48-year-old male, diagnosed with renal cell carcinoma, suffered gastrointestinal bleeding due to omental metastasis requiring surgery despite embolization during fourth-line therapy.

3. A 72-year-old man diagnosed with renal clear cell carcinoma presented with upper gastrointestinal bleeding from a large polypoidal gastric metastasis, necessitating distal gastrectomy.

4. Another 72-year-old male with clear cell renal carcinoma displayed pancreatic and gastric metastases, confirmed through fine-needle aspiration, culminating in fatal upper gastrointestinal bleeding.

CONCLUSIONS: Renal cancer metastases to the upper gastrointestinal tract is NOT a rare phenomenon and can be often missed on routine restaging conventional CT scans. The complex and unique presentations require interdisciplinary collaboration and tailored treatment approaches to optimise patient outcomes in these challenging scenarios.

#abs36 | Incidence of BCG intolerance in non-muscle invasive bladder cancer

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INTRODUCTION AND OBJECTIVES: Bladder cancer accounts for 2% of all cancer cases in Australia [1]. Most patients present with localised disease and are managed with endoscopic resection. For high grade non-muscle invasive bladder cancer (NMBIC)

Intravesical Bacillus Calmette-Guerin (BCG) therapy is the gold standard adjuvant treatment [2], although 30-40% of patients fail BCG treatment with lack of response or disease relapse [3]. An understudied area of treatment failure is BCG intolerance where patients drop out prior to adequate therapy duration due to intolerance of adverse effects. We systematically review the literature to examine the incidence and underlying reasons for BCG intolerance among adult patients with NMIBC.

METHODS: A search on Embase, MEDLINE, and Cochrane Central Register of Controlled Trials was conducted in December 2023 for studies between1/1/1974 to 1/10/2023. 2 authors independently identified relevant articles by screening titles and abstracts, then retrieving full articles, following Preferred Reporting Items for Systematic Reviews and Meta-analyses guidelines. Included studies were English-language publications reporting dropout rates and reasons for discontinuation of BCG therapy. Single case reports of adverse effects were excluded.

RESULTS: There were 3340 studies identified from our initial literature search. Following the screening process, 32 studies were included. The dropout rates reported amongst these studies varied widely from 0% to 65% (average 15%, median 10%). Various BCG strains and dosing regimens were utilised, making direct comparisons difficult. All studies reported local adverse effects such as cystitis as a reason for dropout. Other reasons included cost or loss to follow up. 3 of the 7 studies which reported clinical outcomes for BCG intolerance demonstrated an increased risk of progression or recurrence.

CONCLUSIONS: Across the literature dropout rates due to BCG intolerance average 15%. As cessation of treatment could lead to increased risk in progression or recurrence of disease, strategies to mitigate BCG intolerance would be valuable.

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#abs37 | Inclusiveness in patient-reported outcome measures (PROMs): a resource about translations and cross-cultural validations from CQUEST

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INTRODUCTION AND OBJECTIVES: Indigenous and culturally and linguistically diverse (CALD) Australians encounter barriers to participating in cancer clinical trials. While national initiatives are underway to improve access to trials, is also important to ensure that trial methods are inclusive for enrolled patients. Most patient-reported outcome measures (PROMs) have been developed and validated in English-speaking populations, and to accommodate non-English-speaking populations, it is vital to include PROMs in other languages that are appropriate for target cultural groups. Consistent translation and cultural equivalence of PROMs can enable the collection and pooling of data across participants of various CALD backgrounds.

The Cancer Quality of Life Expert Service Team (CQUEST), funded by Cancer Australia, supports the use of PROMs in cancer clinical trials by developing up-to-date, practical, and accessible resources. We aim to support ANZUP investigators who may require PROMs that are available in more than one language and/or are appropriate for multiple cultural groups.

METHODS: The CQUEST website (www.uts.edu.au/cquest) hosts a resource that describes the importance of PROM translations and cultural validations, along with the differences between translations and cross-cultural validation. The resource also provides a comprehensive list of 76 PROMs commonly used in cancer clinical research, and available evidence of their translations and/or cross-cultural validations across over 100 languages. This list will undergo periodic updates.

RESULTS: CQUEST's online resource will help ANZUP members improve trial inclusivity and PROM data quality. ANZUP members are also invited to request further online resources that will improve the accessibility and utilisation of PROMs in their research. These can be suggested to the CQUEST team during discussion of the abstract.

CONCLUSION: CQUEST invites ANZUP members to engage with our online resources to improve the use of PROMs in cancer trials for patients from Indigenous and CALD backgrounds.

#abs38 | Inhibition of tumour growth with Evexomostat/SDX-7320 in multiple, stage-specific models of prostate cancer

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INTRODUCTION AND OBJECTIVES: The development of resistance to androgen receptor (AR) inhibitors and the emergence of aggressive variant prostate cancer (AVPC) highlights the need for novel, AR-independent therapies. Elevated expression of methionine aminopeptidase 2 (MetAP2) correlates with increased prostate cancer aggressiveness, with enhanced expression in AVPC[1]. MetAP2 regulates protein translation, angiogenesis and has tumour-specific roles coordinating plasticity, vascular mimicry, and cell metabolism. Evexomostat/SDX-7320 is a polymer-drug conjugate of a novel fumagillin-derived MetAP2 inhibitor[2], which overcomes toxicity of earlier METAP2 inhibitors[3] by limiting CNS penetration and improving pharmacokinetics. Evexomostat completed a phase I trial in late-stage cancer patients and is in multiple phase II trials. Our objectives were to test SDX-7320 efficacy in multiple preclinical xenograft models of CRPC and AVPC.

METHODS: SDX-7320 (evexomostat) was tested in NSG mice harbouring LNCaP xenografts (12 mg/kg, SC, Q4D or vehicle 5% mannitol/water) in intact, castrated, and CRPC models. SDX-7320 treatment was also evaluated in LuCaP35.CR patient-derived xenograft (PDX) in castrate mice alone and in combination with enzalutamide following failure on 10mg/kg daily enzalutamide treatment. SDX-7320 efficacy was further evaluated in the LTL545 (AR-negative, NE-positive) model of AVPC. Tumours were assessed for growth, transcriptomic (RNAseq) and histological differences (H&E, CD31, CD34 IHC).

RESULTS: SDX-7320 treatment significantly reduced tumour volume across all models, both as single agent and in combination with AR-targeted therapies, as well as in the AR-negative LTL545 model, suggesting MetAP2 drives important biological pathways in AR-positive and AR-negative tumours. SDX-7320 displayed antiangiogenic effects with reduced CD34 staining. Analysis of RNA-sequenced tumours identified significant changes to genes associated with protein translation, cell proliferation and angiogenesis. We observed increased expression of AR target genes in these models of adenocarcinoma, suggesting pro-differentiation to potentially re-sensitise to androgen-targeted therapies.

CONCLUSIONS: Our results suggest targeting MetAP2 in multiple stages of prostate cancer warrants rapid clinical translation.

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#abs39 | Interim Results From a Phase 1 Study of AMG 509 (xaluritamig), a STEAP1 x CD3 XmAb 2+1 Immune Therapy, in Patients With Metastatic Castration-Resistant Prostate Cancer

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INTRODUCTION AND OBJECTIVES: We report results of xaluritamig monotherapy in a first-in-human study for patients with metastatic castration-resistant prostate cancer (mCRPC). Objectives: evaluate safety, tolerability, antitumour activity, pharmacokinetics (PK); determine maximum tolerated dose (MTD) and recommended phase 2 dose.

METHODS: Patients had mCRPC refractory to novel hormonal therapy and 1–2 taxane regimens, ECOG 0–1, and adequate organ function. Xaluritamig administration: intravenous weekly (QW) or 2-weekly (Q2W) with various dose levels/schedules (DLs).

RESULTS: At 23 March 2023, 97 patients in 15 DLs received ≥1 dose of xaluritamig. Median (range) age was 67 (40–86) years; 67 patients (69.1%) had received >3 prior lines of therapy. Treatment-emergent adverse events were reported in 100% of patients (grade≥3, 74.2%); 95.9% reported treatment-related AEs (TRAEs) (grade≥3, 52.6%). Most common AEs were cytokine release syndrome (CRS; 72.2%), fatigue (52.6%), anaemia (45.4%), pyrexia (40.2%), and myalgia (39.2%). CRS was primarily grade 1/2, one event being grade 3 (no grade 4/5 CRS; cycle 1). In the DL15 QW cohort, 3/6 DLT-evaluable patients experienced DLTs, defining DL14 QW as the MTD. TRAEs leading to discontinuation occurred in 17.5% of patients. Prostate-specific antigen (PSA)50 (≥ 50% PSA decline) responses occurred in 42 patients (47.2%); PSA90, in 24 patients (27.0%). PSA responses (≥50%; ≥90%) were more frequent at higher DLs (DL8–15; 54.3%; 34.8%) than in lower DLs (DL1–7; 39.5%; 18.6%). Overall, RECIST responses included 15 (22.7%) confirmed partial response (PR) and 30 (45.5%) stable disease (SD). At higher DLs, 14 patients (38.9%) had confirmed PR and 12 (33.3%) SD compared with 1 patient (3.3%) and 18 patients (60%) at lower DLs. Preliminary PK showed dose-proportional increase in exposure with mean terminal half-life of approximately 3-4 days.

CONCLUSIONS: Xaluritamig was tolerable with low-grade CRS (occurring primarily cycle 1) with encouraging preliminary efficacy in heavily pretreated patients with mCRPC.

#abs40 | Intravesical Chemotherapy Use Following Radical Nephroureterectomy for Upper Tract Urothelial Caricinoma: A Comparative Audit

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INTRODUCTION: Upper tract urothelial carcinoma (UTUC) has a high morbidity and poor long-term survival rate, with radical nephroureterectomy (RNU) as the standard treatment for localised cases.1,2 Bladder recurrence rates post-RNU range from 22% to 47%, and a single dose of postoperative intravesical chemotherapy, such as mitomycin, has been shown to reduce this risk.3 This audit compared the use

of postoperative mitomycin and other surgical and oncological outcomes in patients undergoing RNU at a tertiary referral centre for UTUC from 2022 to 2023 with those who underwent RNU from 2015 to 2022.

METHODS: We retrospectively reviewed medical records from all patients who underwent RNU at Fiona Stanley Hospital (FSH) between April 2022 and November 2023. Data on patient demographics, surgical technique, hospital stay duration, and postoperative chemotherapy were collected and compared with data from 2015 to 2022.

RESULTS: A total of 22 patients underwent RNU at FSH from April 2022 to November 2023. The median time from referral to ureteroscopy was 61.1 days; from ureteroscopy to RNU, it was 93 days. The median length of stay remained the same at six days in both groups. Robotic surgery increased significantly in the recent cohort (68.2% vs. 26.3%; p = 0.0015), while laparoscopic surgery decreased (22.7% vs. 70%; p = 0.00037). Postoperative mitomycin use increased from 22.8% to 77.7% (p = 0.0016). Other comparisons, such as the rate of 30-day complications, adjuvant chemotherapy, and tumour staging, showed non-significant differences between the two cohorts (p>0.05).

CONCLUSIONS: This audit demonstrates a significant increase in the use of postoperative mitomycin following RNU, suggesting improved adherence to best practices. Future audits will assess surgical outcomes between robotic and laparoscopic approaches and aim to reduce the time between ureteroscopy and RNU. Further analysis is needed to understand the long-term impact of these changes on patient outcomes.

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#abs41 | LEEP study: a randomised phase II window of opportunity, neoadjuvant trial examining the pharmacodynamics effects of CDK4/6 inhibitor LEE011 (ribociclib) prior to radical prostatectomy for high-risk, localised prostate cancer

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INTRODUCTION: Despite treatment advances for prostate cancer, it remains the second leading cause of cancer death in men. Neoadjuvant pharmacodynamic studies allow for rational approaches to decisions regarding which therapies should progress to phase II/III trials. CDK4/6 inhibitors are efficacious in breast cancer but have limited efficacy in metastatic prostate cancer. The LEEP trial aims to assess the pharmacodynamic effects of LEE011 (ribociclib), an orally bioavailable and highly selective CDK4/6 inhibitor, in patients with hormone-naïve high-risk, localised prostate cancer.

