ASIA-PACIFIC JOURNAL
OF CLINICAL ONCOLOGY
Volume 21, Issue S1

ANZUP®
Cancer Trials Group Limited

ANZUP ANNUAL SCIENTIFIC MEETING

20-22 JULY 2025, HYATT REGENCY SYDNEY

'LISTEN, REFLECT, CONNECT'

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Program and Abstracts

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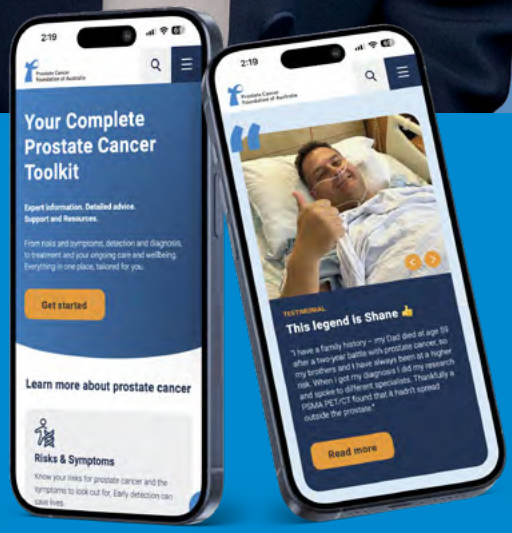

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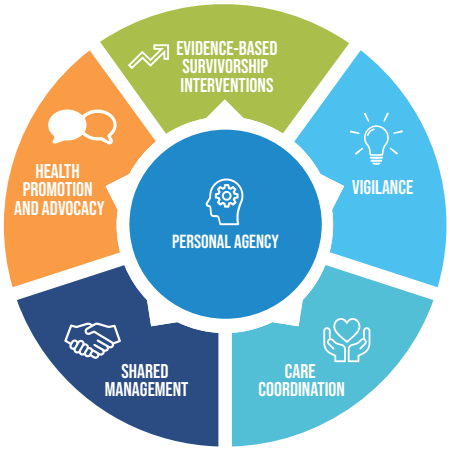
- 1 in 5 men develop anxiety or depression as a result of their diagnosis. In response, our Specialist Nurses deliver **evidence-based survivorship interventions** tailored to each man's individual needs.
- 63% of callers to our Telenursing Service report significant distress related to their diagnosis. In response, our Specialist Nurses arrange referral to PCFA's **Cancer Counselling Service**, and connect patients with Specialist Nurses in their local area.
- Men with prostate cancer face a 70% increased risk of suicide. In response, our Specialist Nurses develop a **Wellbeing Plan** for every man, helping men navigate their diagnosis with expert support at every point along the continuum of care.
- Treatment for prostate cancer often has longlasting and debilitating side effects. In response, our Specialist Nurses champion **multi-disciplinary care for every man**, meeting his unique clinical and psychosocial needs.



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Program and Abstracts

Asia-Pacific Journal of Clinical Oncology • Volume 21, Issue S1

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ANZUP ANNUAL SCIENTIFIC MEETING

20–22 JULY 2025
HYATT REGENCY SYDNEY

'LISTEN, REFLECT, CONNECT'

Contents

The contents attached herein are correct at the time of printing and maybe subject to change. This abstract supplement has been produced using author-supplied copy. Editing has been restricted to some corrections of spelling and style where appropriate. No responsibility is assumed for any claims, instructions, methods of drug dosages contained in the abstracts: it is recommended that these are verified independently.

ANZUP Chair Welcome

Prof Ian Davis

Welcome to the 2025 Annual Scientific Meeting (ASM) of ANZUP, the Australian and New Zealand Urogenital and Prostate Cancer Trials Group!

ANZUP's mission is to improve the lives of people affected by bladder, kidney, testicular, penile and prostate cancers. That's a complex concept framed in a simple sentence. Our vision is even simpler: living life without fear of cancer. Six words that we hope resonate with all our patients and all who care for them.

I don't think it's bragging to say that we know a lot. We know we cannot yet cure most of these cancers. We know that they can cause enormous havoc in people's lives, and that harm from them can continue for long after the cancer is found and treated. We know that these cancers are not going to magically disappear any time soon. We know a lot about them and about how to treat them, and we know for many that we are doing better than was the case in the past, but most of all we know that we cannot yet do enough for the people affected by them.

We also know that the best way to make a real positive difference is to generate evidence to guide patients, their families, and their treating health professionals in making decisions that are the best for them. This might involve discovering and testing new treatments, and it also involves looking at how best to support people through cancer and its treatment.

We do this by building a community of people dedicated to caring for those affected by these cancers. ANZUP performs high quality clinical trials designed to answer the questions we all face every day in our clinics and our lives. We generate new knowledge and we use that to ask and answer the next set of questions. We support basic science, translation of information into the clinical space, and implementation of new evidence into clinical care and health policy. We provide a community of learning from each other's diverse backgrounds and experience, ensuring we have a broad range of perspectives to inform what we do. We support those in training, who will be our research and clinical leaders in the future. And most importantly,

we centre all that we do on our patients, listening to what they say, understanding what their needs are, and following their advice as we prioritise our activities.

The ANZUP Annual Scientific Meeting has become a major forum to bring people together for these purposes. The theme of the meeting this year is "Listen, Reflect, Connect," and you will see this playing out not only in the meeting program but also in the conversations you will have and the new connections you will make. You will bring your own views and approaches and be able to hear how others approach similar questions in different ways. You will hear new information and consider what this means for your everyday practice and how we should continually improve what we do. And you will find like-minded and wonderful people, and build collaborations and friendships that will be long lasting.

We encourage you to embrace the theme of the meeting and allow it to bring you refreshed insights and renewed energy. Take the opportunity to talk with people outside your own area, and to learn from how others go about their own work in pursuit of the same vision. Connect with new groups and new opportunities. Think creatively, and don't be afraid to chime in with your thoughts: some of ANZUP's most impactful work has come from "we bounced around some ideas and it seemed like a good idea at the time!"

A meeting of this quality happens because of the quiet dedication and immense hard work done by a great team. Our convening committee, led by Carole Harris and Laurence Krieger, have been working tirelessly ever since the 2024 meeting to develop a stimulating, engaging, educational, and enjoyable program for you.
Our stellar international faculty includes Roger Li, Tian Zhang, Alison Tree, Marniza Saad, Bishal Gyawali, Emily Grist, and Bertrand Tombal, representing an amazing array of clinical and research professionals with immense experience and expertise.
Our local presenters showcase the fact that Australia and New Zealand are powerhouses on the international scale in this field.

We will include our MDT Masterclass, our nurses symposium, translational sessions, supportive care breakfast, and much more. The submitted abstracts are of a very high quality and we look forward to seeing the cutting edge research they represent.

ANZUP is very grateful to our sponsors and supporters, and to Cancer Australia for its ongoing support. We engage with our sponsors differently at the ANZUP ASM in comparison to some other meetings. You will not find huge showy displays, but instead you will find people keen and interested to join your conversations and genuinely be looking for ways to work with all of us more productively to help us move our mission ahead. Please take the opportunity to meet and thank our sponsors, draw them out from behind their tables, and engage them in conversation.

I hope you enjoy the 2025 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

Dr Carole Harris

Dr Laurence Krieger

On behalf of the ASM Convening Committee, we are delighted to welcome you to the #ANZUP25 ASM in Sydney, the region's premier GU cancer conference. This year's theme, "Listen, Reflect, Connect," underscores the core principles that drive innovation and collaboration in clinical trials for Below the Belt cancers.

This ASM is your gateway to the latest breakthroughs in GU cancer treatment, research, and supportive care. You will also get an exclusive look into ANZUP's ongoing and upcoming impactful clinical trials.

Here's a snapshot of just a few of our engaging sessions:

- **The Perfect Pitch:** This session is all about turning good ideas into great clinical trials. Whether you're an early-career investigator or an experienced clinician, you'll gain valuable insights into the art of pitching and trial development. A must for trainees in medical oncology, radiation oncology, or urology.
- **ANZUP and PCFA Nurses and Allied Health Symposium:** This dedicated symposium brings together the vital perspectives of nurses and allied health professionals to exchange insights and get the inside scoop on ANZUP's impactful projects. So come to connect, collaborate, and elevate your practice!
- **MDT Masterclass:** Learn from a panel of experts as they address real-life complex clinical challenges. This session promises practical insights and thought-provoking discussion. If you're a trainee, this is an essential learning opportunity.

We're honoured to welcome an outstanding international faculty, including Dr Roger Li, Dr Tian Zhang, Dr Alison Tree, A/Prof Marniza Saad, A/Prof Bishal Gyawali, Dr Emily Grist and Prof Bertrand Tombal. Alongside them, leading national experts will offer updates on GU cancer management, research priorities, and strategies to improve access to trials across our region.

This meeting is only possible thanks to the dedication of our incredible ANZUP community. A huge thank you to the ASM Convening Committee for curating such an exceptional program, and to our subcommittee chairs for their diligent review of abstracts and concepts. A special shout-out to the ANZUP management team, led by CEO Adj. Prof Samantha Oakes and Chair Prof Ian Davis, and to everyone at ANZUP who has worked tirelessly to bring this meeting to life. We also extend our sincere thanks to our sponsors, including Cancer Australia, whose crucial infrastructure funding is essential to ANZUP's success.

There's still much to do, and with your help, we can keep pushing the boundaries of GU cancer research and care across Australia, New Zealand, and beyond.

ANZUP is growing stronger every year—and that's because of you. Whether you're attending ASMs, proposing trials, recruiting patients, or joining subcommittees, your participation drives our progress. There's more work to be done. But together, we can keep pushing the boundaries and position Australia and New Zealand at the forefront of GU Oncology.

We hope you enjoy the #ANZUP25 ASM, and take some time to explore Sydney, our stunning harbour city!

Carole Harris and Laurence Krieger
Co-Convenors, ANZUP Annual Scientific Meeting 2025

ANZUP MDT Masterclass Co-Convenors' Welcome

Dr Ciara Conduit

Dr Niara Oliveira

Dr Nadia Hitchen

Join us at the MDT Masterclass session for an engaging exploration of the latest and most thought-provoking developments in urological cancer management. Designed to spark reflection and fuel connection across disciplines.

The 2025 MDT Masterclass is structured into five focused sections, each led by a field expert:

- **Advanced Prostate** – Ed Kwan
- **Bladder** – Harriet Herbison
- **Testicular** – Ben Thomas
- **Renal** – Handoo Rhee
- **Penile** – Jenny Lee

Developed for uro-oncology trainees, consultants, nurses, and allied health professionals, the Masterclass is designed to challenge assumptions, deepen knowledge, and foster a collaborative learning environment.

A core-based, multidisciplinary approach will guide the discussions, with live polling and audience contributions shaping the conversation.

On behalf of ANZUP, we warmly welcome you to this insightful session as part of the **2025 Annual Scientific Meeting**. Let's *listen, reflect, and connect* — and work together to improve the future of GU cancer care.

Ciara Conduit, Niara Oliveira and Nadia Hitchen
Co-Convenors, MDT Masterclass 2025

'LISTEN, REFLECT, CONNECT'

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MDT MASTERCLASS

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Sarah Dixon

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Awards and Scholarships *continued*

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E Qu
Peyman Rezaie
Ferzin Fathima
Sachin Shaji
Grace Tanner
Shendar Webster
Gurdip Hansra
Shikha Sharma

Hazel Bourke
Shraddha Weir
Jacqueline Lee
Sonya Stephens
Jasmin Holyoake-Brady
Sophie O'Haire
Jayne Lim
Stephanie Lloyd
Jemeni Thomas
Vanessa Azzi
Jennifer Edmunds
Van Dong Hoang
Elyse Carr

Awards and Scholarships *continued*

2025 ANZUP Best of the Best Awards

The Best of the Best Awards are open to ANZUP members who have successfully submitted an abstract and have been selected to present an oral or poster at the ASM.

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

There are 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
- Best of the Best Translational

Sponsor Acknowledgements

The Australian and New Zealand Urogenital and Prostate Cancer Trials Group gratefully acknowledge the generous support of our 2025 ASM sponsors.

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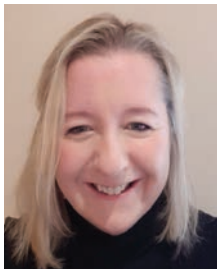


Emily Grist

Dr. Grist is a medical oncology clinician scientist and is a postdoctoral Prostate Cancer Foundation Young Investigator at University College London. She obtained her undergraduate medical degree and biomedical degree from the University of Southampton in 2009. Following completion of a prestigious Cancer Research UK fellowship in 2022 she obtained a PhD studying biomarkers in advanced prostate cancer. Dr. Grist has been an integral member of the STAMPEDE trial biological research group since 2017 and co-led the translational research programme STRATOSPHERE incorporating translational studies into the practice-changing STAMPEDE trial. She is aprincipal investigator of the STAMPEDE-Life translational research programme funded by Prostate Cancer UK to study the spatio-temporal evolution of lethal prostate cancer, integrated within the new STAMPEDE2 trial protocol. Her work has improved our understanding on how genomic copy number alterations associate with disease progression, this was awarded an ASCO merit award in 2021. More recently, Dr. Grist has focused on transcriptome-based re-classification of the disease, identifying novel predictive biomarkers in advanced prostate cancer, this was presented in the ESMO 2024 GU proffered paper session and awarded an ESMO merit award. Dr. Grist is committed to building precision medicine platforms for advanced prostate cancer and leading translational programmes that directly change clinical care.

Bishal Gyawali

A/Prof Bishal Gyawali, MD, PhD, FASCO is a medical oncologist and an associate professor in medical oncology and public health sciences and scientist in the Division of Cancer Care and Epidemiology, in Queen's University, Kingston, Canada. He did his cancer policy fellowship at Harvard Medical School and previously served as a medical consultant for the not-for-profit Anticancer Fund, Belgium, before joining Queen's. His clinical expertise is across multiple adult solid tumors, with special focus on GI and GU malignancies. He is in the editorial and advisory board for multiple medicine and oncology journals and has authored or co-authored more than 180 peer-reviewed articles in high-impact journals. Dr. Gyawali's areas of academic interests include cancer policy, evidence-based oncology, financial toxicities of cancer treatment, clinical trial methods, supportive care, cancer care disparities, and global oncology. He introduced the term "cancer groundshot" and chaired a session on the same at ASCO 2022. His interviews and studies have been reported in several influential media such as CNN, NPR, Washington Post, STAT News etc. He is an expert for the WHO Drug Advisory Panel. He is a member of the WHO Essential Medicines List Committee for cancer drugs, ESMO-Magnitude of Clinical Benefit Scale and ESMO Public Policy committees. He was a member of ASCO-Health Equity and Outcomes Committee 2021-2024, and is now a member of ASCO International Affairs Committee 2024-2027. He is a graduate of ASCO Leadership Development Program, Class of 2023-2024 and co-chairs ASCO Guidelines Committee for use of G-CSF in patients with cancer. In 2023, he co-founded Common Sense Oncology, a growing movement of oncology physicians, patients, advocates, researchers, and stakeholders dedicated to working together to ensure that cancer treatments improve outcomes that matter to patients, and access to such treatments are equitable globally.