METHODS: This open-label, phase II trial randomised patients at three Australian sites 4:1 to ribicoclib or control. Participants in the treatment arm were treated with ribociclib 400mg daily for 21 days prior to radical prostatectomy. The primary endpoint was the frequency of a 50% reduction in Ki-67 from

the pre-treatment biopsy compared to the radical prostatectomy.

RESULTS: Between November 2018 and October 2022, 33 patients were randomised to either ribociclib or control. 17 participants in the ribociclib group and 7 in the control group were evaluable for response (9 participants not evaluable due to surgical delays (including COVID shutdowns) or insufficient cancer in biopsy specimens). When examining a random selection of cancer areas, 10/17 (58%) participants had a greater than 50% reduction in Ki-67, compared to only 2/7 (29%) participants in the control group. When examining hot spot areas of cancer (i.e. areas with the highest grade of cancer), 5/17 participants had a greater than 50% reduction in Ki-67, compared to 0/7 (0%) participants in the control group.

CONCLUSIONS: Following neoadjuvant treatment with ribociclib, a greater number of participants experienced a reduction in Ki-67 compared to controls. Greater responses were seen in random areas compared to hotspots. We hypothesise that these higher risk areas are less responsive to CDK4/6 inhibitors. Further exploratory analysis will be performed to understand biological changes.

#abs42 | LuCape: Phase 1a/b Study of Lutetium-PSMA and Capecitabine in metastatic castration-resistant prostate cancer

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INTRODUCTION AND OBJECTIVES: Prostate-specific membrane antigen (PSMA) represents a highly restricted, overexpressed prostate cancer cell-surface protein which has been successfully utilised for delivery of molecularly targeted radiation for the treatment of prostate cancer1-4. Results from randomised clinical trials investigating PSMA-targeted therapy report improvement in outcomes for patients with metastatic castration-resistant prostate cancer (mCRPC)5,6. Whilst evidence to date has largely investigated Lutetium-PSMA (Lu-PSMA) monotherapy, the addition of radiosensitising agents may give comparatively superior efficacy7,8. We hypothesise that capecitabine is safe and tolerable when used as a radiosensitiser in combination with Lu-PSMA. Our primary objective is to determine the maximum tolerated dose (MTD) of capecitabine when administered in combination with Lu-PSMA.

METHODS: Study design is a single arm phase 1a/1b dose-escalation and dose-expansion study. Dose escalation of capecitabine will occur using a 3+3 schema, with four fixed dose levels of 275mg/m2 bd, 550 mg/m2 bd, 825mg/m2 and 1000mg/m2 bd. Eligible patients require an ECOG 0-2, adequate organ function, PSMA-detectable mCRPC, no previous treatment with PSMA-targeted radiotherapy, refractory to at least one taxane-chemotherapy, one novel androgen receptor signalling inhibitor therapy, and PARP-inhibitor if BRCA mutation positive. Capecitabine commences on day 1 of each cycle and continues for 14 days. Lutetium-177-PSMA I&T (Lu-PSMA) is given on day 10 of every treatment cycle. Patients receive up to six cycles at 42-day intervals. Progression to the expansion phase will occur once the MTD is established. CT scan and bone scan will be performed at baseline and then 12-weekly until progression.

RESULTS: The first patient commenced treatment in Dec 2023 and as of April 2024 four patients have commenced study treatment. Cohort 1 has been completed without DLT. Enrolment to cohort 2 began in March 2024.

CONCLUSIONS: Early results of the LuCape trial are promising that capecitabine with Lu-PSMA is feasible. Recruitment is ongoing.

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#abs43 | Moderate and severe pain is prevalent in people with prostate and urological cancer in the last week of life

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BACKGROUND/AIM: Rarely has the pain affecting people with cancer in the last days of life been investigated. Despite people's short prognosis, optimal pain control must remain a priority. This work aims to better understand the nature of moderate and severe pain for people with cancer in the last week of life and its relationship with other symptoms and demographic characteristics by using data from a national quality improvement program.

METHODS: Prospectively collected sociodemographic and clinical assessment data from Australian adults with cancer as a principal diagnosis who received specialist palliative care from services registered with the Palliative Care Outcomes Collaboration (PCOC) were examined. Correlation between pain and other characteristics were evaluated.

RESULTS: Moderate or severe distress from pain was seen in 31%(n=71,750) of people with cancer at least once during the last seven days of life. Moderate and severe distress from pain in the last week of life was most prevalent in people with primary bone or soft tissue (36.6%), prostate(33.9%) and other urological(33.3%) cancer. Pain-associated distress reduced as death approached and performance status deteriorated. A weak association was noted between distress from pain and fatigue, difficulty sleeping and bowel problems(Pearson correlation coefficient 0.31, 0.28, 0.25; $p<0.001$). We were unable to account for the impact of proxy reporting, although sensitivity analysis suggested assessments in participants with an Australia-modified Karnofsky Performance Status of ten do not change the overall distribution of distress from pain.

CONCLUSIONS: A substantial proportion of Australians with genitourinary and other cancers experience moderate or severe distress from pain on at least one timepoint during the last week of life. This is despite specialist palliative care input. These findings highlight the importance of clinical trials to improve pain management in people with genitourinary cancer.

#abs44 | Novel metabolic strategy to combat treatment resistance in prostate cancer

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INTRODUCTION AND OBJECTIVES: AR-targeted therapies provide incremental improvements in survival, but there remains an urgent need to combat therapy failure. Prostate cancer metabolism is tightly controlled by the AR, and AR inhibition drives molecular reprogramming and switching of mitochondrial fuel pathways. To identify the metabolic adaptations facilitating PCa therapy resistance, we undertook extensive analysis of both publicly available and our own transcriptomic repositories consisting of RNA-sequenced patient tumours and enzalutamide-treated PCa cell lines. This identified the branched chain amino acid (BCAA) catabolism pathway, specifically valine catabolism, as being significantly upregulated in PCa and enhanced in response to enzalutamide. This adaptation has the potential to drive the recently identified succinate-

dependent mitochondrial reprogramming in high-grade prostate tumours[1] [2]. Our objective was to demonstrate the critical role of valine in fuelling the mitochondrial succinate pool to drive tumour growth and resistance.

METHODS: We investigated the metabolic consequence of valine loss by modification of the extracellular environment. The ubiquitous enzyme 3-hydroxyisobutyryl-CoA hydrolase (HIBCH) is a key regulator of valine catabolism which contributes to cell respiration and de novo lipogenesis, particularly in adipocytes. We targeted valine catabolism via HIBCH knockdown across a range of PCa models to characterise anti-tumour activity by measuring mitochondrial function by extracellular flux analysis, mitochondrial morphology via quantitative single-cell imaging using a range of metabolic reporter probes and metabolomics.

RESULTS: Suppression of valine availability reduced lipid content despite compensatory upregulation of fatty acid uptake, indicating valine is an important lipogenic fuel in PCa. Inhibition of HIBCH selectively inhibited cell proliferation of malignant but not benign prostate cells and impaired succinate production, mitochondrial activity, comprehensively demonstrating valine is a source of succinate in PCa models.

CONCLUSIONS: Our work presents a unique metabolic vulnerability and novel potential therapeutic strategy for mCRPC. Identification of potential small-molecule inhibitors against HIBCH also presents a high-degree of translational potential for future preclinical development.

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#abs45 | Oncological outcomes post focal low-dose-rate brachytherapy in men with low- intermediate risk prostate cancer – early results from Australia's LIBERATE Registry

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INTRODUCTION & OBJECTIVES: Focal therapy for prostate cancer (PCa) has emerged as a novel approach to minimise adverse events without compromising oncological outcomes. This study reports oncological control and pathological progression following focal low-dose-rate (LDR) brachytherapy for low-intermediate risk PCa.

MATERIALS & METHODS: Patients were recruited from a prospective, multi-centre clinical registry of focal LDR brachytherapy cases for the treatment of low-intermediate risk PCa (LIBERATE Clinical Registry). Men received monotherapy treatment using iodine-125 seeds to deliver a prescribed dose of 145 Gy to the index lesion. Rigorous follow-up was conducted with surveillance MRI and repeat transperineal biopsy completed at 18-36 months post implant. Control was achieved if there were no visible neoplastic characteristics and/or < Gleason 3+3 in <10mm of core. Progression occurred if there were no pathological changes from baseline or tumour upgrading occurred compared to baseline.

RESULTS: Currently, 77 men are enrolled in the registry with a median follow-up of 18.2 months. Thirty-seven (40%) patients have completed their follow-up imaging and biopsy assessment with a median time between pre- and post-treatment biopsies of 19.1 months. Pathological control was reported in 28 (75%) men, and 8 (21%) patients demonstrated an out-of-field pathological progression that was managed in all cases with continued active surveillance. Pathological progression within the treatment field occurred in 1 (2%) patient, who had 5mm Gleason 4+3 disease identified in one target core. After focal treatment, 2 (3.1%) patients proceeded to radical prostatectomy without acute postoperative complications.

CONCLUSION: These early results suggest that focal LDR brachytherapy for low-intermediate risk, single lesion, imaging-visible PCa demonstrates satisfactory oncological control at 18-36 months given the trade-off of minimised side effects and allows for early recognition of treatment failure. However, longer-term follow-up is needed to assess clinical oncological outcomes.

#abs46 | Overall survival with darolutamide vs placebo in combination with androgen deprivation therapy (ADT) and docetaxel: A sensitivity analysis from ARASENS accounting for subsequent therapy

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INTRODUCTION AND OBJECTIVES: Darolutamide + ADT + docetaxel is approved for metastatic hormone-sensitive prostate cancer (mHSPC) based on the phase 3 ARASENS study (NCT02799602). To address the impact of informative intercurrent events (eg, use of subsequent therapy) in censored patients, we performed a post hoc sensitivity analysis of OS.

METHODS: Patients with mHSPC were randomized 1:1 to darolutamide 600 mg orally twice daily or placebo, with ADT and docetaxel. The primary endpoint was OS. Patients with no documented death were censored at last known alive or data cut-off date, whichever was earlier. The post hoc sensitivity analysis counted initiation of subsequent systemic antineoplastic therapy as an event in censored patients still alive at end of follow-up.

RESULTS: In the primary analysis, darolutamide + ADT + docetaxel significantly improved OS (HR 0.68, 95% CI 0.57–0.80, P<0.0001), despite a high percentage of patients who entered follow-up in the placebo group receiving subsequent life-prolonging systemic therapies (374/495, 76%). Time to first subsequent systemic antineoplastic therapy (a key secondary endpoint) was significantly longer with darolutamide + ADT + docetaxel vs placebo + ADT + docetaxel (HR 0.39, 95% CI 0.33–0.46, P<0.001). Findings from the post hoc sensitivity analysis supported the primary OS analysis: HR 0.47, 95% CI 0.40–0.54, P<0.0001 (patients who died + censored patients who initiated subsequent systemic antineoplastic therapy: darolutamide 300/651, 46.1%; placebo 476/654, 72.8%). Additional planned sensitivity analyses will be presented. Treatment-emergent adverse events (TEAEs) were similar between groups. TEAEs led to darolutamide/placebo discontinuation in 13.5%/10.6% of patients.

CONCLUSIONS: The results of the sensitivity analyses were consistent with the ARASENS primary OS analysis. These data reinforce darolutamide + ADT + docetaxel as an effective and well tolerated new standard of care for early treatment intensification in patients with mHSPC.

#abs47 | Patient-reported outcomes from a randomized, phase 3 trial of enfortumab vedotin plus pembrolizumab versus platinum-based chemotherapy in previously untreated locally advanced or metastatic urothelial cancer

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BACKGROUND: Enfortumab vedotin plus pembrolizumab (EV+P) nearly doubled median progression-free survival and overall survival versus platinum-based chemotherapy (PBC) previously untreated locally advanced or metastatic urothelial cancer (la/mUC) in the phase 3 EV-302 trial (NCT04223856). PROs are reported here.

METHODS: Patients randomized 1:1 to EV+P or PBC completed Questionnaires (EORTC Quality of Life Questionnaire [QLQ-C30] and Brief Pain Inventory Short Form [BPI-SF]) at baseline, weekly for 12 weeks, then every 3 weeks through follow-up. Time-to-pain-progression (TTPP) and mean change from baseline in worst pain at week 26 using BPI-SF were prespecified analyses statistically tested using a gatekeeping strategy. Mean change from baseline through week 26 and time-to-confirmed-deterioration (TTCD) of EORTC-QLQ-C30 and BPI-SF domains were prespecified descriptive analyses. TTPP and TTCD were assessed using Kaplan-Meier.

RESULTS: Of 886 patients, 731 (EV+P: n=376; PBC: n=355) completed baseline questionnaires, with >70% compliance through week 29 for EV+P versus week 17 for PBC. Median TTPP was 14.2 versus 10.0 months for EV+P versus PBC, respectively (hazard ratio [HR]: 0.92 [95% CI, 0.72–1.17]; P=0.48). Least squares (LS) mean reduction in worst pain at week 26 was numerically greater with EV+P versus PBC (−0.61 vs −0.03, LS mean difference: −0.58 [95% CI, −1.05 to −0.11]; P=0.015). Patients with moderate-to-severe baseline pain given EV+P (n=128, 34%) had meaningful >2-point improvement in BPI worst pain from weeks 3–26. In EORTC-QLQ-C30 Global Health Status/Quality of Life [GHS/QoL], EV+P worsened at week 3 (−6.3) but returned to baseline from weeks 4–26; PBC deteriorated from weeks 1–17 (range −1.2 to −7.1) then returned to baseline. TTCD for GHS/QoL was 5.9 versus 3.2 months for EV+P versus PBC, respectively (HR: 0.98 [95% CI, 0.79–1.2]).

CONCLUSIONS: EV+P improved survival of patients with la/mUC versus PBC without lowering quality of life and functioning. Lower-than-expected compliance may have impacted results.

#abs48 | Phase 3 KEYNOTE-992 study: pembrolizumab plus chemoradiotherapy versus placebo plus chemoradiotherapy in patients with muscle-invasive bladder cancer

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Trial registry name and registration number: Clinicaltrials.gov, NCT04241185

FUNDING: This study was supported by Merck Sharp & Dohme LLC, a subsidiary of Merck & Co., Inc., Rahway, NJ, USA.

BACKGROUND: Concurrent chemoradiotherapy (CRT) is an option in patients with muscle-invasive bladder cancer (MIBC) who decline or are ineligible for radical cystectomy. The phase 3 KEYNOTE-992 study (NCT04241185) will evaluate efficacy and safety of pembrolizumab plus CRT versus placebo plus CRT in patients with MIBC who chose bladder preservation.

METHODS: Approximately 636 adults with histologically confirmed MIBC (T2-T4aN0M0) with ≥50% urothelial histology who have planned treatment with one of the specified radiosensitizing chemotherapies will be enrolled. Patients will be randomly assigned 1:1 to receive pembrolizumab 400 mg or placebo intravenously (IV) every 6 weeks for ≥9 cycles, both with CRT. CRT will comprise radiosensitizing chemotherapy with cisplatin (35 mg/m2 IV weekly on day 1), 5-fluorouracil (500 mg/m2 on days 1-5 and days 22-26) plus mitomycin C (12 mg/m2 on day 1), or gemcitabine (27 mg/m2 IV twice weekly on days 1 and 4) and conventional radiotherapy (64 Gray at 2 Gray/fraction over 6.5 weeks [whole bladder with or without pelvic nodes]) or hypofractionated radiotherapy (55 Gray at 2.75 Gray/fraction over 4 weeks [whole bladder only]). Primary end point is bladder-intact event-free survival (time from randomization to first documented occurrence of residual/recurrent MIBC, nodal or distant metastases, radical cystectomy, or death from any cause) per blinded independent central review and/or central pathology review. Secondary end points are overall survival, metastasis-free survival, time to cystectomy, time to occurrence of non-MIBC, safety and tolerability, and patient-reported outcomes.

RESULTS: Recruitment is ongoing in Asia, Australia, Europe, North America, and South America.

CONCLUSIONS: Results from KEYNOTE-992 will determine efficacy and safety of pembrolizumab plus CRT in patients with MIBC who chose bladder preservation.

#abs49 | Phase 3 MK-5684-003 trial: CYP11A1 inhibitor opevesostat (MK-5684) versus next-generation hormonal agent (NHA) switch in patients with metastatic castration-resistant prostate cancer (mCRPC) after NHA and taxane-based chemotherapy

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BACKGROUND: Opevesostat is an oral, nonsteroidal inhibitor of cytochrome P450 11A1 (CYP11A1), which catalyzes the first and rate-limiting step of steroid biosynthesis. In the phase 1/2 CYPIDES trial, opevesostat showed antitumor activity in patients with heavily pretreated mCRPC. The randomized, open-label, phase 3 MK-5684-003 trial (NCT06136624) will evaluate efficacy and safety of opevesostat versus NHA switch in patients with NHA- and taxane-pretreated mCRPC.

METHODS: Eligible patients have mCRPC (unselected for androgen receptor ligand binding domain [AR-LBD] mutations) that progressed on androgen deprivation therapy and on/after treatment with 1 NHA for nonmetastatic (nm) hormone-sensitive prostate cancer (HSPC), nmCRPC, mHSPC, or mCRPC for ≥8 weeks (≥14 weeks with bone progression), and also progressed on/after 1-2 taxane-based chemotherapies for mCRPC. Approximately 1200 patients (300 with and 900 without AR-LBD mutations) will be randomly assigned 1:1 to receive opevesostat 5 mg orally twice-daily (+ dexamethasone 1.5 mg and fludrocortisone 0.1 mg once-daily) or enzalutamide 160 mg orally once-daily (if prior abiraterone) or abiraterone acetate 1000 mg orally once-daily (+ prednisone 5 mg twice-daily; if prior enzalutamide/darolutamide/apalutamide). Randomization will be stratified by measurable disease (yes/no), AR-LBD mutation status (positive/negative), and prior cabazitaxel use (yes/no). Tumor assessments will be performed every 8 weeks up to week 24, then every 12 weeks thereafter. Dual primary end points are radiographic progression-free survival (per

Prostate Cancer Working Group 3 [PCWG3]-modified Response Evaluation Criteria in Solid Tumors version 1.1 [RECIST v1.1] by blinded independent central review [BICR]) and overall survival, analyzed separately in patients with AR-LBD mutation-positive and -negative disease. Secondary end points include time to initiation of first subsequent anticancer therapy or death; objective response rate and duration of response per PCWG3-modified RECIST v1.1 by BICR; time to pain progression; time to prostate-specific antigen progression; time to first symptomatic skeletal-related event; and safety and tolerability. Enrollment is ongoing.

#abs50 | Phase 3 MK-5684-004 study: CYP11A1 inhibitor opevesostat (MK-5684) versus next-generation hormonal agent (NHA) switch in patients with metastatic castration-resistant prostate cancer (mCRPC) after 1 prior NHA

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BACKGROUND: Opevesostat is an oral, nonsteroidal inhibitor of cytochrome P450 11A1 (CYP11A1) that catalyzes the first and rate-limiting step of steroid biosynthesis. Opevesostat demonstrated antitumor activity in patients with heavily pretreated mCRPC in the phase 1/2 CYPIDES study. The efficacy and safety of opevesostat in patients with molecularly unselected mCRPC after 1 prior NHA will be assessed in the randomized, open-label, phase 3 MK-5684-004 study (NCT06136650).

METHODS: Eligible patients have mCRPC unselected for androgen receptor ligand binding domain (AR-LBD) mutations that progressed during androgen deprivation therapy ≤6 months before screening and on/after 1 NHA for hormone-sensitive prostate cancer (HSPC) or nonmetastatic CRPC for ≥8 weeks (≥14 weeks with bone progression). Prior NHA + docetaxel for HSPC is permitted if patients received ≤6 cycles of docetaxel without radiographic disease progression. Approximately 1500 patients (375 with and 1125 without AR-LBD mutations) will be randomized 1:1 to opevesostat 5 mg orally twice-daily + dexamethasone 1.5 mg and fludrocortisone 0.1 mg orally once-daily or abiraterone acetate 1000 mg orally once-daily + prednisone 5 mg orally twice-daily (if prior enzalutamide/darolutamide/apalutamide) or enzalutamide 160 mg orally once-daily (if prior abiraterone). Randomization will be stratified by metastasis (bone only/liver/other), AR-LBD mutation status (positive/negative), and prior docetaxel for HSPC (yes/no). Dual primary end points are radiographic progression-free survival per Prostate Cancer Working Group 3 (PCWG3)-modified Response Evaluation Criteria in Solid Tumors version 1.1 (RECIST v1.1) by blinded independent central review (BICR) and overall survival, analyzed separately in patients with AR-LBD mutation–positive and –negative disease. Secondary end points include time to initiation of first subsequent anticancer therapy or death; objective response rate and duration of response per PCWG3-modified RECIST v1.1 by BICR; time to pain progression; time to prostate-specific antigen (PSA) progression; PSA response rate; time to first symptomatic skeletal-related event; and safety and tolerability. Recruitment is ongoing.

#abs51 | ProFocal®- novel, cooled Laser Focal Therapy. Pivotal trial results of 100 men with localised Prostate Cancer

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INTRODUCTION: ProFocal® (Medlogical Innovations, Sydney, Australia) is a novel, day-only, cooled laser focal ablation treatment for prostate cancer. It is performed via a transperineal route and can be utilised with an MRI/US fusion targeting platform. It provides precise tissue ablation.

We aimed to report the final oncological outcomes of the first in-human trial of this novel treatment for localised prostate cancer.

METHODS: The PFLT-PC (ProFocal Laser Therapy for Prostate Tissue Ablation) trial is a prospective, institutional review board approved trial evaluating the novel ProFocal® device at Nepean Hospital, Australia for localised prostate cancer. Inclusion criteria were men with prostate cancer with PSA ≤15 ng/ml, stage ≤T2c, ISUP 2-3, and 1-2 MRI visible lesions which were concordant with biopsy results. A post treatment MRI was performed within 72 hours to confirm adequacy of tissue ablation. Patients then had a 3-month follow-up transperineal prostate biopsy to assess treatment outcomes. Functional (urinary, sexual and bowel) outcomes were measured using validated questionnaires (IPSS, SHIM, EPIC, SF-12) at 3, 6 and 12 months. Statistical analysis was performed using SPSS 28.0. Wilcoxon sign-ranked test was performed to analyse differences between paired non-parametric variables.

RESULTS: The interim data for the first 100 men who underwent focal laser ablation and had a minimum of 3 months follow-up were included in this analysis. The median age was 66 years (range 49-82), PSA 5.9ng/ml (range 0.7-15), prostate volume 39cc (range 17-170) and MRI lesion volume 0.86cc (range 0.12-1.78). All cases were completed as day only procedures.

On the 3-month follow-up biopsy, 84% of patients had no evidence of ISUP 2 or greater prostate cancer on their in-field biopsies. A learning curve was demonstrated with 100% of cases having no infield recurrences in the last 20 cases performed in this clinical trial.

Patient reported functional outcomes were excellent with no significant worsening in quality-of-life scores (SF-12), lower urinary tract symptoms (IPSS, EPIC-urinary domains) or bowel function. There was a 5% decrease in sexual function scores (SHIM and EPIC-sexual domains) at 3-month and 6-months assessment with a slight improvement at the 12-month assessment.