Roger Li

Dr Roger Li is a urologic oncologist at Moffitt Cancer Center whose practice focuses on the treatment of bladder, upper tract urothelial and prostate cancers. Dr Li's research interest includes the molecular characterization of urothelial malignancies as well as developing novel immunotherapeutic strategies. Dr Li's work has been instrumental in the development of clinical trials in the BCG-unresponsive space. His research is funded by the DoD, ACS, and BCAN. He has authored over 100 peer-reviewed manuscripts and serves as reviewer for many international urologic journals.

Marniza Saad

A/Prof Marniza Saad is a Clinical Oncologist at the Department of Clinical Oncology, University Malaya Medical Centre(UMMC), and an Associate Professor at Faculty of Medicine, University of Malaya (UM), Kuala Lumpur. After obtaining her Medical Degree from University of Wales College of Medicine, Cardiff in 1997, she underwent specialist training in Clinical Oncology at Velindre Cancer Centre, Cardiff in the UK and attained FRCR qualification in 2006. Deeply passionate about education and training of future oncologists, she has been a trainer, programme coordinator and examiner for the Master of Clinical Oncology programme at the Universiti Malaya since 2006. Her areas of special interest include genitourinary, sarcoma, breast and gastrointestinal cancers. She is the principal investigator of numerous multi-centre clinical trials in genitourinary cancers.

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 has both a basic science and a clinical interest in urological oncology, particularly in the field of prostate and bladder cancer.

Alison Tree

Dr Alison Tree was appointed as a consultant clinical oncologist at the Royal Marsden hospital in 2014, specialising in urological malignancies. She is the GU editor for the International Journal of Radiation Oncology Biology and Physics, the lead journal globally dedicated to radiation-related research. She is chair of the MR Linac Consortium Steering Committee and teaches on several ESTRO and ASTRO courses. She is Chief Investigator of the TRAP, DELINEATE, HERMES, DESTINATION 1 and 2 and PACE C trials. She is the joint lead of the Cancer Research UK Radiation Research Centre of Excellence at The ICR/ Royal Marsden. Her research has received funding from Prostate Cancer UK, Cancer Research UK, the Rosetrees Trust, the JP Moulton foundation, Accuray and Elekta. Her current research interests include technical radiotherapy improvements in localised prostate cancer, oligometastatic and oligoprogressive disease.

Tian Zhang

Dr. Zhang received her MD from the Harvard-MIT Health Sciences and Technology (HST) program and completed post-graduate training at Duke University, where she remained on faculty until 2021. She is currently Associate Director of Clinical Research in the Simmons Comprehensive Cancer Center at University of Texas Southwestern Medical Center. Clinically she specializes in genitourinary malignancies and is a clinical researcher focused on improving novel therapies and biomarkers for patients with renal, prostate, and urothelial cancers. She serves as co-chair of the NCI GU Steering Committee Renal Task Force and participates on national committees for ASCO, SITC, CAHON, and KCA.

National Speakers

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 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. 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. His research has led to high-impact co-first author scientific publications including in The Lancet, Nature Medicine, Nature Cancer, and Cancer Cell.

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

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. Narjess 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. Narjess 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.

Charles Bidgood

Charles Bidgood is a postdoctoral cancer researcher at the Queensland University of Technology and member of the Australian Prostate Cancer Research Centre – Queensland (APCRC-Q). His PhD focused on developing therapeutic strategies for men with advanced prostate cancer using a number of innovative metabolic approaches. His research now focuses on the relationship between mitochondrial biology and therapy resistance across multiple cancer types with the goal of translation and future development. He also has a deep interest in live-cell imaging modalities and how they can be applied to shed new light on the unique metabolic landscape of cancer.

Kerry Blacket

Kerry Blacket has worked in Oncology nursing for 16 years and moved into clinical trials in 2020 then took on the role of Teletrials coordinator nearly 2 years ago. Currently working in a large regional hospital serving a population of rural and remote patients. Kerry is a passionate advocate for equity of access to health care has lived in both rural and remote locations with an understanding of the challenges living in these regions can have.

Russell Briggs

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.

Lisa Butler

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). Lisa'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.

Venu Chalasani

Venu Chalasani graduated from the University of Sydney and completed his Urological training in the New South Wales section training scheme. He undertook a general urology fellowship in the United Kingdom, and then subsequently completed a Society of Urological Oncology Fellowship in Canada. His current research activity is centered around Urological Oncology.

Ciara Conduit

Ciara Conduit is a medical oncologist with the Tasmanian Health Service, based at the Royal Hobart Hospital. She completed her advanced training at both the Royal Hobart Hospital and the Peter MacCallum Cancer Centre, gaining specialised experience in early-phase drug development as well as in genitourinary and skin cancers. Her research primarily focuses on genitourinary oncology, with a particular interest in testicular cancer—an area in which she completed her PhD. Ciara has previously served as a Clinical Research Fellow with ANZUP and continues her research at the Walter and Eliza Hall Institute of Medical Research. She currently serves as Deputy Chair of the ANZUP Germ Cell Tumour Subcommittee.

Gaylene Corbett

Gay currently works as the Prostate Cancer Specialist Nurse for the Grampians region hosted at Grampians Health - Ballarat Victoria and has done so for 12 years. Her work involves providing support to men and their families in all areas of prostate cancer care. This includes being of point of contact to assist with accessing services both in the hospital and community, providing reliable information and coordinating the care of men living with prostate cancer. Gay has a particular interest in management of erectile dysfunction post prostate cancer treatment and works closely with men and their partners to navigate this significant side effect of treatment. Gay has developed a 90-minute workshop called 'When prostate cancer joins you in the bedroom' to help men and their partners navigate intimacy post prostate cancer treatments.

Gay has an extensive nursing background within a variety of clinical settings throughout Australia with a particular focus on urology and education.

Donna Cowan

Donna is a Specialist Urology Nurse with over thirty years' experience in Urology Nursing across Private and Public Health sectors and Telehealth, working with people with all functional and oncological urological conditions. Donna is working with Movember as Implementation Director for Cancer Programs supporting the successful delivery of programs in the Asia Pacific region. She has a special focus on prostate cancer, sexual health and wellbeing, clinical quality registries, personalised cancer care, advocacy for access and equity of treatments.

Donna is an active lifetime member of ANZUNS and member of ANZUP and CNSA. She has a continued passion for education, professional development, and the importance of nursing research, ensuring best practice standards are current and up to date, providing excellence in care to all patients, families, carers, and staff.

Megan Crumbaker

Megan Crumbaker is a medical oncologist specialising in genito-urinary cancers at The Kinghorn Cancer Centre, St. Vincent's Sydney where she leads the GU oncology trial portfolio. She completed her PhD in prostate cancer genomics at UNSW and continues to conduct research in translational biomarkers with a special interest in radioligand therapies.

Ian Davis

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. Ian is chair of the ANZUP Board and of its Scientific Advisory Committee.

Juliet De Nittis

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

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.

Louise Emmett

Louise Emmett is the Director of Theranostics and nuclear medicine at St Vincent's Sydney, a conjoint professor (medicine) University of New South Wales and clinical research leader at Garvan Institute of Medicine Research. 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 fellowship (Nuclear Cardiology) in Toronto, Canada in 2001. She has a strong interest in research, having completed a Doctorate of Medicine (Nuclear Cardiology) in 2012. She commenced work in Nuclear Medicine and PET at St Vincent's Hospital, Sydney in 2012, and has since initiated radio-pharmacy production of multiple imaging and therapy tracers on the St Vincent's campus for clinical and research evaluation of cancer. She is heavily involved in multidisciplinary cancer research in Australia, including both imaging and therapy. She is the principal investigator of a number of prospective randomised national trials currently open around Australia. Louise is also involved in translational work, working with biotech companies to bring potentially exciting new theranostic agents into the clinic with phase one clinical trials.

Craig Gedye

Craig Gedye is a medical oncologist and cancer researcher. He works for people with melanoma, brain, prostate, bladder and kidney cancers. His research focuses on complexity and heterogeneity in cancer – why are cancers different between different people; why are cancers cells different to each other; what does this mean for each person's treatment? This challenging problem spans projects across the research spectrum, from patient experience, through clinical trials, translational biomarkers and questions in basic science. Craig is privileged to lead several national cancer clinical trials for the ANZUP and COGNO cancer trials groups, chairs the ANZUP Renal Cell Cancer Subcommittee, is a member of the Mark Hughes Scientific Advisory Committee, HNEHLD Clinical Trials Ethics Subcommittee, COGNO Scientific Advisory Committee and ANZUP Cancer Trials Scientific Advisory Committee.

Chris Gianacas

Chris Gianacas is a Senior Biostatistician at The George Institute for Global Health (TGI), where he manages a team of biostatisticians and oversees a portfolio of clinical trials.

He works across both observational and interventional studies, contributing to all aspects of biostatistical and methodological research.

Chris has particular interests in cardiovascular and oncology clinical research and building capacity and capability in Bayesian methods at TGI.

He holds a Bachelor of Computer Science and a Master of Biostatistics. He is currently completing a Doctor of Public Health at UNSW, examining antihypertensive prescribing patterns in Australian primary care.

Anna Green

Anna Green is a Senior Research Fellow (Prostate Cancer Partnerships) in the Centre for Health Research, University of Southern Queensland. Anne's research is focused on survivorship care for the partners of prostate cancer survivors. Current research includes better understanding the psychosocial needs of female partners to inform service design and delivery to support their health and well-being. Anne also coordinates the NH&MRC Partnership Project - Prostate Cancer Survivorship Essentials for Men with Prostate Cancer on Androgen Deprivation Therapy: Transforming Care to Improve Outcomes.

Carole Harris

Carole Harris BPharm MBBS (Hons) MMed FRACP is a medical oncologist at St George and Sutherland Hospitals, Conjoint Senior Lecturer at UNSW and a Senior Research Fellow at The George Institute and Australian and New Zealand Urogenital and Prostate (ANZUP) Cancer Trials Group.

She graduated from University of Sydney with honours, is a Fellow of the Australian College of Physicians and undertook a Master of Medicine by research. As a clinician she treats patients with genitourinary (kidney, bladder, prostate and testicular cancers) and breast cancer. Her research interests are in the development and running of clinical trials, genitourinary cancer research and cancer survivorship.

Cynthia Hawks

Cynthia Hawks is a Clinical Nurse Specialist (Urology) at Fiona Stanley Hospital who has supported the Fremantle/Fiona Stanley Hospital Urology research programme since 2011as both a Study Coordinator and Research Nurse. Cynthia has worked on ANZUP trials such as BCG+MM and Pain Free TRUS B and the ANZUP ACCEPT-U database for cystectomy and upper tract urothelial cancer.

In 2023 Cynthia was awarded a PhD exploring clinical outcomes, patient experiences and financial and resource efficiencies arising from the One Stop Prostate Clinic, a rapid access and streamlined prostate cancer assessment and diagnostic clinic for rural men in WA.

Dickon Hayne

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.

Nicole Heneka

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 and mixed research methods.

Harriet Herbison

Harriet Herbison is a genitourinary medical oncologist at Monash Health and PhD candidate at Monash University where she is doing a translational PhD in prostate cancer biomarkers.

Nadia Hitchen

Nadia Hitchen is a early career Medical Oncologist with an interest in GU translational and clinical research, she is also ANZUP/Clinical Research Fellow.

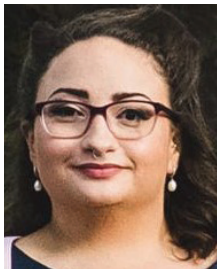
Brandan Holt

Brandan is a molecular biologist and clinical trial coordinator, passionate about making a difference in patient outcomes and quality of life within a clinical setting. They hold a Bachelor of Biotechnology (Hons), from the University of Newcastle, Australia; and were the recipient of the Faculty of Science Medal from the University.

Previously Brandan has worked at the Calvary Mater Newcastle, Icon Cancer Centre, and Queensland Health in patient-facing clinical research and laboratory-based positions.

Currently, they are working as a trial coordinator within the Australian Prostate Cancer Research Centre – Queensland (Queensland University of Technology), based at the Princess Alexandra Hospital, with a main focus on clinical trial and registry management. Brandan is also a member of the MetroSouth, Gold Coast and Ipswich West Moreton Health Human Research Ethics Committees (HRECs).

Brandan identifies as non-binary and has championed more inclusivity and awareness within their workplaces for people and trial participants with disabilities and neurodiversity as well as people of different sexual orientations and gender identities. They have initiated this through workshops, awareness days, and their work within the community.



Jasmine Holyoake-Brady

Jasmine is a Clinical Nurse / Clinical Trial Coordinator Team Lead working in the Oncology Clinical Research Unit at the Royal Brisbane and Women's Hospital. Since 2018, she has served as a Senior Clinical Trial Coordinator within the Integrated CAncer REsearch Centre at the Royal Brisbane and Women's Hospital. In this role, Jasmine has been instrumental in pioneering collaborative theranostics care-planning, driving enhanced efficiency and significant fiscal improvements in clinical trial operations. She has an interest in diagnostic imaging for clinical research and the use of novel radiopharmaceuticals for both diagnosis and therapy as well as early protocol design and logistics.

Lisa Horvath

Lisa Horvath is the Director of Research and Chief Clinical Officer at the 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. She holds academic appointments at both the University of Sydney and the University of New South Wales and is the Head of the Clincal Prostate Cancer research group at the Garvan Institute of Medical Research. Lisa is the Conjoint Chair of Medical Oncology (Genitourinary Cancers) at Chris O'Brien Lifehouse. She has published more than 170 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 elected ANZUP Board Director, a member of the ANZUP Scientific Advisory Committee and is Chair of the ANZUP Prostate Subcommittee.

Belinda Jago

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.

Jonathan Kam

Jonathan Kam is a Urologist at Nepean Hospital and senior clinical lecturer with the University of Sydney. Recently completed a Royal College of Surgeons (RCS) Senior Clinical Fellowship at the Guys Hospital, London.

Laura Kirsten

Laura Kirsten is the Principal Psychologist for the Nepean Blue Mountains Local Health District and a clinical psychologist at Nepean Cancer Services.
She co-chairs the Statewide Psychology Advisory Network for NSW Health, serves as Chair of the Clinical Oncology Society of Australia's Psycho-oncology Group, and is Deputy Chair of the Psycho-oncology Co-operative Group (PoCoG).

In her clinical role, Laura provides specialist psychological care to adults impacted by cancer and their loved ones within a tertiary oncology service. Her practice spans medical oncology, radiation oncology, haematology, and palliative care. She is deeply committed to integrating clinical research into practice and holds considerable expertise in psycho-oncology.

Her research interests include the implementation of clinical pathways for managing anxiety and depression in cancer populations; stress and burnout among oncology health professionals; survivorship; cancer support groups; and fear of cancer recurrence. She is also engaged in health service delivery research and has contributed to investigations into hoarding disorder and its effects on family systems.

Laura brings extensive experience in the supervision of clinical psychologists, psychologists, and psychology students across both clinical and research domains. She has presented at numerous national and international conferences and regularly delivers workshops and training to a wide range of audiences, including psychologists, medical staff, radiation therapists, allied health professionals, and students.

Bogda Koczwara

Bogda Koczwara is an internationally recognised professor and clinician researcher with expertise in cancer survivorship and supportive care. She established one of the first cancer survivorship program in Australia and the longest running cancer survivorship scientific meeting in the world. Her research has contributed to key advancers in the field of survivorship epidemiology, symptom monitoring, self-management support, and the use of patient reported outcomes in cancer. In April 2025 she was appointed as an inaugural Director of the Australian Research Centre for Cancer Survivorship. The Centre, created through a joint investment of $40 million from UNSW and Cancer Council NSW, was established last year with a focus on improving the care and wellbeing of cancer survivors through transformative and impactful research.