CONCLUSIONS: The oncological results from the ProFocal® focal laser ablation trial are promising with 84% of patients having successful infield treatment. Outcomes improved to 100% infield treatment success for the last 20 cases. Excellent functional outcomes were observed with no worsening urinary, bowel or quality of life measures and only a minor reduction in sexual scores.

#abs52 | Prognostic and Predictive Immune-Based Biomarkers to Assess the Benefit of Adding mitomycin to Bacillus Calmette-Guérin as intravesical therapy for high-risk, non-muscle-invasive urothelial bladder cancer

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INTRODUCTION & OBJECTIVES: The BCG-MM trial (NCT02948543) explores adding intra-vesical mitomycin (MM) to first-line intravesical Bacillus Calmette-Guérin (BCG) in NMIBC to improve outcomes. A range of cancer and stromal cell-based factors have been studied, looking to identify patients who most benefit from MM addition.

METHODS: Potential immune-based predictive biomarkers were assessed by immunohistochemistry including; CD8 (cytotoxic T-cells), FOXP3 (regulatory T-cells), CD68 and CD163 (macrophages) and CD56 (natural killer (NK) cells). A pilot cohort of 23 relapsing and 23 non-relapsing patients matched by Ta/T1 and CIS were assessed. Each cell type was counted separately in tumour and stroma. The median score defined high and low scoring tumors.

RESULTS: Low stromal cytotoxic T-cells correlated with higher recurrence with relapse rates15/23 (65%) v 8/23 (35%), p=0.02. High regulatory T-cells did not significantly correlate with outcome. For both the pan-macrophage CD68 marker, and the M2-differentiated macrophage marker CD163, high intra-tumoral but not stromal counts significantly associated with higher relapse, 16/23 (70%) v 7/23 (30%), p=0.004, and 15/23 (65%) v 8/23 (35%), p=0.02 respectively. Further, a high CD163:CD68 ratio in tumour showed a trend to correlation with higher relapse rate relative to a low ratio, 12/19 (63%) v 11/27 (41%), p=0.07. Total NK cell counts correlated with higher relapses 15/24 (62%) v 8/22 (36%), p=0.04, with both stromal and intra-tumoral cells contributing. No biomarker showed a differential effect between treatment arms.

CONCLUSIONS: Low stromal cytotoxic T-cells and high intra-tumoral macrophages significantly predicted relapse risk. Total NK cells, which can

have diverse impacts on outcome depending on the sub-type, had an overall negative effect on outcome. No immune cell group had a differential impact on the two treatment groups suggesting that these biomarkers influence the efficacy of the BCG backbone but do not modify the activity of the additional cytotoxic mitomycin component.

#abs53 | PSA variants modulate prostate cancer tumor progression

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BACKGROUND: Prostate cancer (PCa) susceptibility is influenced by common variants at multiple loci, however, the mechanisms by which these variants influence PCa risk remain largely unknown. The rs17632542 single nucleotide polymorphism (SNP) in exon 4 of the kallikrein-related peptidase 3 (KLK3) gene encoding prostate-specific antigen (PSA) was previously questioned for its association with PCa due to its association with PSA levels. We aimed to verify that this SNP plays a functional role in mediating PCa risk and progression.

METHODS: Recombinant PSA proteins were generated to assess the SNP-mediated biochemical changes by stability and substrate activity assays. PC3-PSA overexpression models were established to evaluate the effect of the SNP on PCa pathogenesis in-vitro and in-vivo.

RESULTS: The rs17632542 SNP (c.536T>C), is associated with disease aggressiveness (OR=0.74, 95% CI 0.72-0.76, P= 6.69 x 10-81) and survival (HR)=1.33, 95% CI=1.24-1.45, P<0.001 in our large cohort of 79,194 PCa cases and 61,112 disease-free controls. The rs17632542 SNP leads to amino acid change 'Ile' to 'Thr' at position 163, which lowers the proteolytic activity of PSA towards extracellular matrix proteins and diminishes the proliferation and migration of PCa cells. Multicellular-spheroid analysis showed a slightly more invasive phenotype for the Thr163 PSA expressing PCa cells compared to the Ile/wild-type PSA variant. In addition, tumour bioluminescence imaging in in vivo mice xenograft models of PCa revealed the Thr163 PSA protein variant led to small, localised tumours but aggressive metastasis indicating that presence of the SNP is deleterious in patients with aggressive disease. The minor 'C' allele leads to lower levels of serum PSA-inhibitor complexes and is associated with higher free PSA levels.

CONCLUSIONS: The rs17632542 SNP could potentially lead to detection-bias affecting the clinical management of the disease, and accounting for the SNP effects may reduce the inaccuracies of PCa diagnosis based on total PSA levels alone.

#abs54 | Radiobiological responses to Lutetium-PSMA-I&T: the impact of underlying tumour biology on treatment response

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INTRODUCTION AND OBJECTIVES: A newly approved treatment for castrate-resistant prostate cancer is 177Lu-PSMA radioligand therapy, which delivers targeted radiation to cells expressing prostate specific membrane antigen (PSMA). While some patients have remarkable responses, ~30% of patients fail to respond and disease progression inevitably occurs in all patients. Eligibility for 177Lu-PSMA is determined by PSMA PET scans, yet even with stringent clinical criteria, patient responses remain unpredictable, revealing a disconnect between PSMA expression and therapy efficacy in some cases. In this study, we aimed to investigate the key mechanisms and radiobiological parameters that determine therapeutic response and resistance to 177Lu-PSMA treatment using patient-derived models of prostate cancer.

METHODS: We investigated PSMA expression and response to 177Lu-PSMA using patient-derived xenografts (PDXs) from the Monash Urology Research Alliance (MURAL). PDXs were treated with [177Lu]-PSMA-I&T, and responses were compared to tumour radiation uptake, PSMA expression

by immunohistochemistry and PET imaging, and differential gene expression by RNA sequencing.

RESULTS: Immunohistochemistry on 70 MURAL PDXs demonstrated heterogeneous PSMA expression within tumours across all stages of disease progression, from treatment-naïve prostate cancer to heavily pre-treated metastatic tumours. Tumours with low PSMA expression had no response to 177Lu-PSMA; however, tumours with high PSMA expression had variable responses, ranging from complete, sustained tumour regression through to transient and non-responsive tumours, consistent with variable responses to 177Lu-PSMA observed in the clinic. Heterogeneous spatial expression of PSMA and whole tumour radiation uptake influenced response to treatment. However, radiation uptake did not always correlate with treatment response, suggesting underlying molecular features conveying radioresistance. Changes in tumour microenvironment composition and gene expression were observed in responsive tumours, including upregulation of inflammatory pathways and downregulation of DNA damage repair pathways.

CONCLUSIONS: The anti-tumour efficacy of 177Lu-PSMA was influenced by tumour radiation uptake and intratumoural PSMA heterogeneity that could not be predicted based on PSMA PET imaging.

#abs55 | Rapid Access Nurse led Cardio-Oncology clinics: Management Impact for Prostate Cancer Patients

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INTRODUCTION AND OBJECTIVES: Although Prostate Cancer (PC) ranks 4th highest in cancer-related deaths, 25% of all deaths in Australia are associated with underlying CVD, with shorter time scales than mortality from PC. Treatment for prostate cancer, can increase CVD mortality and morbidity. Strategies focused on prevention of CVD complications for PC treatments remain underreported. Nurse-led clinics are now mainstays in many specialties. They have shown improvements in survival, quality of life, treatment adherence, and patient satisfaction. Thus, we implemented a nurse-led clinic focused on addressing CVD risk factors, education, referral and clinical assessment in PC patients.

METHODS: Patients are referred to the clinic by their cancer clinicians and the service is co-located with oncology outpatients. Patients undergo a baseline visit, at which demographic characteristics, CV risk factors, past medical history, physical characteristics and results of routine pathology are recorded. Dietary habits, physical activity, and general function are also assessed. Patients undergo cardiovascular assessment, non-invasive and/or invasive tests as clinically required and referral to relevant allied health providers. Satisfaction surveys are undertaken.

RESULTS: From June 2020 till Feb 2023 140 patients with PC were attended the clinic. 69% of PC patients were not receiving guideline directed CV management, and 85% had more than 1 CVD risk factor. Those patients who were commenced on evidenced based treatment, 84% achieved guideline based targets for risk factor modification. Of particular note, 9 patients required invasive revascularisation procedures including urgent stenting and bypass grafting. Acceptability and satisfaction was high with 95% of patients reporting the care high quality.

CONCLUSIONS: Patients undergoing treatment for Prostate Cancer have a high prevalence of CVD risk factors. Nurse-led clinics facilitate timely cardiovascular assessment and management, including ensuring evidenced based treatment, aimed at reducing CV mortality and morbidity in PC patients, and represent an important addition to patient care.

#abs56 | Rates of urological complications following pelvic exenteration and radical cystectomy for primary bladder cancer are comparable

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INTRODUCTION AND OBJECTIVE: Radical cystectomy and urinary diversion is required for both primary muscle invasive bladder cancer and in the setting of pelvic exenteration for advanced malignancy of pelvic organs. Acute and chronic complications following radical cystectomy can be a significant cause of morbidity. We compared the rates of urological complications following these two procedures at our tertiary referral centre.

METHODS: Patients who underwent radical cystectomy and urinary diversion either alone or as part of pelvic exenteration between June 2017 and December 2023 at the Royal Adelaide Hospital were included. Short- and long-term post operative urological complications were collected, data for patient who underwent PE were collected prospectively as part of a larger database.

RESULTS: Ninety-six patients underwent en-bloc cystectomy (58 cystectomy alone, 38 as part of a PE). Median follow up was 25 months in non-PE group and 23 months in PE group, all patients had minimum 90 days follow up. Post operative urological complications occurred in 43% of patients undergoing cystectomy alone, and 41% undergoing cystectomy as part of PE. Urosepsis was the most frequent complication in both groups (21% and 26% for non-PE and PE respectively). Urine leak occurred in 3% of non-PE cases and 10% of PE cases. A subsequent general anaesthetic due to complication was required in 14% and 16% of non-PE and PE patients respectively. No patient, operative or disease characteristic was identified that was predictive of urological complication in either group.

CONCLUSIONS: The rate of urological complications and return to theatres following radical cystectomy and urinary are comparable amongst those undergoing PE and not undergoing PE. No individual factor was identified that was predictive of post operative complications.

#abs57 | Real world treatment and outcomes in metastatic castration-resistant prostate cancer (mCRPC) by relative socioeconomic status (SES) and geographical location

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INTRODUCTION & OBJECTIVES: Outcomes may be worse in rural prostate cancer patients or those from relative socio-economic(SES) disadvantage. At time of mCRPC, patients are usually well established within the healthcare system. We explored if these patients continue to experience disparity in the CRPC setting.

METHODS: ePAD is a multi-national advanced prostate cancer registry collecting data on demographics, treatments and outcomes. Postcode data classified mCRPC patients by Remoteness Area (RA); Major Australian Cities (metro) versus others (non-metro); and relative Socio-economic status (SES); advantage (upper 2 quintiles) vs disadvantage (lowest 3), using the index of relative socio-economic advantage and disadvantage (IRSAD). Clinico-pathologic, treatment and outcome data were described along IRSAD and RA categories and compared with Chi2 squared and Cox regression analysis.

RESULTS: ePAD included 1392 patients (median age 67.87; follow-up from CRPC 1.88 years).RA analysis identified 1142/1388 (82%) metro and 18% (n=246) non-metro. SES analysis identified 64% (n=892) from relative SES advantage and 36% (n=496) disadvantage.