Laurence Krieger

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.

Edmond Kwan

Edmond Kwan is a clinician-scientist and consultant medical oncologist at Eastern Health in Melbourne. He is currently serving as Laboratory Head and Senior Research Fellow at the Eastern Health Clinical School, with a cross-appointment at the Monash Biomedicine Discovery Institute.

After completing his specialist clinical training, Edmond received an NHMRC Postgraduate Scholarship to support his doctoral research investigating whole blood RNA to characterise aggressive molecular subtypes in prostate cancer. Following his PhD, he relocated to Canada for a postdoctoral fellowship at BC Cancer and the Vancouver Prostate Centre, University of British Columbia. His postdoctoral research primarily centred on developing tissue and circulating tumour DNA biomarkers for predicting treatment outcomes in lethal metastatic prostate cancer. Beyond the laboratory, Edmond has maintained strong links to patient care, serving as a Principal Investigator on early and late-phase clinical trials in prostate, bladder, and kidney cancer. He is also on the translational research subcommittee of several ANZUP-led trials, including TheraP, ENZARAD and DASL-HiCaP.

Edmond's expertise encompasses diverse disciplines, including molecular biology, bioinformatics, clinical trials, biobanking, database development, and translational medicine. By combining expertise in cancer genomics and clinical oncology, his research team strives to understand how genomic and epigenomic alterations identified in tumour tissue and blood can better guide therapeutic decision-making in patients with urological cancers.

Les Land

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

Mitchell Lawrence

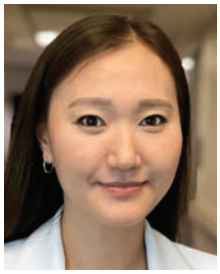
Mitchell Lawrence is a Laboratory Head in the Biomedicine Discovery Institute, Monash University. He also has appointments at the Peter MacCallum Cancer Centre and Cabrini Health. For his research on genitourinary cancers, Mitchell works with patient advocates, community organisations and clinicians to identify critical clinical challenges facing patients. In collaboration with other members of the Melbourne Urological Research Alliance, he is using patient-derived models of penile and prostate cancer, including xenografts and organoids, to uncover why some patients' tumours are more aggressive than others and to identify how to treat these tumours more effectively.

Nicky Lawrence

Nicky is a Medical Oncologist at Te Toka Tumai Auckland with an interest in genitourinary cancers and clinical trial methodology, and is 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 and critical appraisal workshops, and is a member of the international steering committee for the ACORD protocol writing workshop.

Melissa Le Messieur

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.



Jenny Lee

Jenny Lee is a Medical Oncologist at Chris O'Brien Lifehouse, Academic Associate Professor at Macquarie University and an NHMRC Fellow. In line with her research interest, she specialises in head and neck cancers, melanoma and non-melanoma skin cancers. She is also the Co-Director of the Biomarker Research Centre at Chris O'Brien Lifehouse, where she leads efforts to advance personalised cancer treatments through the development of novel diagnostic and therapeutic strategies.

Nicole Lewis

Nicole Lewis is a Clinical Lead, of the Specialist Nursing Program, Prostate Cancer Foundation of Australia (PCFA), Prostate Cancer Specialist Nurse and an Oncology Clinical Nurse Specialist at Goulburn Valley Health.

Nicole has over 30 years of nursing experience, holds a Diploma of Business and a postgraduate qualification in Cancer Studies. Her dedication to enhancing patient understanding and self-care during anti-cancer therapies led to the development of the "Scripted Therapy Exercise" project, aimed at improving outcomes for advanced cancer patients.

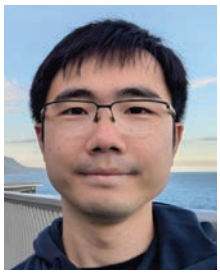
Through her work, Nicole is committed to advancing cancer care and supporting patients in managing and improving their health and wellbeing.

Annaleise Liefting

Annaleise Liefting is the Principal Program Officer for the Australian Teletrial Program with Queensland Health. She has four years' experience working in health and medical research ethics and governance. Prior to this, Annaleise spent 10 years working in hospital outpatient departments where she gained critical exposure to operational requirements of providing healthcare across various levels of administration and clinical specialities.

In her role with the Australian Teletrial Program, Annaleise is focused on harmonisation of regulatory issues to improve and increase pathways to clinical trials for regional, rural and remote patients closer to where they live. She provides strategic advice on how to improve health inequity through policy harmonisation, infrastructure, and through collaboration with key stakeholders like Human Research Ethics Committees and Research Governance Officers. Annaleise is an enthusiastic knowledge sharer and was a founder and inaugural member of the National Ethics Community of Practice, creating a space for ethics officers to network, share resources and learn together.

Annaleise is passionate about improving access and participation in Teletrials for all Australians, particularly following a personal and positive experience with a clinical trial.



Gerald Mak

Gerald Mak is a urology registrar working at St George Hospital, Kogarah. He is a conjoint associate lecturer at UNSW, a visiting scientist at the Garvan Institute and a member of the ANZUP trials group.

Blossom Mak

Blossom Mak is a medical oncologist at Chris O'Brien Lifehouse and an NHMRC Clinical Trials Centre research fellow working closely with ANZUP. She obtained her Bachelor of Medicine with Honours from the University of New South Wales in 2010, and continued her specialist medical oncology training at Chris O'Brien Lifehouse and Concord Hospital. Her clinical interests include genitourinary, gynaecological and breast cancers.

Blossom is passionate about clinical and translational research, and was awarded a PhD from the University of Sydney on lipidomic biomarkers in advanced prostate cancer. She has presented her research at national and international conferences as well as successfully published in numerous peer-reviewed journals.

Raewyn Manssen

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 their 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.

Jarad Martin

Jarad Martin is a Radiation Oncologist working at the Calvary Mater Newcastle and GenesisCare. He completed registrar training in 2005 in Melbourne and subsequently undertook a genitourinary oncology clinical research fellowship at the Princess Margaret Hospital in Toronto winning the academic excellence in research award from that institution. His primary clinical and research interests are in urologic and gastrointestinal cancers, including the application of stereotactic radiotherapy for genitourinary tumours. Jarad is deputy chair of the prostate sub-committee for ANZUP, and convenor of the 2022 Prostate Cancer Rapid-Fire. He is PI on several currently accruing multicentre prospective clinical trials, and believes that offering patients the option of enrolment on randomized clinical trials is a key component of optimal patient care.

Fiona Maclean

Fiona Maclean is an Anatomical Pathologist who is particularly passionate about the genitourinary tract – she enjoys diagnosing diseases and sharing insights with people from all different walks of life be they scientists, fellow clinicians and multidisciplinary team members, or patients. Although she can be serious (she has authored over 100 peer reviewed journal articles as well as textbook chapters), she likes to lighten the load by approaching some of these areas in a light-hearted manner, because she firmly believes that even the most serious pathology deserves a wee bit of humour.

Rhiannon Mellor

Rhiannon Mellor is a medical oncologist at Westmead Hospital in Sydney, specialising in genitourinary cancers with a particular focus on prostate cancer. She is currently completing a PhD on lipidomics in prostate cancer at the Garvan Institute of Medical Research. She also has a strong interest in clinician wellbeing and mentorship, and was on the organising committee for the National Oncology Mentorship Program during her training.

Declan Murphy

Declan Murphy is Consultant Urologist and Director of Genito-Urinary (GU) Oncology at Peter MacCallum Cancer Centre, Melbourne, and Clinical Professor at the University of Melbourne.

Declan is an internationally-recognised key opinion leader in GU Oncology, prostate cancer in particular, and has many hundreds of peer-review publications to his name, with a h-index of 75. He is a full-time prostate cancer surgeon.

Declan is Associate Editor of European Urology and has editorial experience with many other top journals. He is well known worldwide for co-hosting the top-rated GU Cast podcast and the European Urology Podcast.

Samantha (Sam) Oakes

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.

Colin O'Brien

Colin O'Brien was diagnosed with prostate cancer in 2005 and since then has been actively involved as a consumer advocate with numerous cancer committees that include the Victorian government's Department of Health Cancer Quality Outcomes Committee, Prostate Cancer Outcomes Registry Steering Committee and Cancer Vic Cancer Registry. He has 40 years-experience in small business as an owner, business advisor, workshop developer and presenter, and as EO of Australia's largest network of small business providers. He has a strong interest in improved benchmarking regarding the treatment, care and outcomes for cancer patients as they journey through the health care system. Taking time out from his business he has completed small business volunteer assignments in Thailand, Solomon Islands, Fiji, Papua New Guinea, Vanuatu and Bali, Indonesia. Passions include sharing a good meal and wine with family and friends, travel (in particular Canada) and competitive mountain biking.

Niara Oliveira

Niara Oliveira is a Senior Medical Oncologist at Mater Hospital Brisbane with a subspecialty interest in genitourinary 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. Niara 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.

Abhijit Pal

Abhijit Pal is a medical oncologist who works as a staff specialist at Liverpool Hospital and Bankstown Hospital (South Western Sydney Local Health District) and specialises in early phase cancer trials and thoracic malignancies. He completed a Phase 1 trials fellowship at the Drug Development Unit, Royal Marsden Hospital in London from 2019 – 2020. He was awarded a PhD in 2024 through the University of Sydney (supervised by Professor Frances Boyle), looking at informed consent for Phase 1 trials and ways to improve the representation of patients from culturally and linguistically diverse backgrounds on to cancer clinical trials.

Greg Pratt

Greg Pratt, an Associate Professor, is a Quandamooka man of the Noonucal tribe of Stradbroke Island (Minjerribah), and Principal Research Fellow for the Jingay Research Cluster of Central Queensland University. He works part-time for Queensland Aboriginal and Islander Health Council (the peak body for Aboriginal and Community Controlled Health Organisations of Queensland) as Principal Research Advisor. For over 20 years, he has collaborated nationally, and internationally to translate research for a clinical benefit. He has extensive experience in stakeholder engagement, community consultation, and co-design, and a track record leading policy development and research for a First Nations health benefit. Greg has facilitated over 150 community consultations and workshops over the past 5 years for an implementation science goal. His research focuses on realising equitable access to health research; focusing most recently on mental health and genomics.

Weranja Ranasinghe

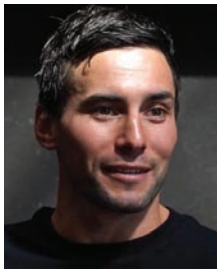
Weranja Ranasinghe is a consultant urologist and the Clinical Lead of Urologic Oncology Surgery at Monash Health. He is the leader of the Urological Society of Australia and New Zealand Genito-Urinary Oncology Special Advisory Group. Weranja graduated from the University of Bristol, UK and was awarded a Ph.D. at the University of Melbourne. He completed his urology training (FRACS Urology) and the Society of Urologic-Oncology fellowship at the MD Anderson Cancer Center, USA. He is also a US DOD Early Career Research fellow at the University of Monash Biomedical Discovery Center.

Handoo Rhee

Handoo Rhee is a urological and transplant surgeon. He obtained his MBBS, FRACS (Urol) and PhD in the field of advanced genito-urinary oncology. He was the research and clinical fellow at Princess Alexandra Hospital from 2014-2016 in the field of urology and transplantation. He has current research grants from numerous funding bodies including NHMRC, MRFF, PA Research Foundation, Gallipoli Research Foundation and private companies. He supervises higher degree students through the University of Queensland and the Griffith University, and holds international, national and state leadership positions within TSANZ, VSEAC, OTA, RACS and USANZ.

Natasha Roberts

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



Josh Robson Diagnosed with Testicular cancer in 2021. I am a triathlon coach and also a foreman in civil construction. I do endurance sports in the spare time I have. I am a husband to Emma and a dad to Isaac.

Ben Rogers

Ben is Director of Health Professional Education at Movember. Ben is currently leading the design and implementation of health professional training on gender responsive healthcare for men, in Australia and other Movember markets.

Ben has over a decade of clinical mental health experience, including a focus on supporting boys and men through life's challenges. Alongside his clinical work, Ben has a track record in leading complex programs and professional development training initiatives in both Australia and the UK. This includes in his previous role at the National Workforce Centre for Child Mental Health (Emerging Minds), where he managed a team of clinicians, researchers, and content creators, to successfully implemented a portfolio of evidence-based workforce training and e-CPD programs across the country.

Shahneen Sandhu

Shahneen Sandhu is a Professor, Consultant Medical Oncologist and a leading clinician researcher with a full time appointment in the melanoma/skin and uro-oncology units at Peter MacCallum Cancer Centre, in Melbourne. She is also Research Lead for the Melanoma Medical Oncology Service at Peter Mac. She leads several investigator-initiated clinical research studies in melanoma/skin and prostate cancer and is study chair of the ANZUP 2001 EVOLUTION trial. Her major research interests include the study of biological mechanisms that lead to aggressive forms of skin cancer and prostate cancer; the preclinical identification of new targets; the design, conduct and analysis of early clinical trials with novel drugs that aim to co-develop predictive biomarkers in conjunction with therapeutics; and personalisation of cancer treatments.

Sally Sara

Sally Sara is Director of Nursing for the Prostate Cancer Foundation Australia (PCFA), leading a team of over 110 specialist prostate cancer nurses in every state and territory in Australia. A clinician researcher and PhD candidate, Sally also holds a Master of Clinical Nursing and has over 35 years of nursing experience in a broad range of specialty areas, with a strong interest in improving health care and quality of life outcomes for men diagnosed with prostate cancer. Sally is an elected Councillor on the Coalition of National Nursing and Midwifery Organisations and represents the Australian College of Nursing on the Cancer Australia Intercollegiate Advisory Group. She is an Adjunct Professor in the University of Southern Queensland's Centre for Health Research, and an Adjunct Associate Professor in the School of Nursing at the University of Technology Sydney.

Darren Saunders

Darren is a Eureka Prize winning scientist, with over 20 years' experience in cancer biology and neuroscience in Australia and North America. He is NSW Deputy Chief Scientist & Engineer, leading the development of the NSW RNA Ecosystem, including RNA Pilot Manufacturing Facility, and leading independent scientific reviews for NSW Government. Darren has worked with EB&Co since 2017 as a senior research advisor and data expert on numerous reviews into workplace culture, harmful behaviours and systemic discrimination in the mining, aviation, education, arts and law enforcement sectors. Darren is an Adjunct Associate Professor in Medical Sciences at the University of Sydney, has held senior roles in peak professional bodies – leading policy and regulatory reforms in science and technology, and is a regular commentator on television and radio. Darren is also a committed thalassophile.

Anne Savage

Anne Savage is the CEO of Prostate Cancer Foundation of Australia. She has more than two decades of policy and advocacy experience, with degree qualifications in journalism. Her work in the non-profit sector includes nearly ten years at Cancer Council Queensland prior to taking up a position at Prostate Cancer Foundation of Australia. Over the past five years PCFA has grown its support for ANZUP significantly, funding the EVOLUTION Clinical Trial and launching a Prostate Cancer Future Fund for new research, in addition to creating new Telenursing and Counselling Services and doubling the number of PCFA nurses working in hospitals and cancer centres around the country.

Tahlia Scheinberg

Tahlia Scheinberg (MBBS, Hons 1, FRACP, PhD) is a medical oncologist at Chris O'Brien Lifehouse, with a special interest in prostate and gynaecological cancers, clinical trials and translational research. Tahlia's research interests are predominantly in prostate cancer, including prognostic biomarkers, prostate cancer biology including lipid metabolism and clinical trials. Tahlia developed a NATA-compliant circulating lipid biomarker, PCPro, capable of prospectively identifying patients with metastatic hormone sensitive or hormone resistant prostate cancer, with a poor prognosis. She is the study co-chair for the DARO-LIPID trial, a multicentre ANZUP clinical trial for patients with poor prognostic castration resistant prostate cancer.

Kath Schubach

Kath 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

Shomik Sengupta

Shomik Sengupta is Professor of Surgery and deputy Head of School at the Eastern Health Clinical School, Monash University and consultant urology Visiting Medical Officer and Uro-Oncology lead at the Department of Urology, Eastern Health. Shomik has a practice with a uro-oncology subspecialty interest – including open, laparoscopic and robotic cancer surgery. He completed his urological training through the Victorian Section of the Urological Society of Australia & New Zealand (USANZ) and subsequently completed a Uro-Oncology fellowship at the Mayo Clinic, USA. He has also completed a Masters in Surgery (2002) and a Doctorate in Medicine (2014) through the University of Melbourne. Shomik is a key opinion leader in Australian Urology and a strong contributor to USANZ, having been Chair of the Victorian training subcommittee from 2014 to 2016, and leader of the GU Oncology advisory group from 2013 to 2019. His international profile has included co-opted membership of the UAA Board as deputy-director of research, USANZ representative on the Education Council of SIU, Membership of the International Bladder Cancer Group and Executive Committee membership of the World Urological Oncology Federation. Shomik has a strong interest in urologic research, including involvement in clinical trials through the Australian and New Zealand Urogenital & Prostate (ANZUP) cancer trials group, where he is a member of the Board and the Scientific Advisory Committee. Shomik has more than 165 original publications to date and has been an invited speaker/session chair at a number of scientific meetings. His involvement in leadership of scientific meetings includes current membership of the Scientific program committee for the Societe Internationale d'Urologie (SIU) 2025 Annual Congress and having been Scientific Co-chair of the Urological Association of Asia (UAA) 2022 Annual congress, Scientific Program Director for the 2017 USANZ Annual Scientific Meeting and Convenor of the 2013 ANZUP Annual Scientific Meeting. Shomik is also on the editorial board of multiple journals including the ANZ Journal of surgery, Translational Andrology and Urology, BMC Urology etc.

Amy Smith

Amy Smith is a graduate of the Notre Dame University Sydney, having completed her Doctor of Medicine. She completed her junior medical officer training at Royal Prince Alfred Hospital and Basic Physician's Training at St Vincent's Hospital. Amy is currently a Provisional Fellow at Nepean hospital, having complete her first two years of medical oncology advanced training in the Dubbo Base Hospital/Concord Repatriation and General Hospital/ Chris O'Brien Lifehouse network.

Wee-Kheng Soo

Wee-Kheng Soo's research is focused on improving health outcomes for older people with cancer in healthcare systems within Australia and on a global scale. During his PhD, he made substantial contributions to geriatric oncology by leading the INTEGERATE Study – a landmark randomised controlled trial that showed the effectiveness of geriatric assessment and oncogeriatric management for older patients receiving anticancer treatment – and through developing and validating the Elderly Functional Index. His research work (24 publications) has been translated into clinical resources and used to inform health service design to improve the quality of care for older people with cancer. Currently, he leads the Ageing Resiliency in Cancer clinics as a medical oncologist and geriatrician.

Marcel Svatos

Marcel Svatos is a seasoned leader with over 15 years of management experience across seven industries in Australia and Europe. A versatile generalist, he excels in people management, leadership, stakeholder engagement, and implementing innovative systems and technologies to enhance efficiency. His corporate governance experience ensures robust strategy development, aligning philanthropy with organisational goals.

Marcel's ability to streamline processes and engage diverse stakeholders makes him a trusted authority in advancing sustainable funding solutions, including philanthropy initiatives. Marcel joined ANZUP in October 2023. In his free time, he enjoys playing tennis, running, swimming and cooking.

Chris Sweeney

Chris Sweeney is the inaugural Director of the South Australian immunoGENomics Cancer Institute (SAiGENCI), and a professor of medicine at the University of Adelaide. Chris 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. Chris joined the Lank Center for Genitourinary Oncology at Dana-Farber Cancer and Harvard Medical School in 2009 and was promoted to full Professor of Medicine at Harvard Medical School in 2018.

Renea Taylor

Professor Renea Taylor is co-Head of the Cancer Program at the Monash Biomedicine Discovery Institute and leads the Prostate Cancer Research Laboratory. She heads a translational research program focused on developing and applying clinically relevant models to better understand prostate cancer, with a particular emphasis on aggressive and treatment-resistant forms of the disease.

Her research aims to discover and validate new therapeutic strategies by leveraging patient-derived models in collaboration with the Melbourne Urological Research Alliance (MURAL) - bringing discoveries one step closer to clinical trials. Her work supports therapy prioritisation, biomarker discovery, patient stratification, and the identification of resistance mechanisms.

Renea is Chair of the Australian Prostate Cancer Bioresource and leads the Victorian node of this national initiative. She also serves on the Research Standing Committee for Cancer Council Australia. Actively involved in multidisciplinary cancer care, she contributes to clinical meetings including Cabrini Urology, Peter MacCallum Cancer Centre, and the Monash Partners Comprehensie Cancer Consortium (MPCCC) Molecular Tumour Board. A strong advocate for consumer engagement and science communication, she is committed to increasing prostate cancer awareness and strengthening ties between researchers, clinicians, and the community.

Monika Tencic

Monika Tencic, based in Garran, ACT, AU, is currently a Clinical Trials Coordinator Registered Nurse – Medical Oncology at Canberra Health Services. Monika brings experience from previous roles at Canberra Health Services, Epworth and University of Melbourne. Monika holds a 2014 - 2017 bachelor of nursing/public health and health promotion in health sciences at Deakin University plus a postgraduate degree in health research. Monika is currently undertaking a Masters by research, exploring the nurses scope and utilisation in oncology and haematology clinical trials, at Flinders University.

Ben Thomas

Benjamin Thomas is a consultant urological surgeon specialising in urological oncology surgery including robotic surgery and is a senior research fellow in the Department of Surgery, University of Melbourne.

He completed his undergraduate medical degree at the University of Melbourne followed by surgical and urological training at the Royal Melbourne Hospital. He completed robotic and urological oncology fellowships at Addenbrooke's Hospital, Cambridge (United Kingdom) and the Karolinksa Institute, Stockholm (Sweden). He has postgraduate research and management degrees and qualifications from the University of Cambridge and Harvard University.

He was a substantive consultant urological surgeon in Cambridge where he was the lead surgeon for robotic surgery development and was previously Chair of the Urology Cancer Specialist Multidisciplinary Team in Cambridge. He was also previously chair of the Victorian Comprehensive Cancer Centre Penile and Testicular Cancer Forum.

Ben Tran

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. Ben currently leads the GU clinical trials program at Peter MacCallum Cancer Centre and is Chair of the Phase 1 Group within Cancer Trials Australia, and Chair of the ANZUP Germ Cell Subcommittee.

Rick Walker

Rick Walker is a Consultant Paediatric and AYA Oncologist at QCH and PAH in Brisbane, Australia.

Rick is the Medical Director of the Queensland Youth Cancer Service. He is on the Partnership of Cancer Alliance Queensland and is Chair of the Youth Cancer Subcommittee. He is also a member Queensland Collaborative for Cancer Survivorship Executive Committee and part of the national Youth Cancer service delivery advisory group in partnership with CanTeen.

Tim Weale

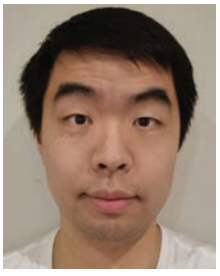
Tim Weale has a powerful story to share about his journey with stage four prostate cancer. Tim's experience highlights the importance of early detection, proactive health management and the invaluable work of organisations like ANZUP in researching and treating genitourinary cancers.

At only 44 years old, Tim was diagnosed with advanced prostate cancer, despite having no family history of the disease and leading a healthy lifestyle. He initially dismissed early warning signs, attributing them to age or travel fatigue having been on a 'trip of a lifetime' with his family.

His journey includes navigating complex treatments, including hormone therapy, radiation and chemotherapy, while maintaining a positive outlook and active lifestyle. Tim's story underscores the significance of being vigilant about one's health, the crucial role of support networks and the value of life without fear of advanced cancer thanks to medical research and trials.

Tim is now dedicated to raising his family and awareness about prostate cancer.

Tim's story is not just about survival; it's about resilience, determination, the importance medical research and prioritising health and well-being.



Kain Xu

Kain Xu, MBBS, PGDipAnat, is a non-training urology registrar based in Auckland, New Zealand. He has a strong interest in surgical innovation, with a particular focus on sustainability in healthcare and improving patient outcomes.

Mei Ling Yap

Mei Ling Yap MBBS BSc FRANZCR PhD, an Associate Professor, is a radiation oncologist clinician researcher based in South-Western Sydney Local Health District. She is the Head of the Cancer Program at the George Institute for Global Health, UNSW and lead of the Collaboration for Cancer Outcomes, Research and Evaluation (CCORE), the Ingham Institute for Applied Medical Research. Mei Ling holds a National Health and Medical Research Council Emerging Leader Fellowship (2023-2027) investigating cancer control in refugee and recent migrant populations in Australia. In 2024, was awarded the NSW Premier's Award for Outstanding Cancer Research for "Improving Equitable Outcomes".

Jasmine Yee

Jasmine Yee is the Enrico Piccioli Postdoctoral Research Fellow at the University of Sydney and Terry Langbaum Survivorship Fellow with the Multinational Association of Supportive Care in Cancer (MASCC). Her research focuses on supportive care and survivorship, aiming to improve outcomes for people with cancer. Drawing on her background in exercise physiology, Jasmine explores how exercise can be effectively integrated into cancer care to optimise patient engagement, enhance physical and psychological wellbeing, and improve clinical outcomes. She is particularly interested in innovative exercise approaches that seek to transform the treatment experience and support recovery.

Leonie Young

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

Paul Zawa was born in Chicago and immigrated to Australia in January 1986. He is married with two children. Paul 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.

Launching the ANZUP Gifts in Wills Program

ANZUP is pleased to announce the launch of our ***Gifts in Wills Program***, an important new initiative designed to secure long-term support for our clinical trials and research into Below the Belt cancers. Through this program, ANZUP aims to give members, supporters, and the broader community an opportunity to contribute to a lasting legacy that will help advance innovative research, fund future clinical trials, and improve outcomes for those affected by prostate, kidney, testicular, penile and bladder cancers.

As part of this initiative, ANZUP has partnered with Safe Will and Gathered Here, two trusted online platforms that provide accessible tools and guidance for those wishing to consider leaving a gift in their Will. Over the coming months, ANZUP will be sharing more information and resources to support this program, and to help raise awareness of how these meaningful contributions can make a lasting difference.

For more information visit https://anzup.org.au/gifts-in-wills/

Safewill

gatheredhere

ANZUP Scientific Program and Pre-Conference Meetings

SUNDAY 20 JULY 2025

0730 - 0800 – *Breakfast*

0830 - 1030

The Perfect Pitch
Grand Ballroom

Co-Chairs: Craig Gedye and Blossom Mak

- Why? – **Melissa Le Mesurier**
- Can? – **Chris Gianacas**
- Small? – **Natasha Roberts**
- Medium? – **Marcel Svatos**
- Large? – **Ian Davis**
- Commercial? – **Shahneen Sandhu**
- How? Successful trials amid a changing landscape: lessons learned from PDIGREE – **Tian Zhang**
  Sponsored by AstraZeneca

AstraZeneca

- **Discussion**

0800 - 1030

ANZUP PCFA Nurses & Allied Health Symposium
Maritime Ballroom 4
Sponsored by Novartis

NOVARTIS

Co-Chairs: Kath Schubach and Donna Cowan
Sponsor Welcome – **Stamati Margelis**, Clinical Research Medical Advisor – Radioligand Therapies, Novartis

PhD updates:
- **Kath Schubach** • **Sally Sara** • **Russell Briggs**

Service Developments:
- Prostate Cancer Exercise Program GV Health – **Nicole Lewis**
- When Prostate Cancer Joins you in the Bedroom – **Gay Corbett**

Study updates:
- Design, implementation and evaluation of PC Essentials Study – **Anna Green**
- Research Update – **Cynthia Hawks**
- Unmet needs in prostate cancer care – **Natasha Roberts**

Education:
- How to do a poster presentation – **Nicole Heneka**
- ANZUNS Research Committee – **Kath Schubach**

0800 - 1030

Study Coordinator Session
Wharf Room 2-5

Co-Chairs: Brandan Holt and Monika Tencic

- From Radionuclides to Results: Bringing Nuclear Medicine to the Table – **Jasmine Holyoake-Brady**
- Experiences with Ninja and engaging consumers from conception – **Jarad Martin**
- Australian Teletrials Program – overview of program – **Annaleise Liefting**
- Teletrials – a coordinators experience of benefits and barriers to conducting tele-trials oncology – lessons learned – **Kerry Blacket**

5 minute break

- How to talk to participants and loved ones about dying – **Haryana Dhillon**

Panel Discussion: Jasmine Brady, Haryana Dhillon and Jarad Martin

- Workshop event – Clinical trials, an ever changing role: problem solving together – **Brandan Holt and Monika Tencic**

1030 - 1100 — ***Morning Tea***

1100 - 1230

Translational Highlights Session
Grand Ballroom

Co-Chairs: Renea Taylor and Luke Selth

- Improved treatment selection in advanced hormone-sensitive prostate cancer: ancillary studies of the STAMPEDE trials – **Emily Grist**
- Biomarker-driven clinical trials: lessons learned from the GUIDE and DARO-LIPID trials – **Tahlia Scheinberg**
- Experience in setting up a trial from translational research project – **Roger Li**
- Translational Research in Penile Cancer – **Mitchell Lawrence**
- Panel discussion

ANZUP PCFA Nurses & Allied Health Symposium and Study Coordinators combined session
Maritime Ballroom 4
Sponsored by Novartis

NOVARTIS

Co-Chairs: Kath Schubach and Monika Tencic

- Feedback on earlier two sessions – selected on the day.
- Priorities work – **Natasha Roberts**
- Oration: **Margaret McJannett**

Continued over

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ANZUP Scientific Program and Pre-Conference Meetings

SUNDAY 20 JULY 2025 *continued*

1230 - 1330	***Lunch*** – Maritime Ballroom 1-3
1330 - 1515	**ANZUP Masterclass** **Co-Chairs: Ciara Conduit, Niara Oliveira and Nadia Hitchen**
1340 - 1410	• Bladder **Chair: Harriet Herbison**
1410 - 1440	• Advanced Prostate **Chair: Ed Kwan**
1440 - 1515	• Renal **Chair: Handoo Rhee**
1515 - 1545	***Afternoon Tea*** – Maritime Ballroom 1-3
1545 - 1700	**ANZUP Masterclass continues…** **Co-Chairs: Ciara Conduit, Niara Oliveira & Nadia Hitchen**
1545 - 1615	• Penile **Chair: Jenny Lee**
1615 - 1700	• Testicular **Chair: Ben Thomas**
1700 - 1830	**ANZUP Welcome Reception** Maritime Ballroom 1-3
1815 & 1845	Coach Transfer from the Hyatt Hotel to the Evening Symposium Gather in the Loading Dock for transfer to Ilumina.
1830 / 1900 for 1915 - 2200	**ANZUP 2025 Evening Symposium** North Hall, Ilumina, 1 Elizabeth Street, Sydney, NSW 2000 ***Sponsored by Johnson & Johnson*** Johnson&Johnson **Light Reflections** We're really looking forward to what promises to be a lively and engaging session. We've got a novel session planned which will be a mix of a gameshow format somewhat akin to "Have You Been Paying Attention" but with a genitourinary focus, interspersed with a more serious but key session on the role of reflection in each of our lives. You may be even see things in a new light – pun very much intended! **Co-Chairs: Fiona Maclean and Haryana Dhillon**