There were no differences in metro/non-metro nor IRSAD low/high patients respectively for: age, Gleason score 8+ (76/77%; 76/76%), synchronous disease (46/48%; 49/45%) or median time to CRPC (53.06/50.42; 48.05/50.28mo). The proportion of ECOG 0 patients across cohorts was (40 vs 37%; 36 vs 41%).

1L treatment received was also comparable across all four cohorts.

Factors predictive of worse survival included: increased age (p=0.000), higher Gleason (9-10; p=0.000) and synchronous disease (p=0.000).

Univariate analysis demonstrated no differences in survival from diagnosis for RA or IRSAD cohorts. IRSAD 1 patients appeared to have better survival (HR = 0.44; p = 0.001), however no consistent trend was demonstrated across cohorts.

CONCLUSIONS: While data suggests disparity in prostate cancer amongst rural and SES disadvantaged patients, our data proposes this is related to delayed diagnosis and treatment access, as CRPC outcomes are similar after linkage into the healthcare system.

#abs58 | Real-world Avelumab uptake for first-line (1L) treatment for metastatic urothelial bladder cancer (mUC)

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INTRODUCTION AND OBJECTIVES: Enfortumab vedotin with pembrolizumab (EV+P) represents a new 1L standard of care (SoC) for mUC. However, low uptake (30%) of maintenance avelumab was observed in the control arm, which may have negatively impacted survival. We sought to describe the uptake of maintenance avelumab and outcomes in real-world patients receiving treatment for mUC in Australia.

METHODS: We interrogated BLADDA, a multi-national, multi-site, urothelial cancer registry collecting demographic, diagnosis, treatment, and outcome data, to identify a contemporary cohort of mUC patients. We describe 1L treatment before and after maintenance avelumab became widely accessible in Australia (April/2022) and explore the impact on progression-free survival (PFS) and overall survival (OS).

RESULTS: 227 patients were identified, 182 pre- and 45 post-April/2022. The median age of the pre-and post-April/2022 cohorts was 70 vs 71 years, respectively (range 29-86). A similar proportion were male (72% vs 78%) and metastatic at diagnosis (56% vs 58%).

Pre-April/2022, 140 (77%) patients received 1L platinum-based chemotherapy including cisplatin/gemcitabine (66/182, 36%), carboplatin/gemcitabine (64/182, 35%) or other (10/182, 5%). Of these, 101 (72%) of had stable disease, or partial/complete response and were potentially eligible for avelumab; 17 (17%) received avelumab (via access program). Post-April/2022, 37 (82%) patients received 1L platinum-based chemotherapy including cisplatin/gemcitabine (16/45, 36%) and carboplatin/gemcitabine (19/45, 42%). Of these, 24/29 (83%) evaluable patients met eligibility for avelumab;14 (58%) received it.

In eligible patients, maintenance avelumab was associated with significantly improved PFS (11.76 vs 7.45mo, p=0.012) and numerically improved OS (40.57 vs 31.96mo, p=0.315), calculated from commencement of 1L platinum-based chemotherapy.

CONCLUSIONS: Until EV+P becomes available, 1L platinum followed by maintenance avelumab in eligible patients remains SoC. Our real-world data suggests a PFS advantage for maintenance avelumab, however uptake remains low, which needs to be further explored.

#abs59 | Real-world Clinical Outcomes in Non-metastatic (M0) Castration-Resistant Prostate Cancer (CRPC) Patients in Australia

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INTRODUCTION: Second-generation androgen receptor signaling inhibitors (ARSIs) improve metastasis free survival (MFS) and overall survival (OS) in non-metastatic castrate resistant prostate cancer (M0CRPC).1 Enzalutamide, apalutamide and darolutamide recently became available under Australia's Pharmaceutical Benefits Scheme (PBS), changing the M0CRPC treatment landscape. This real-world study describes treatment patterns and outcomes in Australian M0CRPC patients.

METHODS: Patients diagnosed with M0CRPC between 30 June 2006 and 2 February 2024 were identified from the electronic Prostate Cancer Australian Database (ePAD), a multi-centre, prospective clinical registry. Data relating to treatment patterns, patient and disease characteristics were analysed using descriptive statistics. MFS and OS were calculated via the Kaplan Meier method.

RESULTS: 184 M0CRPC patients were included. Median age was 75 years (range: 37-94). 40% had a Gleason score ≥8. 77% were ECOG 0-1. 71% had prior local therapies, including 32% with previous prostatectomy. 13% had undergone prostate-specific membrane antigen positron emission tomography (PSMA PET) imaging. Median time to CRPC was 44 months (range 0.9-303). 49% had a PSA-doubling time (PSADT) <7 months.

50% (92/184) of patients received systemic therapy (ARSI/Docetaxel/Trial treatment in addition to ADT +/- first-generation anti-androgens). These patients had a younger median age and 48% (44/92) had PSADT <7 months. 91% received a second-generation ARSI; 45% received Enzalutamide, 38% Darolutamide and 9% Abiraterone. 2% received Docetaxel.

As access to ARSIs improved, use of systemic therapy increased from 41% (63/152) before the first ARSI access program on 1/9/2020, to 88% (28/32) and post PBS-approval of darolutamide, to 95% (18/19).

Median MFS was 40 months in patients on systemic therapy. MFS was 51.5 months on Enzalutamide, 13.3 months on Abiraterone, and not reached for Darolutamide (60% metastasis-free at 38-month median follow-up). OS data remains immature.

CONCLUSIONS: The availability of ARSIs has led to a rapid adoption by Australian clinicians in treating M0CRPC patients. MFS data reflect those of pivotal trials. As outcome data mature, analysis of real-world survival and toxicity will inform clinical practice.

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#abs60 | Registries and Clinical Trials (REACT) Network

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INTRODUCTION AND OBJECTIVES: Australia has well-established cancer cooperative trial groups as well as clinical quality and cancer registries. However, these high-quality data assets are currently operating independently thus limiting the research potentials of these data assets.

METHODS: The REACT-Network is a new partnership between 11 major and complementary research partners, including: the Australia and New Zealand Prostate Cancer Outcomes Registry (PCOR-ANZ), the Bowel Cancer Outcomes Registry (BCOR), the Upper GI Cancer Registry (UGICR), Treatment of Recurrent and Advanced Colorectal Cancer (TRACC) registry, Pancreatic cancer: Understanding Routine Practice and Lifting End results registry (PURPLE) registry, Electronic Prostate Cancer Australian Database (EPAD) registry, Palliative Care Outcomes Collaboration (PCOC), Australian and New Zealand Urogenital and Prostate Cancer Trials Group (ANZUP), the Australasian Gastro-Intestinal Trials Group (AGITG), the Trans-Tasman Radiation Oncology Group (TROG), and the ASPREE (ASPirin in Reducing Events in the Elderly) clinical trial, and the trial extension (ASPREE-XT) cohort and the biobank samples collected as part of the trial.

RESULTS: Data linkages and sharing between the partner organizations in the REACT-Network will allow us to (1) provide more robust estimate of trial recruitment and explore new trial methodologies e.g. registry-based trials and use of 'real-world' control in clinical trials, (2) assess and provide benchmark of the current practice of early palliative care referral (an area of unmet need), design and conduct registry-based palliative care implementation trial, (3) evaluate uptake and conduct economic analyses of new interventions, and (4) link registry data with a biobank to support future translational research.

CONCLUSION: We anticipate that the establishment of REACT-network will build on, and optimize the use of multiple data assets, enhancing the research return on investment, and creating momentum towards new and sustainable linked research data infrastructure in Australia.

#abs61 | Registry-Based Randomised Study of Enzalutamide vs Abiraterone Assessing Cognitive Function in Elderly Patients with Metastatic Castration-Resistant Prostate Cancer (REAL-Pro)

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INTRODUCTION: The median age at metastatic castration-resistant prostate cancer (mCRPC) diagnosis is 69 years. While older patients can present unique challenges, those ≥75 years are underrepresented in conventional clinical trials. Registry-based trials are a novel methodology that allows broader representation. Older patients commonly receive androgen receptor pathway inhibitors (ARPI). However, cognitive impairment, depression, falls and cardiovascular risks are important concerns, influencing treatment selection.

METHODS: REAL-Pro is a prospective registry-based randomised trial utilising the electronic Prostate cancer Australian Database (ePAD) to collect clinical data. Patients ≥75 years suitable to receive ARPI for mCRPC were randomised to receive abiraterone or enzalutamide, stratified by prior docetaxel use. Telephone assessments were conducted at baseline and following 12 weeks, including the Blessed-Orientation-Memory-Concentration (BOMC), Geriatric Depression Scale (GDS) and Falls Risk Questionnaire (FRQ). Descriptive statistics and mixed-effects linear regression were used to compare score changes.

RESULTS: We enrolled 76 men between 12/06/2019 and 11/09/2023. Nineteen (25%) had received prior docetaxel. Recruitment ceased in December 2023 due to slow accrual. Fifty-six (74%) completed both telephone assessments (28 in each group). There were no differences in mean baseline scores between groups. Numerically more patients receiving enzalutamide had worsening 12-week scores for BOMC (enzalutamide N=11,39%; abiraterone N=8,29%) and GDS (enzalutamide N=13,36%; abiraterone N=8,29%). Patients treated with enzalutamide had numerically greater changes in BOMC (+0.64 vs -0.51, p=0.46), GDS (+0.70 vs +0.06, p=0.06) and FRQ (+1.4 vs -0.12, p=0.06) scores. Those who received enzalutamide experienced more falls (N=6,21%) than abiraterone (N=3,11%).

CONCLUSION: Our results suggest differences in ARPI toxicity profiles, highlighting the importance assessing cognition, depression and falls risk in older men. Analysis of outcome data could further inform clinical treatment decisions. While registry-based trials are logistically simple, slow accrual in REAL-Pro demonstrates the need to ensure equipoise in treatment selection, develop strategies to engage investigators and optimally promote recruitment.

#abs62 | Remote Physical Activity Program for Patients with Metastatic Renal Cell Carcinoma Undergoing Immunotherapy

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BACKGROUND: Patients with metastatic renal cell carcinoma (mRCC) on immuno-oncologic therapies (IO) often face impaired health-related quality of life (HRQOL) due to physical and emotional symptoms. Recent studies have underscored the potential for exercise to potentiate the effects of fatigue, anxiety and depression, as well as enhance overall HRQOL and physical functioning. This study sought to determine the effect of a 12-week remote intervention on HRQOL among patients with mRCC undergoing IO therapy.

METHODS: From June 2022 to June 2023, 19 eligible patients diagnosed with mRCC and receiving IO, either as monotherapy or in combination, were enrolled. Patients' HRQOL, physical, and emotional symptoms were assessed using the Functional Assessment of Cancer Therapy-General (FACT-G) and Edmonton Symptom Assessment System (ESAS) scales. Assessments were conducted at baseline (T1) and 3-month follow-up (T2). The intervention consisted of a remote, supervised 12-week physical activity program, incorporating resistance, aerobic, and mobility exercises. Linear mixed models were employed for statistical analysis.

RESULTS: The median age of patients was 67 years (range: 32-88), with 57.9% being male. The majority of patients were White (78.9%), married (63.2%), and held at least a college degree (52.7%). The predominant treatment regimens included

ipilimumab/nivolumab (21.1%), nivolumab/cabozantinib (15.8%), and nivolumab (15.8%). Subsequent to the intervention, significant improvements were observed in overall HRQOL (Mean: T1=85.4 to T2=95.2, P=0.001), as well as fatigue (Mean: T1=5.9 to T2=0.9, P=0.001), anxiety (Mean: T1=3.7 to T2=1.0, P=0.02), appetite (Mean: T1=2.7 to T2=0.5, P=0.01), sleep quality (Mean: T1=2.6 to T2=0.8, P=0.02), depression (Mean: T1=2.1 to T2=0.9, P=0.01), and shortness of breath (Mean: T1=1.9 to T2=0.1, P=0.01). Notably, no significant changes were observed for pain (Mean T1=1.1 to T2=0.6, P=0.1) and nausea (Mean T1=1.1 to T2=0.3, P=0.1). Adherence to the program varied among patients, with a substantial proportion (57.9%) demonstrating high adherence throughout the 8 to 12-week duration.