Continued over

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ANZUP Scientific Program and Pre-Conference Meetings

MONDAY 21 JULY 2025

0645 - 0715

Breakfast – Maritime Ballroom 1-3

0715 - 0815

***ANZUP sponsored* Translational Science Breakfast**
Translational Rapid-Fire updates
Grand Ballroom

Co-Chairs: Weranja Ranasinghe and Charles Bidgood

- Translational Insights from TheraP ctDNA analysis – **Ed Kwan**
- SPECT research in ENZAP and EVOLUTION – **Narjess Ayati**
- Neoadjuvant combination therapy in locally advanced ccRCC (NEBULA) – **Lewis Au**
- Translational research in germ cell cancers – **Nadia Hitchen**
- Translational Insights and Upcoming Plans from the BCG+MM study – **Dickon Hayne**
- Translational Insights from Upper-tract studies – **Shomik Sengupta**

Supportive Care Breakfast
Maritime Ballroom 4
Sponsored by Astellas

Co-Chairs: Haryana Dhillon and Leonie Young

Welcome and introduction by **Naseem Ali**, Medical Affairs Co-Lead, Astellas

- Developing a Quality of Life-derived Frailty Index and assessing the effects of Enzalutamide on Frailty and Resilience in Prostate Cancer and Older Cancer Patients: insights from the ENZAMET randomised controlled trial **Wee-Kheng Soo**
- Prostate Cancer Screening Guidelines: Are They Inclusive of Gender Diverse Populations? A Systematic Rubric-Based Evaluation – **Afolabi Opeyejesu**
- Prostate cancer in transgender women: what the evidence means for healthcare providers in Australia & New Zealand – **John Peacey**
- How health professionals can best advise men to seek help and care – **Donna Cowan and Ben Rogers**
- Panel discussion

0830 - 0900

Opening Session
Grand Ballroom

Co-Chairs: Ian Davis, Carole Harris and Laurence Krieger

- Welcome and housekeeping – **Ian Davis**
- Welcome to Country, Gadigal Elder – **Binowee Bayles**
- Introduction to ASM – **Carole Harris and Laurence Krieger**
- Welcome from ANZUP CEO – **Samantha Oakes**
- Welcome by Platinum Sponsor – **Steve Callister**, National Chairman, Prostate Cancer Foundation of Australia

0900 - 1030

Keynote Session One:
Session Title: Connecting with Big Ideas
Grand Ballroom

Co-Chairs: Carole Harris and Laurence Krieger

- Introduction by Co-Chairs
- Patient voice – **Leonie Young**
- Common sense communication of evidence: balancing power, clarity, and accuracy – **Bishal Gyawali**
- Engaging men in treatment and health care – **Ben Rogers**
- Challenges of integrating systemic therapies in bladder cancer – **Roger Li**
- The ANZUP theranostics Glow-Up – **Louise Emmett**
- Half-Life, Full Team: Energising Multi Departmental Trials in Theranostics – **Jasmine Holyoake-Brady**
- Update: Theranostics subcommittee – **Andrew Scott**
- Panel discussion / questions

1030 - 1100

Morning tea – Maritime Ballroom 1-3
Sponsored by Johnson & Johnson

Continued over

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ANZUP Scientific Program and Pre-Conference Meetings

MONDAY 21 JULY 2025 *continued*

1100 - 1235	**Keynote Session Two:** **Session Title:** Latest information on Prostate Cancer Grand Ballroom ***Sponsored by Prostate Cancer Foundation of Australia*** **Co-Chairs: Jeremy De Leon, Les Land and Tahlia Scheinberg** • Introduction by Co-Chairs • Patient voice – **Colin O'Brien** • Biomarker-driven strategies for treatment intensification in advanced hormone-sensitive prostate cancer – **Emily Grist** • Synchrony fellow: Multimodal ctDNA analysis and novel imaging to inform precision use of PSMA radioligand therapy – **Edmond Kwan** • The lived experience of active surveillance for prostate cancer **Russell Briggs** • Curing prostate cancer in 5 sessions: PACE-ing ahead – **Alison Tree** • DASL updates – **Chris Sweeney** • Prostate sub committee overview of trials – **Lisa Horvath** • Questions
1235 - 1245	**ANZUPx** Grand Ballroom The Cure is Just the Beginning – **Bogda Koczwara**
1245 - 1345	***Lunch – Maritime Ballroom 1-3***
1345 - 1510	**Best of the Best Oral Abstracts Session** Grand Ballroom **Co-Chairs: David Pook and Lisa Horvath** • Immune and Genomic Profiling to Inform Risk Stratification in Muscle-Invasive Bladder Cancer – **Nadia Hitchen** • Uncovering the mechanisms linking mitochondrial dysfunction and valine metabolism in the development of castrate-resistant prostate cancer – **Charles Bidgood** • Bladder Cancer Staging with Pre-Cystoscopic Multiparametric MRI: A Multicentre Evaluation of the Vesical Imaging Reporting and Data System and Diffusion Kurtosis Imaging – **Gerald Mak** • Review of relapse detection methods in stage 1 testicular germ cell tumours in patients after orchidectomy managed with active surveillance: Is Physical Examination required? – **Amy Smith** • A Review of the diagnosis, treatment and outcomes for Adolescents and Young Adults with testicular Germ Cell Tumours in Queensland from 2017 to 2023 – **Rick Walker** • Is PSA Testing Beneficial for Men with Low-Grade Prostate Cancer on Watchful Waiting? – **Kain Xu** • Oncological and functional outcomes of apical prostate cancers treated with focal laser ablation (ProFocal®) – **Jonathan Kam**
1510 - 1540	***Afternoon Tea – Maritime Ballroom 1-3 – Sponsored by Astellas***
1540 - 1700	**Keynote Session Three:** **Session Title:** Health Equity Grand Ballroom ***Sponsored by Prostate Cancer Foundation of Australia*** **Co-Chairs: Mei Ling Yap and Abhi Pal** • Introduction by Co-Chairs • Patient voice – **Paul Zawa** • Equitable Access to Health Research: Emphasising First Nations Leadership – **Greg Pratt**

Continued over

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ANZUP Scientific Program and Pre-Conference Meetings

MONDAY 21 JULY 2025 *continued*

	Keynote Session Three (continued) • The Hunger Games of prostate cancer diagnosis – **Anne Savage** • Decentralised clinical trials in Aotearoa New Zealand: developing approaches relevant to Māori and those living in rural areas – **Nicky Lawrence** • Mind the gap, value the gain – **Marniza Saad** • Cancer Groundshot: Going Global Before Going to the Moon – **Bishal Gyawali** • Panel discussion
1700 - 1730	**ANZUP AGM Members only** – Maritime Ballroom 4
1730 - 1830	***Poster Walkaround and pre dinner drinks***
1900 - 2300	***ANZUP Conference Dinner – Grand Ballroom***

TUESDAY 22 JULY 2025

0715 - 0815	**Breakfast Session:** **Session Title:** From Lab to Life: Translational Science in Kidney Cancer Maritime 4 ***Sponsored by MSD*** MSD **Co-Chairs: Aaron Hansen and Megan Crumbaker** • Co-Chair Welcome and Introduction to Session • Welcome and introduction by sponsor – MSD, **Rosemary Schuster**, Brand Manager, MSD • Circulating Biomarkers in metastatic renal cell carcinoma – **Tian Zhang** ***Sponsored by AstraZeneca*** AstraZeneca • Tissue-based biomarkers in ccRCC – **Lewis Au** • Prognostic and Predictive Biomarkers in the Adjuvant Setting for high risk RCC – **Megan Crumbaker** • What patients need to know for adjuvant therapy **Belinda Jago** • Questions
0830 - 1000	**Keynote Session Four:** **Session Title:** Updates on Non-Prostate Cancer Grand Ballroom ***Sponsored by MSD*** MSD **Co-Chairs: Melissa Le Mesurier & Andrew Weickhardt** • Introduction by Co-Chairs • Patient voice – **Josh Robson** • Considerations for LGBTQIA+ and other vulnerable communities – diversity and intersectionality in research; how can we be more inclusive with clinical trial participation? – **Brandan Holt** • Preserving life with a functional bladder – **Marniza Saad** • Novel Therapies for Testis Cancer – **Ben Tran** • Testicular Cancer sub committee update – **Ben Tran** • Role of psycho-oncology in a resource limited setting – **Laura Kirsten** • **Improving clinical out**comes in metastatic renal cell carcinoma: updates in immunotherapy combinations, HIF inhibitors, and landscape opportunities – **Tian Zhang** ***Sponsored by AstraZeneca*** AstraZeneca • Showcase trial: Outcomes of Australians with Kidney Cancer (OAK) – **Natasha Roberts and Belinda Jago** • RCC subcommittee update – **Craig Gedye** • Questions

Continued over

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

ANZUP Scientific Program and Pre-Conference Meetings

TUESDAY 22 JULY 2025 *continued*

1000 - 1030	**Plenary Session: Mentorship** **Chair: Declan Murphy** • Inspire and be inspired – **Marniza Saad** • Human moments in a busy system: the gift of mentorship – **Rhiannon Mellor** • Panel discussion • Mentorship announcement – **Samantha Oakes**	Grand Ballroom
1030 - 1100	***Morning Tea***	***Maritime 1-3***
1100 - 1250	**Keynote Session Five** **Session Title:** Incurable now curable? ***Sponsored by Merck Healthcare*** **Co-Chairs: Juliet De Nittis and Venu Chalasani** • Introduction by Co-Chairs • Patient Voice – **Raewyn Manssen** • Achieving cures in prostate cancer: approaching heterogeneous states of biochemical recurrence – **Tian Zhang** ***Sponsored by AstraZeneca*** • Extending the envelope of cure in oligometastatic prostate cancer – **Alison Tree** • Reimagining the chair: Exercise as a therapeutic adjunct – **Jasmine Yee** • Treatments for BCG unresponsive for Non-muscle invasive bladder cancer – **Roger Li** • Results from ANZUP1301: The BCG+MM trial – **Dickon Hayne** • Update: BUP subcommittee – **Dickon Hayne** • Leaving Your Comfort Zone: Embracing Curiosity, Communication, & Collaboration – **Darren Saunders** • Questions	Grand Ballroom MERCK AstraZeneca
12.50 - 1300	ANZUPx Grand Ballroom Origins of Common Sense Oncology – The Why and The How – ***Bishal Gyawali***	
1300 - 1400	***Lunch***	
1400 - 1420	**Plenary Session** **Session Title:** Translating Holistic Care **Co-Chairs: Bertrand Tombal and Niara Oliveira** • Update: Translational subcommittee – **Ed Kwan** • Noel Castan ANZUP fellowship research: The supportive care needs of patients diagnosed and living with non-muscle invasive bladder cancer and the perceived impact on their health-related quality of life: A Multi-method study – **Kath Schubach** • Update: Supportive Care & Quality of Life subcommittee – **Natasha Roberts and Haryana Dhillon**	Grand Ballroom
1420 - 1500	**Plenary Session** **Session Title:** Who Wants to be a Millionaire? **Chair: Henry Woo**	Grand Ballroom
1500 - 1530	**Plenary Session** **Session Title:** ANZUP Awards & ASM close **Co-Chairs: Ian Davis, Carole Harris & Laurence Krieger** • ANZUP Awards • Introduction to 2026 / Meet the Convenors for 2026	Grand Ballroom
1530	***End of ASM***	
1545	***Coaches depart to the Airport***	

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

List of Poster Abstracts

A Comparative Analysis of Robotic vs Laparoscopic Partial Nephrectomy for a Complex Renal Mass (R.E.N.A.L. Score ≥ 10); Single surgeon study
#abs1

Mr Sepehr Miran, Dr Anne Hong, Dr Homayoun Zargar

A comprehensive look into robotic and laparoscopic partial nephrectomy: Achievement of Trifecta and optimal perioperative outcomes in surgical management of renal cancer by a single surgeon
#abs2

Mr Sepehr Miran, Dr Anne Hong, Dr Homayoun Zargar

A Decade of Testicular Cancer Management: Single Tertiary Centre Experience with an Insight on Future Directions
#abs3

Dr Thilina Samarasinghe, Dr. Arthur Yim, Dr. Tina Zafari, Dr. Brion Brady, Dr. Arjun Guduguntla, Dr. Prassannah Satasivam

A Rare and Risky Surprise of Immunotherapy: Pembrolizumab-induced Neutropenia in Renal Cell Carcinoma
#abs4

Dr Savisha Fernando, Dr Ayesha Saqib

A retrospective analysis of clinical profile and outcome of treatment in patients with Denovo Small cell Neuroendocrine carcinoma prostate and Adenocarcinoma prostate with neuroendocrine differentiation in a tertiary center, India
#abs5

Dr AN Venkatesh Darshan, Dr Amandeep Arora, Dr Mahendra Pal, Dr Nandini Menon, Dr Kumar Prabhash, Dr Vanita Noronha, Dr Gagan Prakash, Dr Santosh Menon, Dr Archi Agarwal, Dr Nilesh Sable, Dr Palak Popat, Dr Vedang Murthy, Dr Priyamvada Maitre, Mr Chaitanya Sagvekar, Dr Amit Joshi

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#abs6

Dr Rick Walker, Ms Lauren Buckley, Ms Emily Reilly, Dr Alyce Taylor-Brown, Dr Catherine Gorrie, Ms Stacey Pulford

Active surveillance – when is enough enough?
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Hyerin Park, A/Prof Marlon Perera

Androgen receptor genomic structural rearrangements reshape the AR cistrome in castration-resistant prostate cancer
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ARCHES 5-year follow-up overall survival analysis of enzalutamide plus androgen-deprivation therapy in patients with metastatic hormone-sensitive prostate cancer
#abs9

Dr Andrew J. Armstrong, Dr. Daniel P. Petrylak, Dr. Neal D. Shore, Dr. Russell Z. Szmulewitz, Dr. Jeffrey Holzbeierlein, Dr. Arnauld Villers, Dr. Antonio Alcaraz, Dr. Boris Alekseev, Dr. Taro Iguchi, Dr. Francisco Gomez-Veiga, Dr. Ruslan Croitoru, Dr. Ruishan Wu, Dr. Matko Kalac, Dr. Yiyun Tang, Dr. Arnulf Stenzl, **Dr. Arun Azad**

Artificial intelligence in predicting biochemical recurrence following radical prostatectomy: A systematic review
#abs10

Dr Haoyue Zhang, Dr Jianliang Liu, Dr Dixon Woon, Dr Marlon Perera, Prof Nathan Lawrentschuk

Australian, multi-centre assessment of Focal Laser Ablation with ProFocal® in Localised Prostate Cancer
#abs11