CONCLUSION: This study is the first to investigate the effects of a remote, supervised physical activity program among patients with mRCC on immunotherapy. Our findings suggest that remote interventions are feasible and may be effective in improving symptoms and quality of life. Moreover, this approach enhances patient accessibility due to reduced cost and overcoming geographical barriers, which is particularly valuable in developing countries. Further research among larger cohorts, with longer follow-up, is needed to confirm these findings and explore the long-term benefits of physical activity interventions among this vulnerable group.

#abs63 | Retrospective Analysis to Identify Factors Predictive of Adherence to Follow Up in Stage I Testicular Cancer

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INTRODUCTION: Most international guidelines advocate for active surveillance following orchidectomy in clinical stage I testicular cancer depending on patient, malignancy, and treatment factors1,2. Our aim was to identify factors in patients with stage I testicular cancer that correlate with adherence to follow up.

METHODS: Data for patients with stage I testicular cancer was collected from the 1st January 2014 and the 31st December 2021 at the Gold Coast University Hospital (GCUH) through the hospital electronic medical record. Associations between baseline characteristics and adherence to follow up were analysed using logistic regression. Time to non-adherence and recurrence free survival was first measured from the date of surgery and analysed using Kaplan and Meier methodology.

RESULTS: Forty-eight patients with stage 1 testicular cancer were diagnosed at GCUH. The median age of patients' adherent to follow up was 40.5 years (IQR 32.3-46.2) and those not adherent was 36.8 years (IQR 31.4-43.9). Thirty-two (67%) patients had seminoma, 16 (33%) patients had non-seminomatous histology. Twenty-one (44%) patients had adjuvant chemotherapy, 27 (56%) patients were followed up with active surveillance. Twenty-six (54%) patients had a supportive person for their first consultation. In a multivariate analysis, there was a trend towards employment status (OR 4.30, 95% CI 0.22-85.99, p=0.34), seminoma histological subtype (OR 2.95, 95% CI 0.24-36.28, p=0.39) and supportive person present (OR 2.63, 95% CI 0.27-25.11, p=0.40) being associated with adherence to follow up.

With a median follow up of 39 months (IQR 14.5-52.5), of the patients who did not adhere to follow up, the median time to non-adherence was 20 months (95% CI 11-37, p= 0.09).

CONCLUSIONS: Our study suggests that patients who are employed and have a support person may be more likely to adhere to follow up for their testicular cancer although our study was underpowered to determine statistical significance.

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#abs64 | Setting up penile cancer database; lessons learnt from an Australian experience

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INTRODUCTION: Penile cancer is a rare malignancy with an estimated incidence of 1 in 100,000 men in Western countries. The disease is characterized by a wide range of clinical presentations, from localized and curable tumours to advanced and aggressive forms with high morbidity and mortality rates. Despite its clinical significance, there is a paucity of comprehensive data on the epidemiology, risk factors, and management of penile cancer in Australia. There are significant known and proposed benefits of use of large databases and research networks in rare cancer research.[1, 2]

METHODS: To address this gap in knowledge, we are establishing an Australia Penile Cancer Registry with the financial support of ANZUP. The registry will serve as a centralized and standardized database of clinical and pathological information on patients with penile cancer, including demographics, tumour characteristics, treatment modalities, and outcomes with aims to align database variables with international projects for global interoperability. The registry built around the FAIR principles of registry data design, will allow for the identification of patterns and trends in the incidence, prevalence, and outcomes of penile cancer in Australia and facilitate the evaluation of the effectiveness and safety of different treatments and management strategies. This will be built upon an existing Victorian dataset with globally significant retrospective series and a proven publication record. As a national registry it aims to overcome barriers to access for interdisciplinary work with a wider lens with more significant impact.

CONCLUSION: The proposed registry will strive to advance our understanding of penile cancer biology and improve patient outcomes by identifying modifiable risk factors and optimizing treatment approaches. By bringing together clinicians, researchers, and patients, the registry will facilitate collaboration and knowledge exchange and promote the development of evidence-based clinical guidelines and best practices.

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#abs65 | STELLAR-304: A Randomized Phase 3 Study of Zanzalintinib (XL092) Plus Nivolumab in Non-Clear Cell Renal Cell Carcinoma

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INTRODUCTION AND OBJECTIVES: Non-clear cell renal cell carcinoma (nccRCC) is a heterogeneous group of rare, histologic subtypes with limited randomized controlled studies to inform disease management. Novel treatment options supported by robust clinical trials are needed. Sunitinib, a tyrosine kinase inhibitor (TKI), is commonly used for nccRCC based on clinical benefit in phase 2 trials. To date, no treatment has improved overall survival (OS) versus sunitinib in nccRCC. Immune checkpoint inhibitors (ICIs) have shown modest response rates, but TKI-ICI combinations have shown promising activity in phase 2 trials.[1,2]

Zanzalintinib, a novel, multi-targeted TKI of VEGFR, MET, and the TAM kinases, has demonstrated antitumor and immunomodulatory activity alone and in combination with ICIs in animal models.[3] In the phase 1 STELLAR-001 study, single-agent zanzalintinib showed promising antitumor activity and manageable safety in patients with heavily pretreated advanced clear-cell RCC.[4] STELLAR-304 will assess efficacy and safety of zanzalintinib plus nivolumab versus sunitinib in previously untreated advanced nccRCC.

METHODS: STELLAR-304 (NCT05678673) is a phase 3, randomized, open-label study enrolling patients aged ≥18 years with unresectable/advanced/metastatic nccRCC. Eligible patients have measurable disease per Response Evaluation Criteria in Solid Tumors (RECIST) v1.1, Karnofsky performance status ≥70%, and papillary, unclassified, or translocation-associated histology (sarcomatoid features allowed). Chromophobe, renal medullary carcinoma, and pure collecting duct histologies are excluded. Prior systemic anticancer therapy for advanced/metastatic nccRCC is not allowed; however, one prior systemic adjuvant therapy, including ICI (but excluding sunitinib), is permitted for completely resected RCC if recurrence occurred ≥6 months after last dose.

Patients (N=291) are randomized 2:1 to zanzalintinib plus nivolumab, or sunitinib. Dual primary endpoints are progression-free survival and objective response rate per RECIST v1.1 by blinded independent review. The secondary endpoint is OS; safety will be assessed. Recruitment is ongoing in Europe, North and South America, and the Asia-Pacific region.

RESULTS: NA

CONCLUSIONS: NA

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#abs66 | Talazoparib Plus Enzalutamide in Metastatic Castration-Resistant Prostate Cancer: Subgroup Analyses of the All-Comers Cohort From TALAPRO-2 by Homologous Recombination Repair Status

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INTRODUCTION AND OBJECTIVES: The randomized, Phase 3, placebo-controlled TALAPRO-2 study (NCT03395197) demonstrated statistically significant improvements in radiographic progression-free survival (rPFS) for first-line talazoparib plus enzalutamide vs placebo plus enzalutamide in patients with metastatic castration-resistant prostate cancer (mCRPC) in all-comers and in homologous recombination repair (HRR) subgroups. Here, we report baseline characteristics and secondary efficacy and safety endpoints for all-comers by HRR status

(HRR-deficient [HRR+] vs HRR-non-deficient [HRR-]/unknown).

METHODS: Patients randomized 1:1 to talazoparib 0.5 mg or placebo, plus enzalutamide 160 mg/day, were stratified by prior abiraterone or docetaxel for castration-sensitive prostate cancer (yes/no) and by HRR status. The primary endpoint was rPFS by blinded independent central review. Secondary endpoints included overall survival (OS), objective response rate (ORR), time to PSA progression (TTPP), time to initiation of cytotoxic chemotherapy (TTCC), time to progression on first subsequent antineoplastic therapy or death (PFS2), and safety.

RESULTS: All 805 enrolled patients had prospective tumor tissue HRR test results (HRR+, n=169; HRR-/unknown, n=636). Overall, baseline demographic characteristics were generally well-balanced between treatment groups and by HRR status; however, the younger group (age <65 years) had more HRR+ (29.6%) than HRR-/unknown (19.3%) patients. HRR+ patients had evidence of more aggressive disease. Treatment with talazoparib plus enzalutamide compared with placebo plus enzalutamide improved ORR (HRR+: 78.8% vs 46.2%, respectively; HRR-/unknown: 55.2% vs 43.4%, respectively), and prolonged TTPP (hazard ratio [HR] [95% CI]: 0.53 [0.34–0.82]; HR [95% CI]: 0.78 [0.62–1.00]), TTCC (HR [95% CI]: 0.71 [0.40–1.26]; HR [95% CI]: 0.44 [0.32–0.61]), and PFS2 (HR [95% CI]: 0.47 [0.27–0.81]; HR [95% CI]: 0.88 [0.67–1.14]) with benefit seen in both HRR+ and HRR-/unknown subgroups. OS remains immature.

CONCLUSIONS: Talazoparib plus enzalutamide demonstrated improvements in secondary efficacy endpoints over placebo plus enzalutamide as first-line treatment in patients with mCRPC in both HRR+ and HRR-/unknown subgroups.

#abs67 | Targeting epigenome regulators in neuroendocrine prostate cancer

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INTRODUCTION AND OBJECTIVES: In patients with different types of castration-resistant prostate cancer (CRPC), including neuroendocrine disease, the responses to drug treatments are varied. In preclinical studies, it is difficult to compare how different types of prostate cancer respond to treatments, because insufficient models are available.

To address this challenge, we established a large collection of patient-derived models with diverse clinico-pathologic features. Our goal was to use these models to test NEO2734, a first-in-class dual inhibitor of BET and CBP/p300 proteins, which regulate chromatin architecture. This class of compounds is known to target androgen receptor (AR)-positive prostate cancer, but we hypothesised that neuroendocrine tumours are also responsive since their phenotypic transformation involves epigenome remodelling.

METHODS: To compare BRD4, CBP, and p300 expression, we used immunohistochemistry with 170 patient-derived xenografts (PDX). To test the effect of NEO2734 on cell viability and growth, we undertook in vitro experiments with a high-content organoid assay, and in vivo treatments of PDXs. We investigated transcriptional responses using RNAseq after acute and long-term timepoints.

RESULTS: Across a large cohort, BRD4, CBP, and p300 were co-expressed in AR-positive and neuroendocrine prostate cancer. NEO2734 reduced the growth of both AR-positive and neuroendocrine organoids, based on independent readouts of viability, size and composition. NEO2734 treatment also consistently downregulated cell cycle pathways. In neuroendocrine models, we identified a consistent transcriptional signature of NEO2734 responses across organoids and PDXs. This included decreased ASCL1 expression,

a key neuroendocrine transcription factor. NEO2734 also reduced neuroendocrine tumour growth in vivo.

CONCLUSIONS: In previous studies, the efficacy of BET and CBP/p300 inhibitors in prostate cancer has been attributed, at least in part, to decreased AR signalling. We found that NEO2734 also causes decreased growth and phenotype-dependent disruption of lineage regulators in neuroendocrine disease. Other BET inhibitors are poorly tolerated, so careful clinical development is warranted to further assess this class of compounds in neuroendocrine prostate cancer.

#abs68 | Testosterone Recovery following ANdrogen Suppression and PrOstate RadioTherapy (TRANSPORT) – final individual-patient-data meta-analysis from the MARCAP Consortium

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INTRODUCTION AND OBJECTIVES: Time to testosterone recovery following androgen deprivation therapy (ADT) varies widely. Herein, we evaluate the kinetics of testosterone recovery and the oncological impact of effective castration period in patients receiving radiotherapy and ADT for prostate cancer.