Dr Ymer Bushati, Dr Jonathan Kam, Dr Bertram Canagasingham, Dr Ahmed Goolam, Dr Andrew Hadley, Dr Matthew Winter, Professor Mohamed Khadra, Dr Nicholas Mehan, Dr Isaac Thangasamy, Dr Celi Varol

Avelumab first-line maintenance in advanced urothelial carcinoma: conditional survival and long-term safety in patients treated for ≥1 or ≥2 years in JAVELIN Bladder 100
#abs12

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#abs13

Shilpa Gupta, Petros Grivas, Se Hoon Park, Daniel Petrylak, Karin Tyroller, Jason Hoffman, Annie Sangaroonthong, Joaquim Bellmunt

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Dr Po Lin Ooi

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Dr David Homewood, Mr Prabhpreet Mangat, Professor Niall Corcoran

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Dr Kain Xu

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Dr Jane McKenzie, Lauren Howard, Joseph Park, Bilal Ashraf, Tara Seibert, Kallie White, Sundhar Ramalingham, Jeff Shevach, Michael Harrison, Chris Holmes, Matthew Labriola, Hannah McManus, Shahla Bari, Daniel George, Andrew Armstrong

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Dr Jim Smith, Atreyi Dutta, Angela Yee, Dr John Woodfield, Dr Michael Lau, Dr Stephen Mark, Dr Amir Zarrabi, Dr Euan Rodger, Associate Professor Aniruddha Chatterjee

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Neeraj Agarwal, **Arun Azad**, Joan Carles, André Fay, Nobuaki Matsubara, Cezary Szczylik, Ugo De Giorgi, Jae Joung, Peter Fong, Eric Voog, Robert Jones, Neal Shore, Curtis Dunshee, Stefanie Zschäbitz, Jan Oldenburg, Xun Lin, Cynthia Healy, Matko Kalac, Dana Kennedy, Karim Fizazi

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#abs43

Dr Jonathan Kam, Mohan ARIANAYAGAM, Bertram CANAGASINGHAM, Ahmed Saeed GOOLAM, Nicola JEFFERY, Mohamed KHADRA, Raymond KO, Nicholas MEHAN, Isaac THANGASAMY, Celi Varol

Oncological and functional outcomes of apical prostate cancers treated with focal laser ablation (ProFocal®)
#abs44

Dr Jonathan Kam, Mohan ARIANAYAGAM, Bertram CANAGASINGHAM, Ahmed GOOLAM, Nicola JEFFERY, Mohamed KHADRA, Raymond KO, Nicholas MEHAN, Isaac THANGASAMY, Celi VAROL

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Dr Jonathan Kam, Mohan ARIANAYAGAM, Bertram CANAGASINGHAM, Ahmed Saeed GOOLAM, Nicola JEFFERY, Mohamed KHADRA, Raymond KO, Nicholas MEHAN, Isaac THANGASAMY, Celi VAROL

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Dr SAURABH BAGRA, Dr Amandeep Arora, Dr Mahendra Pal, Dr Nandini Menon, Dr Kumar Prabhash, Dr Vanita Noronha, Dr Gagan Prakash, Dr Santosh Menon, Dr Archi Agrawal, Dr Nilesh Sable, Dr Palak Popat, Dr Priyamvada Maitre, Dr Siddhartha Laskar, Dr Nehal Khanna, Ms Bhagyashri Jadhav, Dr Amit Joshi

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Dr Kain Xu, Dr Nikhar Shah, Dr Madhu Koya, Dr Tony Beaven

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Dr Henry H. Woo, Dr Stephen J. Freedland, Dr Martin Gleave, Dr Ugo De Giorgi, Dr Antti Rannikko, Dr Swetha Sridharan, Dr Klaus Brasso, Dr Antonio Gómez Caamaño, Dr Luke T. Nordquist, Dr Yiyun Tang, Dr Ruslan Croitoru, Dr Matt Rosales, Dr Matko Kalac, Dr Olivier Peraud, Dr Fong Wang, Dr Neal Shore

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Dr Raveendranath Puviarasan, Dr Aditya Dhanawat, Dr Ruchita Raghuwanshi, Mr. Chaitanya Sagvekar, Dr Minit Shah, Dr Nandini Menon, Dr Priyamvada Maitre, Dr Mahendra Pal, Dr Amandeep Arora, Dr Ankit Mishra, Dr Rachel Sequeira, Dr Nilesh Sable, Dr Archi Agrawal, Dr Santosh Menon, Dr Gagan Prakash, Dr Vedang Murthy, Dr Vanita Noronha, Dr Kumar Prabash, Dr Amit Joshi

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Poster Abstracts

#abs1 | A Comparative Analysis of Robotic vs Laparoscopic Partial Nephrectomy for a Complex Renal Mass (R.E.N.A.L. Score ≥ 10); Single surgeon study

Mr Sepehr Miran[1,2], Dr Anne Hong[3], Dr Homayoun Zargar[3,4,5]

[1]Monash Uni, [2]Alfred Health, [3]University of Melbourne, [4]Western Health, [5]Western Clinical trials

Introduction
This study retrospectively reviews prospectively collected data to compare perioperative and postoperative outcomes in patients with a complex renal mass (R.E.N.A.L. score≥10) undergoing robotic partial nephrectomy (RPN) or Laparoscopic partial nephrectomy (LPN). In addition, we asses achievement of the defined trifecta and "optimal outcome".

Materials and methods
From 2017 to 2024, a total of 56 patients underwent partial nephrectomy performed by a single surgeon (39 RPN, 17 LPN). Trifecta was defined as achieving three criteria: warm ischemia time greater than 25 minutes, negative surgical margins, and absence of postoperative complications. "Optimal outcome" was defined as achieving the trifecta in addition to a short-term (3-month) estimated glomerular filtration rate (eGFR) preservation of greater than 90%. Postoperative complications were classified according to the Clavien-Dindo classification. Statistical analyses were conducted using GraphPad Prism (version 10.4).

Results
Of the 56 patients, 39 underwent RPN, and 17 underwent LPN. The groups had comparable median age (65 vs. 58 years), tumor size (median 43.00 mm vs. 60.00 mm), R.E.N.A.L. scores (median 10.0 vs. 10.0). WIT was 0 minutes in 11 RPN and 6 LPN cases, with no significant difference in mean WIT (13.74 vs. 12.00 minutes, p = 0.6506). Negative surgical margin rates (86.84% vs. 92.31%, p >0.9999), complication rates (6.25% vs. 9.09%, p = 0.6463), and eGFR preservation > 90% (71.05% vs. 66.67%, p = 0.7510) were comparable between groups.

The rates of achieving trifecta (69.23% RPN vs. 76.47% LPN, p=0.7510) and optimal outcome (55.00% RPN vs. 52.94% LPN, p >0.9999) showed no significant difference between the groups.

Conclusion
There was no statistically significant difference in the achievement of Trifecta or Optimal outcome rates between RPN and LPN. Both studies showed comparable perioperative and postoperative outcomes when performed by an experienced surgeon. The findings suggest that RPN and LPN are equally safe and effective in the management of complex renal masses with a R.E.N.A.L. score≥10.

#abs2| A comprehensive look into robotic and laparoscopic partial nephrectomy: Achievement of Trifecta and optimal perioperative outcomes in surgical management of renal cancer by a single surgeon

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Introduction
This study is a retrospective review of prospectively collected data comparing perioperative and postoperative outcomes in patients undergoing robotic partial nephrectomy (RPN) or laparoscopic partial nephrectomy (LPN) for renal masses. Additionally, we evaluate the rates of achieving trifecta and "optimal outcome."

Materials and Methods
A total of 215 patients who underwent partial nephrectomy by a single surgeon between 2017 and 2025 were included (135 RPN, 80 LPN). Trifecta was defined as warm ischemia time (WIT) < 25 minutes, negative surgical margins, and no postoperative complications. "Optimal outcome" was defined as achieving the trifecta along with short-term (3-month) estimated glomerular filtration rate (eGFR) preservation > 90%. Postoperative complications were analysed using the Clavien-Dindo classification. Statistical analysis was performed using GraphPad Prism (version 10.4).

Results
Of the 215 patients, 135 underwent RPN and 80 underwent LPN. The groups had comparable median age (61 vs. 58 years), tumor size (32 mm vs. 31 mm), and R.E.N.A.L. scores (8.0 vs. 8.0). WIT was 0 minutes in 46 RPN and 33 LPN cases, with no significant difference in median WIT (10 vs. 8 minutes, p = 0.6802). Negative surgical margin rates (93.60% vs. 86.11%, p = 0.1210), complication rates (5.93% vs. 6.25%, p = 0.5699), and eGFR preservation > 90% (77.59% vs. 77.63%, p = 0.9999) were comparable between groups.

The rates of achieving trifecta (83.70% RPN vs. 77.50% LPN, p = 0.2800) and optimal outcome (70.37% RPN vs. 63.75% LPN, p = 0.3650) showed no significant difference between the groups.

Conclusions
There was no statistically significant difference in trifecta or optimal outcome rates between RPN and LPN. Both techniques demonstrated comparable perioperative and postoperative outcomes when performed by an experienced surgeon. These findings suggest that RPN and LPN are equally effective and safe options for partial nephrectomy.

#abs3 | A Decade of Testicular Cancer Management: Single Tertiary Centre Experience with an Insight on Future Directions

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Introduction
Testicular cancer predominantly affects young males and has a high cure rate. However, there remains potentially unmet needs in diagnosis, prognostication and treatment which still lead to rare but devastating treatment failures. This study aimed to evaluate clinical, histopathological, and biochemical predictors of chemotherapy use and retroperitoneal lymph node dissection (RPLND) over a 10-year period at a single tertiary centre.

Methods
A retrospective review of inguinal orchidectomies performed at a single tertiary center for testicular masses between 2012-2023 was conducted. Trends in clinical, histopathological, biochemical parameters were correlated to predict the treatment response, identify risk of progression and recurrence. Statistical analysis included univariate and multivariate testing using SPSS v30(IBM Corp.,NY,USA).

Results
Of 86 patients who underwent inguinal orchidectomy, 64(74.41%) were confirmed to have testicular malignancy. The median age at diagnosis was 33 years(range 17–66years), and the median follow-up duration was 72 months(range 24–158months). Loss to follow-up occurred in 10(15.6%) patients by 2 years of orchidectomy. Six patients(9.4%) were transferred to another health service. Histologically 58%(n=37) were seminomas, non-seminomatous GCT(n=13,20%) and mixed GCT(n=7,11%). Stage at diagnosis was 62.5%, 20% & 17.2% for Stage I, II and III respectively. Chemotherapy was administered in 31(48.4%) patients of which 10(15.6%) had stage 1 disease. Retro-peritoneal lymph node dissection(RPLND) was performed in 11(17.2%) patients for post chemotherapy recurrence. Seven(11%) patients had recurrent disease at the 3 years of which 2 had recurrence after initial diagnosis of stage 1 disease. Tunica albuginea invasion was significantly associated with an increased risk of recurrence(OR 6.27,95% CI 1.21–32.47,p=0.029). Rete testis invasion(RTI) demonstrated a trend toward increased recurrence risk(OR 4.63,p=0.10), without reaching statistical significance. Post-operative AFP level was the only significant predictor on Mann-Whitney U tests(p=0.020) to predict RPLND.

Conclusion
This decade-long review confirms excellent long-term outcomes for patients with testicular GCTs managed at a tertiary centre. Stable orchidectomy rates underscore a consistent disease burden within the population studied. Loss to follow-up remains a challenge, emphasising the need for structured survivorship care. Predictive models utilizing large collaborative datasets may enable earlier, personalized interventions to prevent late failures.

#abs4 | A Rare and Risky Surprise of Immunotherapy: Pembrolizumab-induced Neutropenia in Renal Cell Carcinoma

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Introduction
Immune checkpoint inhibitors (ICI) are being increasingly utilized in the treatment of urological cancers, particularly in recurrent and metastatic bladder and kidney cancer[1]. Recent trials exploring its use in the adjuvant setting of resected renal cell carcinoma (RCC) show promising results[2]. Hematological ICI-related adverse events are uncommon, only accounting for up to 1% of all ICI-related events but have a significant mortality rate of 2-14%[3]. Due to its relative rarity, there are no established recommendations on ICI-related neutropenia and management is often guided by extrapolations from previous case reports[4]. Our case aims to highlight the importance of early recognition and treatment of ICI-related neutropenia.

Methods
We report a case of ICI-related neutropenia in a patient with RCC receiving adjuvant pembrolizumab. Her initial diagnosis, presentation and management of neutropenia were reviewed and discussed. Patient consent was obtained.

Results
A 62-year-old female with stage 4 resected RCC on cycle fifteen of adjuvant pembrolizumab presented with sepsis secondary to tonsilitis. Her bloods demonstrated an isolated grade 4 neutropenia. Initially thought to be secondary to sepsis, she was treated with antibiotics with no improvement in her neutrophil count. She was then suspected to have ICI-related neutropenia which was confirmed on bone marrow biopsy, and subsequently received intravenous methylprednisolone and filgrastim. With ongoing neutropenia by day 5 of treatment, she was also commenced on cyclosporine as well as intravenous immunoglobulin on day 7 and 8. Her counts began to recover on day 8. Her pembrolizumab was ceased and she continues to be closely monitored.

Conclusions
Patients on ICIs who present with neutropenia should be promptly considered to have an ICI-related adverse event. Despite having a rare occurrence, increased awareness amongst health professionals is important to ensure early recognition and treatment to reduce the duration and severity of neutropenia and risk of associated complications.

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#abs5 | A retrospective analysis of clinical profile and outcome of treatment in patients with Denovo Small cell Neuroendocrine carcinoma prostate and Adenocarcinoma prostate with neuroendocrine differentiation in a tertiary center, India

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Introduction and Objectives

Denovo Small cell neuroendocrine carcinoma of the prostate (SCNECP) is a rare aggressive subtype (0.6–1%) with a median survival of 18–20 months, treated using platinum-based chemotherapy and etoposide. Focal neuroendocrine differentiation (NED), seen in 6.1%–75% of prostate adenocarcinomas, lacks specific treatment guidelines and is typically managed with androgen depriving therapy (ADT) and abiraterone and prednisolone (AAP). This study was done to compare overall survival (OS) and progression-free survival (PFS) in SCNECP and focal NED, while also analyzing clinical profiles, age distribution, metastasis patterns, and prognostic factors influencing survival outcomes.

Methods

This retrospective study includes denovo SCNECP and focal NED prostate adenocarcinoma patients treated at Tata Memorial Hospital/ ACTREC Hospital, Mumbai, India. Data from electronic medical record (EMR) will be analyzed for outcomes, survival, and prognostic factors using descriptive statistics, Kaplan-Meier survival analysis, and Cox regression to assess OS, PFS, and clinical correlations.

Results

Between January 2012 and December 2022, data from 37 patients with denovo focal NED prostate adenocarcinoma and 15 with SCNECP were analyzed. Distant metastases were present in 75% of focal NED cases and 80% of SCNECP cases. First-line ADT was administered to 78% of focal NED patients versus 53.3% of SCNECP patients. Median OS was significantly longer in focal NED patients (57.6 months, 95% CI: 34.8 - 80.3) than SCNECP patients (26.5 months, 95% CI: 0-56.48). Median PFS also favored focal NED (25.2 months, 95% CI: 15.94–34.52) over SCNECP (6.5 months, 95% CI: 2.31–11.04), with statistical significance. Notably, 91% of NECP patients received platinum-based chemotherapy, while only 40% of focal NED patients received carboplatin with etoposide.

Conclusion

Although focal NED prostate adenocarcinoma had relatively better prognosis compared to SCNECP, but outcomes are still poor compared to conventional adenocarcinoma prostate. Further studies are needed to identify prognostic markers for selecting patients with focal NED who may benefit from chemotherapy over ADT + AAP in first-line therapy.

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#abs6 | A Review of the diagnosis, treatment and outcomes for Adolescents and Young Adults with testicular Germ Cell Tumours in Queensland from 2017 to 2023

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Cancer remains the leading cause of non-accidental death in Adolescents and Young Adults AYA (15-24 years) with an average of 230 new cancer diagnoses in Queensland each year (QCCAT). Germ cell tumours (GCT) affect 12% of the AYA population in Queensland and are the most common cancer affecting males in this cohort. Overall survival for testicular GCT (tGCT) is excellent, however, patients

in the AYA population fare significantly worse compared to their younger and older counterparts, despite cancer clinical trials (CCTs) being available. The AYA cohort is heavily underrepresented in CCTs, compared to pediatric and adult cohorts, resulting in slow progress in improving survival rates, prevention of collection of valuable biospecimens, and poorer outcomes.

We reviewed the epidemiology of AYA diagnosed with GCT in Queensland between 2017-2023 and aimed to evaluate the incidence, referral pathways, treatment, surveillance, and outcomes of these patients, with particular interest in clinical trial participation. During this time period, Queensland hospitals had open trials for good-, intermediate- and poor-risk GCT as well as a trial for relapsed/refractory patients. We analysed our findings in the context of evidence-based best practise to identify opportunities to improve the standard of care to AYAs with tGCT in Queensland.

A cohort of 193 AYA non-CNS GCT patients (171 males and 22 females) was defined via an initial search of the Queensland Oncology Repository (QOR), a statewide clinical database collating patient demographics, cancer diagnosis and treatment information. 164 of 171 AYA males had testicular primary germ cell tumours. 88 patients (54%) presented with stage 2 or 3 disease. 56 patients presented with metastatic disease, and 83 patients had lymphovascular invasion (37% and 49%, respectively).

At present, 3 or 4 cycles of BEP (bleomycin, etoposide, cisplatin) is considered standard of care (SOC), depending on risk. In those patients that received chemotherapy (n=105) only 67% (n=70) received SOC, which demonstrates inconsistencies in the treatment of AYAs with GCT. These findings have prompted a review of referral pathways and treatment schedules for tGCT in Queensland to understand if there are any reversible delays, system barriers and patient education that can be addressed. The P3BEP trial was open at three quaternary hospitals and AGCT1531 trial was open at one hospital. The enrolment rate across these three hospitals was 57% (8 of 14 patients). Therefore, this is evidence that AYAs offered to participate in a trial are likely to enrol.

#abs7 | Active surveillance – when is enough enough?

Hyerin Park[1], A/Prof Marlon Perera[1,2,3]

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Introduction

Active surveillance remains an important treatment pathway for patients with low to favourable intermediate risk prostate cancer. Despite increasing uptake of active surveillance, there remain ongoing uncertainties regarding when patients are suitable for de-escalation of surveillance intensity. A narrative review was conducted to address this question.

Methods

A narrative review was conducted with keywords including “active surveillance”, “prostate cancer”, “prostate adenocarcinoma”, “watchful waiting”, “de-escalation”, “stop”, “cease”, and “end”. Abstracts were screened for relevance, and references of included studies were also reviewed.

Results

There remains a paucity of evidence to guide this complex decision. However, multiple studies suggest historic favourable disease behaviour should not falsely reassure clinicians or patients when it comes to making this decision. Instead, competing mortality risks should be considered, with suggested groups for de-escalation including patients with a BMI >25kg/m2 and <11% positive cores at initial biopsy, or patients aged >70 years old, BMI >25kg/m2 and <20% positive cores at initial biopsy. The evidence is mixed for using age as a standalone risk factor, and other potential predictive risk factors in isolation have inadequate evidence to support or discourage their use. Individual factors that may guide this decision include patient tolerance of ongoing investigations, anxiety from surveillance or ceasing surveillance, and financial toxicity.

Conclusion

De-escalating active surveillance is a complex decision which should continue to be made on an individual basis with shared decision making. Important factors to consider are competing mortality, namely BMI and tumour volume, as well as patient preferences.

#abs8 | Androgen receptor genomic structural rearrangements reshape the AR cistrome in castration-resistant prostate cancer

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Introduction and Objectives

Prostate cancer cells acquire diverse mechanisms of castration resistance under the selective pressure of treatment. This includes expression of constitutively active androgen receptor (AR) variants. Whether AR variants drive resistance is contested, because they often co-exist with full-length AR. Yet, some tumours with AR genomic structural rearrangements (AR-GSRs) only express AR variants and not full-length AR. Therefore, our objective was to investigate how truncated variants shape the AR cistrome and responses to treatments, with or without full-length AR.

Methods

We selected patient-derived xenografts of prostate cancer from the Melbourne Urological Research Alliance (MURAL) cohort. We compared the landscapes of AR binding using chromatin immunoprecipitation sequencing and transcriptomic profiles using RNA sequencing. We also determined the responses of tumours to castration and bipolar androgen therapy in vivo.

Results

We identified a distinct group of patient-derived models with structural rearrangements of the AR gene. These tumours all expressed ARv567es, a constitutively active AR variant. They had varying levels of full-length AR, depending on the nature of the genomic rearrangements. These tumours had distinctive AR cistrome profiles, gaining some AR binding sites and losing others compared to tumours without AR structural rearrangements. ARv567es-positive tumours also had a different profile of H3K27ac histone marks. Moreover, we defined transcriptional differences, with depletion of canonical AR-regulated gene signatures but enrichment of AR-repressed genes. Consistent with ARv567es having ligand-independent activity, ARv567es-positive tumours were resistant to castration and bipolar androgen therapy. In tumours that co-express full-length AR, this involves disruption of the autoregulatory loop that modulates AR levels.

Conclusions

The emergence of ARv567es through AR gene rearrangements alters the pattern of AR binding, reprograms the transcriptome, and is associated with resistance to therapies targeting the AR ligand-binding domain. Thus, AR genomic structural rearrangements and ARv567es expression are potential markers to guide treatment decisions.

#abs9 | ARCHES 5-year follow-up overall survival analysis of enzalutamide plus androgen-deprivation therapy in patients with metastatic hormone-sensitive prostate cancer

Dr Andrew J. Armstrong, Dr. Daniel P. Petrylak, Dr. Neal D. Shore, Dr. Russell Z. Szmulewitz, Dr. Jeffrey Holzbeierlein, Dr. Arnauld Villers, Dr. Antonio Alcaraz, Dr. Boris Alekseev, Dr. Taro Iguchi, Dr. Francisco Gomez-Veiga, Dr. Ruslan Croitoru, Dr. Ruishan Wu, Dr. Matko Kalac, Dr. Yiyun Tang, Dr. Arnulf Stenzl, **Dr. Arun Azad**

Introduction and objectives

In 2021, the final prespecified overall survival (OS) analysis of the ARCHES trial (NCT02677896) demonstrated that enzalutamide (ENZA)+androgen-deprivation therapy (ADT) significantly reduced the risk of death by 34% versus placebo (PBO)+ADT in patients with metastatic hormone-sensitive prostate cancer (mHSPC). To assess long-term efficacy of ENZA+ADT, we report an updated OS analysis.

Methods

In ARCHES, 1,150 enrolled patients with mHSPC were randomized 1:1 to ENZA+ADT or PBO+ADT. After the primary analysis of radiographic progression-free survival (primary endpoint), ARCHES was unblinded to allow eligible patients receiving PBO+ADT to cross

over to ENZA+ADT in an open-label extension. The Kaplan–Meier method was used to summarize OS by treatment at 61.4 months (cut-off date: 31 July 2024). Hazard ratios (HRs) relative to PBO+ADT were determined using a Cox regression model stratified for prior docetaxel use and disease volume, with two-sided 95% CIs calculated by the Brookmeyer–Crowley method.

Results

The ENZA+ADT (n=574) and PBO+ADT (n=576) cohorts had similar baseline characteristics. 184 (31.9%) PBO+ADT patients crossed over to open-label ENZA+ADT. After a median follow-up of 61.4 months, ENZA+ADT significantly extended survival versus PBO+ADT (medians not reached; HR: 0.70; 95% CI: 0.58–0.85; P=0.0003). Improved OS (HR; 95% CI) was consistent across relevant subgroups: age <65 years (0.63; 0.42–0.93); age ≥65 years (0.73; 0.58–0.91); low-volume disease (0.71; 0.49–1.05); high-volume disease (0.70; 0.56–0.88); no prior docetaxel (0.71; 0.57–0.88); prior docetaxel (0.67; 0.43–1.05); synchronous disease (de novo, ≤90 days) (0.71; 0.57–0.88); and metachronous disease (relapsed, >90 days) (0.66; 0.41–1.08).

Conclusions

Long-term follow-up of ARCHES demonstrated results consistent with previous OS analyses, with marked benefits in all study subgroups, including patients with high- and low-volume disease, despite a substantial cross-over cohort. These findings further support ENZA+ADT as a standard-of-care for patients with mHSPC.

Original research: This abstract reports original research. Clinical trial registration number: NCT02677896

Funding: This study was funded by Astellas Pharma Inc. and Pfizer Inc., the co-developers of enzalutamide.

Acknowledgements: Medical writing and editorial assistance were provided by Arshiya Hakim, Olga Klibanov, Nathaniel Grubbs, and Daria Renshaw from IQVIA, funded by the study sponsors.

#abs10 | Artificial intelligence in predicting biochemical recurrence following radical prostatectomy: A systematic review

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Introduction and objectives

Biochemical recurrence (BCR) following radical prostatectomy (RP) serves as a critical indicator of distant metastases and increased mortality risk in prostate cancer (PCa) patients. This systematic review aims to assess the effectiveness of artificial intelligence (AI) models in predicting BCR after RP.

Methods

A thorough literature search was performed across databases including Medline, Embase, Web of Science and IEEE Xplore, in line with PRISMA guidelines. Studies were included if they utilised AI to predict BCR in patients after RP. Studies were excluded if patients received radiotherapy or salvage RP.

Results

Out of 9,764 articles screened, 24 studies met the inclusion criteria, which involving a total of 27,216 patients, of which 7,267 experienced BCR. AI models incorporating radiological parameters achieved higher predictive accuracy (median AUROC of 0.90) compared to models based only on pathological features (median AUROC of 0.74) or combined clinicopathological factors (median AUROC of 0.81). Evaluation using the Prediction Model Risk of Bias Assessment Tool (PROBAST) revealed an unclear risk of bias in three studies due to unclear inclusion criteria and significant exclusion of patients due to missing follow-up data.

Conclusions

AI shows promise in predicting BCR post-RP, particularly when radiological data was used in its development. These AI algorithms often outperform traditional methods of BCR prediction. However, significant variability in AI performance and study methodologies highlights the need for larger, more standardised prospective studies with external validation prior to clinical application.

#abs11 | Australian, multi-centre assessment of Focal Laser Ablation with ProFocal® in Localised Prostate Cancer

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Introduction
Focal laser ablation (FLA) is an emerging, minimally invasive treatment for localised prostate cancer. ProFocal® device (Medlogical Innovations, Sydney, Australia) is a novel, cooled, focal laser ablation device for prostate cancer with the pivotal PFLT-PC study completed in 2023. We aimed to assess the real-world oncological outcomes in patients undergoing FLA with the ProFocal® device.

Materials and Methods
Following the completion of the PFLT-PC trial, we established a prospective database tracking patients treated with the ProFocal® device across four institutions in Australia. Inclusion criteria were PSA ≤15 ng/mL, clinical stage ≤T2c, ISUP 2–3, and one or two MRI-visible lesions concordant with biopsy findings. Treatment success was assessed by transperineal biopsy at 3 months post-procedure.

Results
The data from 87 patients with a total of 97 MRI-biopsy concordant lesions were analysed. The median age was 67 years (IQR 62–74), PSA 6.0 ng/mL (IQR 4.1–7.1), prostate volume 42cc (IQR 32–57) and MRI lesion volume 0.90cc (IQR 0.5 – 1.35).

All cases were completed as day only procedures. Median treatment duration was 57.4 minutes (IQR 45–75), involving a median of 8 ablations (IQR 7–10) across 4 locations (IQR 3–5).

PSA significantly decreased at 3 months, with a median reduction of 1.05 ng/mL (IQR 0.0–3.4; $p < 0.001$). Follow-up biopsies identified residual cancer (ISUP ≥2) in 17 of the patients. Four patients with infield residual cancer also had ISUP ≥2 in their outfield biopsies, thus overall true treatment failure occurred in 15% of patients.

Conclusions
FLA using the ProFocal® device provides promising oncological outcomes in a multi-centre, real world Australian context, achieving successful infield ablation in 85% of patients with a treatment duration of under one hour, highlighting its efficiency and clinical value.

#abs12 | Avelumab first-line maintenance in advanced urothelial carcinoma: conditional survival and long-term safety in patients treated for ≥1 or ≥2 years in JAVELIN Bladder 100

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Introduction and objectives
In the JAVELIN Bladder 100 phase 3 trial, avelumab first-line maintenance (1LM) + best supportive care (BSC) significantly prolonged overall survival (OS) and progression-free survival (PFS) vs BSC alone in patients with advanced urothelial carcinoma (aUC) that had not progressed with 1L platinum-based chemotherapy (PBC). Here, we report conditional survival estimates and safety in patients treated with avelumab for ≥1 or ≥2 years.

Methods
Eligible patients with aUC without progression after 1L PBC were randomized 1:1 to receive avelumab + BSC (n=350) or BSC alone (n=350). The primary endpoint was OS from randomization. Secondary endpoints included PFS and safety.

Results
Among 350 patients randomized to avelumab + BSC, treatment duration was ≥1 year in 118 (33.7%) and ≥2 years in 68 (19.4%). In patients with ≥1 year of treatment, the probability of an additional 1 or 1.5 years of OS was 93.2% and 86.8%, and an additional 6 months or 1 year of PFS was 77.9% and 66.7%, respectively. In patients with ≥2 years of treatment, the probability of an additional 1 or 1.5 years of OS was 95.8% and 90.3%, and an additional 6 months or 1 year of PFS was 82.9% and 66.7%, respectively. Among patients treated for ≥1 or ≥2 years, any-grade treatment-related adverse events occurred after ≥1 year in 50.0% and after ≥2 years in 35.3% (grade ≥3 in 11.9% and 5.9%, respectively).

Conclusions
Patients with aUC who received ≥1 or ≥2 years of avelumab 1LM in JAVELIN Bladder 100 had a high probability of surviving for an additional 1 year or more. No new safety concerns were identified with longer treatment duration.

#abs13 | Avelumab first-line maintenance in patients with advanced urothelial carcinoma with or without diabetes mellitus: long-term outcomes from JAVELIN Bladder 100

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Introduction and objectives
In the JAVELIN Bladder 100 phase 3 trial, avelumab first-line maintenance (1LM) + best supportive care (BSC) significantly prolonged overall survival (OS) and progression-free survival (PFS) vs BSC alone in patients with advanced urothelial carcinoma (aUC) not progressed with 1L platinum-based chemotherapy (PBC). In some cancers, the presence of diabetes mellitus (DM) is associated with reduced efficacy of immunotherapy; however, data in UC are limited. We report post hoc exploratory analyses from JAVELIN Bladder 100 in patients with or without DM at randomization.