METHODS: Individual patient data from five randomised trials of radiotherapy with ADT with prospectively-collected serial testosterone data were obtained. Times to non-castrate (>1.7 nmol/L) and non-hypogonadal (>8.0 nmol/L) testosterone recovery were estimated for each prescribed ADT duration. The association between effective castration period and metastasis-free survival (MFS) for any given ADT duration was evaluated with multivariable Cox regression and nomograms were developed. To evaluate non-linear associations between effective castration period and MFS, natural cubic spline analysis was used in patients receiving 6 or 18 months of ADT, as the cohort size was largest for these durations.

RESULTS: Overall, 1444 men were included (n=115, 880, 353, 36, and 60 receiving 4-, 6-, 18-, 28-, and 36-months ADT, respectively). Times to recovery to non-castrate and non-hypogonadal testosterone levels varied considerably between ADT durations. Higher baseline testosterone and age <65 years were associated with increased likelihood of testosterone recovery ($p<0.001$ for both). Effective castration period was not associated with MFS for any duration of ADT in Cox regression. In spline analysis, for men who received 6- and 18-months ADT, the optimal effective castration period for MFS benefits were 10.6 and 18 months, respectively.

CONCLUSION: Time to testosterone recovery varies with prescribed duration of ADT as well as baseline testosterone and age. The relationship between effective castration period and MFS may be non-linear, with a longer effective castration period potentially being helpful for men receiving 6 months ADT.

#abs69 | The effect of multimodal prehabilitation interventions in people affected by bladder cancer on long-term physical, clinical and patient reported outcome measures: A systematic review

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BACKGROUND: Patients with bladder cancer who undergo radical treatment often have high rates of post-treatment complications and physical function

deficits. Rehabilitation and Enhanced-Recovery-After-Surgery protocols are essential in optimising their recovery; however, it remains unclear if prehabilitation could improve the outcomes, especially in the bladder cancer patient population who often have high rates of existing co-morbidities.

OBJECTIVES AND METHOD: This systematic review was aimed to evaluate the impact of prehabilitation interventions on the ≥30 days post-treatment outcomes including clinical, physical functioning and patient-reported outcomes. The searches were performed on electronic databases including Medline, Embase, CINAHL, Cochrane, and clinicaltrials.gov. Randomised, quasi-randomised trials and single arm prospective studies were included. The primary outcomes were clinical, physical function and patient-reported outcomes described at ≥30 days post-treatment completion.

RESULTS: 932 studies were identified from the searches, of which 14 studies were included in the final review after screening as per pre-specified criteria. The studies included randomised controlled trials (n=6), quantitative non-randomised studies (n=7) and a qualitative study (n=1) with a total sample size of 1034 participants, predominantly male and predominantly tumour stage ≥ T1. There were no studies of prehabilitation conducted for patients outside of neoadjuvant or surgical settings, including for patients undergoing tri-modality approach. Prehabilitation interventions included exercises, nutritional supplements, stoma education, smoking cessation and multimodality prehabilitation programs. The findings were integrated as a narrative synthesis.

CONCLUSION: There was significant heterogeneity in the reported outcomes, the intervention and study design. The review identified that prehabilitation, including multimodality programs, are feasible to conduct with high prehabilitation adherence rate. There is a positive impact on patient-reported outcome from stoma education prior to treatment. Prehabilitation for patients undergoing bladder cancer treatment remains an emerging area in need for further research and this review could be used as a reference to further develop a suitable prehabilitation program.

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#abs70 | Theranostic targeting of CAIX in patients with clear cell renal cell carcinoma: first-in-human safety, imaging and dosimetry findings with [68Ga] Ga-DPI-4452

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Tumoural carbonic anhydrase IX (CAIX) overexpression is associated with poor outcomes and treatment resistance. CAIX is currently exploited for antibody-based tumour imaging; however, peptide-based targeting may offer valuable characteristics for innovative CAIX theranostics. DPI-4452, a first-in-class, CAIX-binding peptide, can be radiolabelled with gallium-68 ([68Ga]Ga-DPI-4452) or lutetium-177 ([177Lu]Lu-DPI-4452) for diagnostic and therapeutic use, respectively, in CAIX-positive tumours. NCT05706129 is a first-in-human study evaluating the theranostic potential of radiolabelled DPI-4452 in patients with advanced solid tumours. Safety, dosimetry and imaging findings from the completed clear cell renal cell carcinoma (ccRCC) [68Ga]Ga-DPI-4452 imaging cohort are presented.

[68Ga]Ga-DPI-4452 was intravenously administered (mean activity=185 MBq) to patients who then underwent serial PET-CT imaging, urinalysis and blood sampling. Patients were followed for 7 days post-injection for safety observations.

Three patients received [68Ga]Ga-DPI-4452. PET-CT imaging demonstrated rapid, sustained tumour uptake. One-hour post-administration, high-quality tumour images were observed, with maximum tumour standardised uptake values ranging from 6.8 to 211.6 (mean=64.6) across 36 lesions, 17 of which were not detected with prior contrast-enhanced CT. Organs receiving the highest absorbed doses (mean [SD] mGy/MBq) were the stomach (0.33 [0.10]), small intestine (0.33 [0.08]) and gallbladder (0.21 [0.12]) walls. The mean whole-body effective dose was 0.06 [0.02] mSv/MBq, while absorbed doses in the kidney, liver and bone marrow were low. Over 80% of total administered radioactivity cleared from the bloodstream within 1 hour; rapid renal elimination was observed. No clinically significant toxicities were reported.

[68Ga]Ga-DPI-4452 offers rapid, high-quality imaging of ccRCC tumours without clinically significant toxicity. These results support the exploration of [68Ga]Ga-DPI-4452 and [177Lu]Lu-DPI-4452 for diagnostic use/patient selection and radioligand therapy, respectively. A multicentre investigator-initiated study to evaluate the management impact and accuracy of [68Ga]Ga-DPI-4452 in patients with ccRCC in the Australia-New Zealand region is being planned.

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#abs71 | Treatment patterns and outcomes for younger patients with metastatic castrate-resistant prostate cancer (mCRPC); an Australian prospective registry study

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INTRODUCTION AND OBJECTIVES: There is an increasing incidence of early-onset cancer, including prostate (1). In certain early-onset tumours a more aggressive phenotype has been reported (2). We examined characteristics and outcomes of early-onset mCRPC to determine if this population represents a distinct clinical entity.

METHODS: We examined prospectively collected data from consecutive mCRPC patients enrolled on the multi-site Electronic Prostate Cancer Australia Database (ePAD) to compare those aged < 55 (YP) and those aged ≥ 55 (OP). Demographic and clinicopathologic characteristics were compared using Chi-square analyses and time-to-event investigation was undertaken using Kaplan-Meire estimates and log-rank testing.

RESULTS: 1001 patients with mCRPC were identified; 59 were YP. YP had a higher proportion of patients with ECOG 0 (66% vs 43%, p<0.001) and lower Charlson Comorbidity Index 0-2 (86% vs 18% p<0.001). Fewer YP had bone only metastases at mCRPC diagnosis (20% vs 37%, p=0.008). De-novo metastatic presentation, gleason score, liver metastasis, time to mCRPC and PSA doubling time at mCRPC were similar. YP, compared to OP respectively, did not receive more first-line mCRPC treatment with docetaxel (15% vs

19%, p=0.49) or ARPI (53% vs 61%, p=0.17). Although YP received more upfront docetaxel (36% vs 24% p<0.03) and a higher proportion enrolled on mCRPC clinical trials (24% vs 15% p=0.10). Median time-to-treatment discontinuation for ARPIs was similar in the YP vs OP group (12.4m vs 13.9m, p=0.95, HR 1.02 (95% CI 0.62-1.65). Median overall survival was also similar between the groups (41.9m vs 34m, p=0.10, HR 1.478 95% CI 0.92-2.38).

CONCLUSIONS: Performance status and comorbidity favoured YP. There was a trend to improved survival in mCRPC with remaining features showing many similarities. This data does not support the hypothesis that YP represents a distinct clinical phenotype.

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#abs72 | Tumor Response by Baseline Metastases in Patients With Renal Cell Carcinoma Treated with Lenvatinib Plus Pembrolizumab vs Sunitinib: Post Hoc Analysis of the CLEAR Trial

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INTRODUCTION AND OBJECTIVES: Lenvatinib plus pembrolizumab (L+P) significantly improved efficacy versus sunitinib (S) in the CLEAR study. This post-hoc analysis examined tumor response by baseline metastases at the final prespecified overall survival analysis timepoint (cutoff: 31Jul22) in the L+P (n=355) versus S (n=357) arms.

METHODS: Treatment-naive adults with renal cell carcinoma (RCC) were randomized to L (20mg orally daily in 21-day cycles) plus P (200mg intravenously every 3 weeks) or L (18mg orally daily in 21-day cycles) plus everolimus (5mg orally daily in 21-day cycles) or S (50mg orally daily; 4 wks on/2 wks off). Tumor assessments were by independent imaging review per RECIST v1.1. Odds ratios (ORs) for objective response rate (ORR) and hazard ratios for PFS with 95% CIs were generated.

RESULTS: The most common metastatic site at baseline was lung (L+P: 71.0%; S: 63.9%); 22.5% and 24.9% of patients, respectively, had bone metastases. 65.1% Of patients randomized to L+P and 66.1% of patients randomized to S had metastases at ≥2 sites.

ORR (OR [95% CI]) favored L+P vs S across subgroups of patients with baseline metastases: lung, 5.19 (3.48-7.72); lymph node, 3.66 (2.28-5.88); bone, 4.09 (2.11-7.94); liver, 3.51 (1.68-7.30); brain, 3.00 (0.43-20.72). ORR (OR [95% CI]) favored L+P in patients with 1 (2.98 [1.71-5.21) or ≥2 metastatic sites (5.06 [3.40- 7.53]), and in patients with target lesion diameter sums ≥60 mm (10.50 [6.08-18.13]) or <60 mm (3.14 [1.94-5.07]). Similarly, ORR favored L+P vs S in the absence of baseline metastases in the aforementioned organ subgroups. PFS also favored L+P vs S irrespective of metastatic site, number of metastatic sites, and baseline target lesion size.

CONCLUSIONS: Tumor response favored L+P vs S in all subgroups of interest, particularly in patients with increased burden of disease. Data further support L+P as a first-line standard-of-care in patients with RCC.

#abs73 | UNICAB: Cabozantinib In Locally Advanced Or Metastatic Non-Clear Cell Renal Cell Carcinoma Post Immunotherapy or in those Unsuitable For Immunotherapy (ANZUP 1802)

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BACKGROUND: Rare variant non-clear cell renal cell cancer (nccRCC) have diverse biology and therapeutic response. Immune checkpoint immunotherapy (ICI) can benefit some people with nccRCC, but many experience progression. We sought to test cabozantinib (C) in people with nccRCC refractory to, or unsuitable for ICI.

METHODS: Eligible participants (pts) had advanced/metastatic nccRCC with good ECOG PS (<2) and either prior treatment with ICI or were unsuitable for ICI due to a contraindicating autoimmune disorder. Pts with urothelial or collecting duct tumour were excluded. Eligible pts started C at 60mg per day with dose modifications as required. Clinical cycles were 28 days and radiological assessment occurred 8-weekly for 12 months. Pts could then continue C via an access program.

RESULTS: 33 pts with nccRCC were recruited from Mar 2019 to Dec 2022. Recruitment was influenced by the COVID19 pandemic. Two pts were found ineligible (brain metastasis, concurrent CYP3A4 inducer). Pts tumour histology included papillary type 1 (10), chromophobe (7), papillary type 2 (4), Xp11 translocation (3) and other histologies (7). 24 pts had received prior ICI, mostly nivolumab alone (17) or anti-PD1-antibodies in combination with other agents (anti-CTLA4, anti-TIGIT). Median duration of therapy was 9 cycles. 17 pts ceased for unacceptable toxicity or disease progression and 12 pts completed the 12 months of treatment, with 2 remaining on trial treatment at time of analysis. A partial response was seen 7/31 (22%) pts overall, including 7/24 pts with prior ICI and 0/7 pts unsuitable for ICI. Median treatment duration was 7.5 cycles (range 2-12) in pts with prior ICI treatment, and 11 cycles (range 2-12) in pts unsuitable for ICI. 90% of pts required dose reduction, most often due to fatigue, hypertension, diarrhoea and hand-foot syndrome, with a mean C dose of 46mg/day. No new safety signals were observed.

CONCLUSIONS: C is an active treatment for people with nccRCC previously treated with ICI, with similar toxicity to previous reports in other cancers. Pts unsuitable for ICI may have poorer outcomes for C therapy in nccRCC. Further follow-up will determine duration of response and overall survival.

#abs74 | Updated results from AVENANCE: real-world effectiveness of avelumab first-line maintenance (1LM) in patients with advanced urothelial carcinoma (aUC) and analysis of second-line (2L) treatment

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INTRODUCTION AND OBJECTIVES: Previous results from the noninterventional, ambispective AVENANCE study (NCT04822350) showed the effectiveness and safety of avelumab 1LM in patients with aUC in France. We report updated data and analyses by 2L treatment.

METHODS: Eligible patients had aUC that had not progressed with 1L platinum-based chemotherapy and previous, ongoing, or planned avelumab 1LM treatment. The primary endpoint is overall survival (OS). Additional follow-up and analysis is ongoing.

RESULTS: 595 patients were analyzed. At data cutoff (December 7, 2023), median follow-up was 26.3 months (range, 0.6-43.7); 125 patients (21.0%) remained on avelumab. Median duration of avelumab treatment was 5.6 months (95% CI, 4.9-6.9). Reasons for discontinuation were disease progression in 340 patients (72.5%), adverse event in 53 (11.3%), death in 44 (9.4%), and other reasons in 32 (6.8%). 330 patients (55.5%) received 2L treatment, including chemotherapy in 244 (73.9%) and antibody-drug conjugate (ADC) in 62 (18.8%; including enfortumab vedotin in 56 [17.0%]). Characteristics of patients who received 2L ADC or chemotherapy were generally similar; most patients had received 1L carboplatin + gemcitabine (62.3% vs 63.6%), and had an ECOG performance status of 0/1 (81.6% vs 82.3%) and metastatic disease at start of 1L chemotherapy (96.8% vs 95.0%). In the overall population, median OS from start of avelumab 1LM was 21.3 months (95% CI, 17.6-24.6), and 1- and 2-year OS rates (95% CI) were 66.52% (62.53%-70.19%) and 45.89% (41.55%-50.12%), respectively. In patients who received 2L ADC or chemotherapy, median OS (95% CI) from start of avelumab 1LM was 31.3 months (29.1-not estimable) and 14.4 months (13.2-15.9).

CONCLUSIONS: Updated results from the AVENANCE study confirm the effectiveness of avelumab 1LM in a real-world population. In patients with 2L treatment (≈70% of patients who discontinued), a contemporary sequence of ADC after 1L platinum-based chemotherapy and avelumab 1LM treatment showed encouraging OS.

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#abs75 | Updated results from the RESECT study of Transurethral Resection of Bladder tumours (TURBT)

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BACKGROUND: RESECT is an international, multi-centre observational study of TURBT practice (shown to be associated with oncological outcomes) with an embedded cluster randomised trial of an institution-targeted performance feedback and educational tool (intervention) vs standard of care.

METHODS: Globally, any site performing TURBT surgery for NMIBC was eligible. Baseline retrospective data were collected on consecutive TURBTs and then sites were randomised to performance feedback, education, and access to operative pro-forma, vs standard clinical care. Data were then collected prospectively on consecutive TURBTs after randomisation. There were 4 co-primary outcomes (site level), adjusted for baseline achievement (rate of detrusor muscle sampling (DM+), rate of single instillation intravesical chemotherapy administration (SI-IVC+), rate of resection completeness documentation (RES-DOC) and rate of key tumour feature documentation (TUMF-DOC)). As a secondary outcome, the rate of recurrence at the first cystoscopy after complete TURBT was assessed at the patient level after adjustment for surgeon, site (random effects) and tumour number, size, grade and stage (fixed effects).

RESULTS: 219 sites were randomised between 05/10/21 and 15/03/23 collecting data on 15,879 patients undergoing TURBT. At baseline, the achievement of each of the TURBT quality indicators had wide variation between sites both within and between countries. All 4 QI's varied from <10% achievement to 100% achievement across sites.

After controlling for tumour size, number, stage and grade (all significantly and independently associated with early recurrence) (Table 1) there was also significant residual variation in the baseline early recurrence rates attributable to site (p<0.0001, intra-class correlation, 0.1).

After 18 exclusions (9 intervention, 9 control), 201 sites were included in the primary outcome analysis (Intervention: 100, Control: 101). Arms were comparable for patient, tumour, and site level variables.

Sites having feedback and education had significantly greater achievement of both documentation outcomes (Adjusted mean difference (95% CI), RES-DOC: 5.6%(1.6,9.6) p=0.006; TUMF-DOC: 6.1%(1.8,10.3) p=0.005). There was no difference in SI-IVC+, DM+ or early recurrence rate.

In the control arm, the early recurrence rate was significantly lower in the prospective phase vs the retrospective phase after adjusting for tumour size, number, grade and stage (Recurrence rate retrospective: 679/2748 (24.7%) vs prospective: 415/2245 (18.5%), Adjusted difference -5.5% (95% CI: -7.7%,-3.2%), p<0.001, relative difference, 25%).

CONCLUSION: Enhanced audit and feedback with education on TURBT performance improves documentation quality indicators, but not detrusor muscle sampling or SI-IVC. There was evidence that taking part in a global study of TURBT practice resulted in significant reduction in recurrence rates even in those without the intervention. This supports the conduct of organised audits with feedback of TURBT practice.

#abs76 | Urinary and bowel function post focal low-dose-rate brachytherapy for low-intermediate risk prostate cancer – LIBERATE Registry

Dr Mohammadmehdi Adhami[1], Dr Elliot Anderson[1], Dr Lloyd Smyth[1], Dr Richard O'Sullivan[1], Dr Andrew Ryan[1], Prof Nathan Lawrentschuk[1], Dr Andrew See[1], A/Prof Jeremy Grummet[1]

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INTRODUCTION & OBJECTIVES: This study measures the genitourinary and rectal toxicity and patient impact following focal low-dose-rate (LDR) brachytherapy for low-intermediate risk prostate cancer.

MATERIALS & METHODS: LIBERATE Registry is a prospective, multi-centre clinical registry of patients who underwent focal LDR brachytherapy for low-intermediate risk prostate cancer. This registry was utilised to evaluate clinician and patient-reported outcomes at six weeks following implant, and three monthly thereafter. The impact of treatment was assessed using validated questionnaires (International Prostate Symptom Score [IPSS], Expanded Prostate Cancer Index Composite [EPIC] Bowel Assessment) and adverse events were clinically graded as per Common Terminology Criteria for Adverse Events [CTCAE] guidelines. The minimal important difference (MID) was ±3.1 points for IPSS and ±5.1 points for EPIC bowel assessment.

RESULTS: Of 77 patients, 65 (84.4%) and 64 (83.1%) patients responded to IPSS and EPIC questionnaires respectively, with a median follow-up duration of 18 months. The cohort had a mean IPSS score of 6.6 at baseline, 10.0 at 6 weeks, 7.8 at 6 months, improving to 7.0 at the time of last follow-up. Fourteen (21.5%) men had a worse MID IPSS score during their last assessment compared to their baseline. Mean EPIC Bowel Assessment score was 91.6 at baseline, 87.8 at 6 weeks, 90.7 at 6 months and 89.8 at last follow-up. Sixteen (25%) men had a negative MID at last follow-up. Overall urinary incontinence rate was 2.6%, and at last follow-up, grade 2 urinary frequency and urgency occurred in 4 (5.2%) and 3 (3.9%) respectively. No grade ≥2 bowel symptoms were described.

CONCLUSION: Focal LDR brachytherapy was associated with superior functional outcomes with only mild initial urinary and bowel function impairment that most men make a durable recovery from by six months post-implant.

#abs77 | Using conceptual frameworks to guide the selection of patient reported outcome measures (PROMs) in cancer clinical trials: A CQUEST Resource

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INTRODUCTION AND OBJECTIVES: The Standard Protocol Items: Recommendations for Interventional Trials–patient-reported outcome (SPIRIT-PRO) extension requires trial protocols to justify selection of patient-reported outcome measures (PROMs) and hypothesise expected effects. Ideally, the rationale for PROM selection should be supported by a conceptual framework, which provides an empirical and theoretical basis to ensuring the trial measures what matters most to patients. However, many protocols default to a standard set of widely-used PROMs, resulting in important outcomes being missed, unnecessary respondent burden, and difficulty interpreting findings.

The Cancer Quality of Life Expert Service Team (CQUEST) has developed a resource to help investigators establish a conceptual framework and associated measurement model for their trial protocol.

METHODS: The conceptual framework resource is available on the CQUEST website, and outlines the definition of a conceptual framework, its rationale, and a step-by-step guide on developing a framework. A template is also available for investigators to create their own framework, which can be inserted into a study protocol. The poster/oral presentation will include an exemplary framework to aid ANZUP members in contextualising its utility and application within a cancer clinical trial setting.

The authors of SPIRIT-PRO have been involved to provide consensus on this resource.

RESULTS: ANZUP investigators are invited to utilise the conceptual framework template to inform PROM selection in their trials. CQUEST can collaboratively build this with investigators and then assist with the choice of PROMs after key concepts of interest have been identified. The framework template is adaptable to various trial settings, thereby addressing the diverse needs of cancer clinical trials and other study types involving PROMs.

CONCLUSION: CQUEST invites ANZUP members to engage with our conceptual framework resource to facilitate thoughtful selection of PROMs in cancer clinical trials, so as to directly address the trial objectives and yield results optimally informative to stakeholder needs.

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Our vision is a future where no man dies of prostate cancer and the men diagnosed, and their families, get the support they need.

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We are committed to reducing the burden of prostate cancer for all Australians, mobilising the community to drive research, prevention and early detection, improved treatment, and world-class psychosocial care. To get involved in our work, register for PCFA's signature campaign this September for Prostate Cancer Awareness Month, The Long Run: www.thelongrun.org.au

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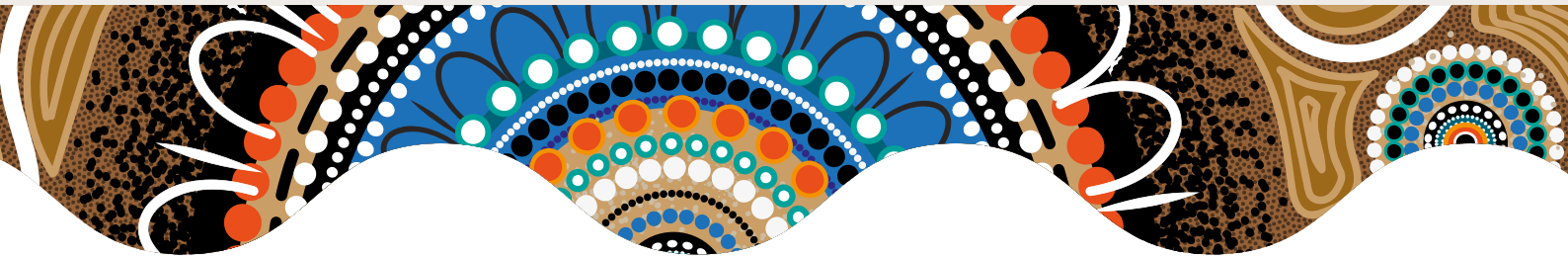

See you next year in Sydney, July 2025!

WILEY