Methods
Eligible patients with aUC without progression after 1L PBC were randomized 1:1 to receive avelumab + BSC or BSC alone. The primary endpoint was OS measured from randomization; secondary endpoints included PFS and safety.

Results
At randomization in the avelumab + BSC (n=350) and BSC alone (n=350) arms, 55 (15.7%) and 59 (16.9%) patients had documented controlled DM, and 295 and 291 patients did not have DM, respectively. Median follow-up in both arms was ≥38.0 months (cutoff, June 4, 2021). In the avelumab + BSC and BSC alone arms, hazard ratios (HR, 95% CI) for OS in patients with or without DM were 0.60 (0.37-0.95) and 0.78 (0.64-0.96), and for PFS (investigator assessed) were 0.50 (0.33-0.77) and 0.54 (0.45-0.65), respectively. In safety analyses of avelumab-treated patients with (n=54) or without (n=290) DM, respectively, any-grade treatment-related adverse events (AEs) occurred in 75.9% and 78.6% (grade ≥3 in 24.1% and 18.6%) and led to discontinuation in 9.3% and 12.1%, and any-grade immune-related AEs occurred in 31.5% and 32.4%.

Conclusions
In exploratory analyses, avelumab 1LM was associated with long-term efficacy and consistent safety in patients with aUC with or without DM.

#abs14 | Beyond Treatment: Listening, Understanding, and Empowering Patients

Dr Po Lin Ooi[1]

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Introduction and Objectives

A 54-year-old gentleman, with an Eastern Cooperative Oncology Group (ECOG) score of 0, was initially diagnosed with right clear cell renal cell carcinoma (RCC) in 2016, staged as pT1bN0M0. Unfortunately, his disease progressed with metastasis to the adrenals and bones, presenting with oligoprogressive disease since 2021. This case illustrates the importance of multidisciplinary team (MDT) involvement in the treatment decision-making process, emphasizing the integration of patient preferences, financial considerations, and systematic adjustments in therapy. The objective is to explore the role of MDT discussions, surgical interventions such as metastatectomy, and individualized adjustments to systemic therapy.

Methods

The patient underwent multiple lines of treatment, including palliative external beam radiotherapy, systemic therapies (pembrolizumab, axitinib, everolimus, lenvatinib), and stereotactic body radiotherapy (SBRT). Regular surveillance with imaging, including MRI and PET-CT, was conducted to assess disease progression. Additionally, next-generation sequencing (NGS) revealed mutations in ARID1A, ATR, and MTOR, influencing treatment decisions. An MDT approach, consisting of oncologists, radiologists, and surgeons, was employed to collaboratively discuss treatment strategies, reflecting on the patient's evolving condition and his input in treatment preferences.

Results

The most recent imaging, including a PET-CT, revealed oligoprogressive disease in the left 7th rib and right femoral head, with soft tissue involvement in the left rib. Given the localized progression and limited disease burden, the MDT, after careful reflection on the patient's wishes and concerns, reached a consensus to proceed with metastatectomy for the lesions in the left 7th rib and right hip. The MDT also recommended delaying systemic therapy to avoid unnecessary toxicities and allow the patient an optimal window for recovery post-surgery, considering his preferences and quality of life.

Conclusions

The involvement of an MDT was pivotal in the decision-making process, ensuring that all relevant perspectives were considered. Listening to the patient's preferences, reflecting on the consensus, and connecting across disciplines allowed for an informed, patient-centered approach. The decision to pursue metastatectomy while delaying systemic therapy aimed at controlling localized progression, improving the patient's quality of life, and minimizing side effects. This case highlights the value of personalized treatment plans and continuous MDT collaboration in achieving the best possible patient outcomes.

#abs15 | Bladder Cancer Staging with Pre-Cystoscopic Multiparametric MRI: A Multicentre Evaluation of the Vesical Imaging Reporting and Data System and Diffusion Kurtosis Imaging

Dr Gerald Mak[1], Dr Ramesh Shanmugasundaram[1], Dr Kenneth Chew[1], Dr Athos Katelaris[1], Ms Khanh Linh Dao[2], A/Prof Claudia Hillenbrand[2], A/Prof Suresh de Silva[3], Prof Daniel Moses[2], A/Prof James Thompson[1]

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Introduction

Accurate assessment of muscle invasion is critical for guiding bladder cancer treatment. Under-staging remains a well-recognised limitation of transurethral resection of bladder tumour (TURBT), even when detrusor muscle is present. Multiparametric MRI (mpMRI) offers a non-invasive tool for staging; the Vesical Imaging Reporting and Data System (VI-RADS) offers a structured approach to determine the likelihood of muscle invasion based on T2-weighted, diffusion-weighted (DWI), and dynamic contrast-enhanced (DCE) imaging. Diffusion kurtosis imaging (DKI), an advanced extension of DWI, may further improve pre-TURBT grading. This study evaluates VI-RADS and DKI in pre-resection bladder cancer staging.

Materials

In this multicentre prospective study, 100 patients with suspicious bladder lesions on ultrasound or CT underwent pre-TURBT mpMRI using a standard protocol. VI-RADS scores were independently

assigned by two radiologists. Diagnostic accuracy was assessed at VI-RADS cutoffs of ≥3 and ≥4. DKI parameters were derived from DWI to calculate mean kurtosis, which was correlated with tumour grade.

Results
Muscle-invasive bladder cancer (MIBC) was present in 23%, 69% had non-muscle-invasive disease and 8% had non-bladder cancer conditions. High-grade tumours were present in 67%, and 72% had pure urothelial carcinoma without variant histology. At VI-RADS ≥4, the sensitivity, specificity, PPV, and NPV for detecting MIBC were 78.3%, 85.7%, 64.3%, and 92.2%, respectively. At ≥3, this was 91.3%, 54.5%, 37.5%, and 95.5% respectively. Inter-reader agreement was strong (□=0.81). Probability of MIBC increased progressively with higher VI-RADS scores, from 0% at a score of 1 to 90.9% at a score of 5. Diffusion kurtosis imaging (DKI) moderately correlated with tumour grade (r=0.44, p=0.058).

Conclusions
Pre-cystoscopic mpMRI using VI-RADS offers strong diagnostic accuracy for identifying MIBC. A low VI-RADS score can reassure clinicians when muscle invasion is not seen on TURBT. Diffusion kurtosis imaging may be a useful adjunct for tumour grading and support more accurate preoperative risk stratification.

#abs16 | Building a predictive model for prostatectomy tumour volume

Dr David Homewood[1,2,3], Mr Prabhpreet Mangat[3], Professor Niall Corcoran[2,3]

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Predicting post-operative tumour volume in prostate cancer can improve surgical planning and risk stratification. This study developed a linear regression model using pre-operative clinical and pathological variables to estimate tumour weight post-prostatectomy. The model explained 61.1% of variance ($R^2 = 0.611$, $F(4, 83) = 32.6$, $p < .001$). Significant predictors included pre-treatment PSA ($\beta = 0.172$, $p < .001$), number of positive biopsy cores ($\beta = 0.359$, $p < .001$), ISUP score ($\beta = 2.500$, $p < .001$), and multifocality ($\beta = 2.043$, $p = 0.005$). Data from 95 patients were analysed, with key variables including age (mean = 63.1 years), PSA (mean = 8.5 ng/mL), MRI tumour volume (mean = 1.71 cc), and percentage of positive cores (mean = 30.3%). The model had low multicollinearity (VIFs < 1.1), though residuals were non-normally distributed (Shapiro-Wilk $p < .001$). These findings suggest that pre-operative factors can estimate tumour volume with reasonable accuracy, informing clinical decision-making. Further refinement using non-linear models or machine learning may improve predictive performance.

#abs17 | Case Presentation and Literature Review: Stromal Sarcoma of the Prostate

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Informed Consent
Written informed consent was obtained from the patient.

Presentation of Case
A 66-year-old male without significant medical comorbidities was initially referred in October 2023 with rapidly progressive lower urinary tract symptoms (LUTS). His symptoms, which had developed over a few months, were severe and unresponsive to medical therapy. PSA level was normal at 1.4ng/ml and digital rectal examination (DRE) was unremarkable.

Ultrasound and cystoscopy were scheduled. The ultrasound, performed in early February 2024, revealed a grossly abnormal 323cc prostate. The flexible cystoscopy demonstrated a grossly enlarged prostate with mass effect from the anterior portion. An urgent MRI later in February 2024 identified locally advanced T4 prostate cancer, and biopsy results confirmed a diagnosis of high-grade stromal sarcoma.

Staging CT in March 2024 indicated multiple lung metastases. The case was reviewed at the sarcoma multidisciplinary team (MDT) meeting, where recommendations were made for palliative chemotherapy and radiotherapy. By April 2024, the patient had received 25 Gy of palliative radiotherapy but experienced significant clinical deterioration, making chemotherapy unsuitable. Consequently, the patient was transitioned to best supportive care.

Objective: This case report highlights the possibility of high-grade prostate cancer even in the presence of normal PSA levels and a normal digital rectal examination.

Literature Review
Stromal sarcoma of the prostate constitutes approximately 0.1% of all prostate cancers. There is a paucity of large-scale studies on prostatic stromal sarcoma, with only a few dozen cases reported in the literature. Common presenting symptoms include urinary tract obstruction and hematuria, with PSA levels typically remaining within normal limits. The primary sites for metastasis are the lungs and bones, and the prognosis is generally poor. Due to its rarity, there is no standardized treatment pathway for this cancer. Rapidly progressive LUTS should prompt consideration of prostatic stromal sarcoma, which may be present despite normal PSA levels and benign digital rectal exam.

#abs18 | Changing landscape of initial real-world treatment of metastatic hormone-sensitive prostate cancer (mHSPC)

Dr Andrisha - Jade Inderjeeth[1,2], Dr Richard Kelly[2,14], Dr Angelyn Anton[2,9,10], Professor Peter Gibbs[2], Dr Julie Johns[2], Dr Liz Liow[2,3], Dr Krishna Rachakonda[4], Dr Mark Warren[5], Dr Annabel Smith[6], A/Prof Christopher Steer[7], Dr Niara Oliveira[8], A/Prof Phillip Parente[9,10], A/Prof Jeremy Shapiro[10], A/Prof Anthony Joshua[11,12], Dr Stephen Brown[13], Prof Arun Azad[14], Dr Shirley Wong[15], Prof Andrew Weickhardt[16], Prof Ben Tran[2,14]

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Introduction and Objectives
mHSPC treatment has evolved from Androgen Deprivation Therapy (ADT) alone or in combination with docetaxel, to current doublet combinations with Androgen Receptor Pathway Inhibitors (ARPI) or ARPI plus docetaxel (triplet). Analysis of real-world data can evaluate uptake of new standards of care and identify factors influencing treatment selection.

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 availability of ARPI (January 2023).

Results
We identified 1537 eligible patients; 1184 prior to and 272 after January 2023. Comparing earlier to later cohorts there were no differences in the proportion with visceral metastases (7% vs 9%), median PSA at ADT initiation (31 vs 38ng/ml) or median age (69 vs 69 years). The earlier cohort had fewer patients with synchronous disease (46% vs 68%,$p< 0.001$), or higher grade histology (Gleason 8-10; 71% vs 81%, $p= 0.004$) and more with ECOG performance status 0-1 (97% vs 93%, $p=0.004$).

After January 2023, ADT was given alone in 18% (from 62% prior), together with ARPI in 61% (from 6%), with Docetaxel in 4% (from 30%) and as triplet in 13% (from 1%). Those receiving triplet were younger (median 63 vs 69 years, $p=0.005$). Of those with synchronous disease and visceral metastases, numerically fewer received triplet compared to doublet, 16% vs 61% and 13% vs 58% respectively.

The most common ARPI was Darolutamide (48%), followed by Enzalutamide(33%) and Abiraterone (27%).

Conclusions
Following ARPI access, the majority of Australian mHSPC patients have received combination treatment, with doublet therapy most common. As accrual increases, ePAD data analysis may identify additional factors influencing treatment selection, while longer follow up will allow comparisons of survival outcomes between groups.

#abs19 | Clinical and genomic profiling of long-term benefiters (LTB) and short-term benefiters (STB) to androgen receptor pathway inhibitors (ARPI) for metastatic hormone-sensitive prostate cancer

Dr Jane McKenzie[1,2], Lauren Howard[1], Joseph Park[1], Bilal Ashraf[1], Tara Seibert[1], Kallie White[1], Sundhar Ramalingham[1], Jeff Shevach[1], Michael Harrison1, Chris Holmes[1], Matthew Labriola[1], Hannah McManus[1], Shahla Bari[1], Daniel George[1], Andrew Armstrong[1]

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Background
In clinical practice, a subset of patients treated with androgen deprivation therapy (ADT) plus ARPI for metastatic hormone-sensitive prostate cancer (mHSPC) achieve prolonged benefit (LTB) while others experience early resistance (STB).

Methods
A review of Duke Health patients prescribed ARPI from 2015–2024 was conducted. LTB and STB were defined by upper and lower quartiles of duration of ARPI clinical benefit (DoCB; ARPI start to discontinuation for progression or next therapy). Temporal molecular testing was defined as tissue or blood ctDNA testing prior to ARPI commencement or within 3mo if STB or 6mo if LTB. Standard of care use of docetaxel was allowed. The primary objective was to associate baseline molecular profiles and clinical factors with LTB vs STB status. This analysis focusses on the subset treated for mHSPC.

Results
Of 3,363 prescribed an ARPI, 749 (22%) had any tumour molecular data registered. Of the 291 treated for mHSPC, 62 had temporal molecular testing (84% Foundation CDX of tumour tissue) and met upper quartiles for LTB (n=34; >35mo) or STB (n=28; <11.3mo). Expectedly, median time to castrate-resistance (70mo vs 6.1mo) and OS (NR vs 18mo) was longer for LTB vs STB patients. All LTB patients achieved PSA50 and PSA90 responses, compared to 93% and 75% of STB, respectively. Clinical predictors of LTB included ECOG 0, low disease volume, and lack of pain, anemia, raised ALP or low albumin. Adjusting for a 10% false discovery rate, a lack of TP53 or any tumour suppressor (TP53, RB1, PTEN) alteration, lack of MYC gain, and presence of APC mutation were associated with LTB to ARPI therapy. On multivariate analysis, ECOG 0, lack of liver metastases or anemia, and lack of TP53 alteration independently associated with LTB.

Conclusions
In this real-world, selected cohort of long-term and short-term benefiters to ARPI, pre-treatment clinical and molecular predictors of patient benefits and survival were identified.

#abs20 | Clinical Registry Protocol for FIREFLY: A Clinical Registry of Focal Irreversible Electroporation in Men with Biopsy Confirmed Low-Intermediate Risk Prostate Cancer

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Introduction and objectives
Focal irreversible electroporation (IRE) for prostate cancer (PCa) appears to be a safe, feasible option in carefully selected patient cohorts, but robust evidence to support its efficacy and optimal utilisation is still maturing.

Methods
A prospective, single-centre, clinical research registry.

Primary objectives
1. Determine the rate of 18 to 36-month local disease control
2. Determine the rate of 5-year biochemical progression-free survival.

Secondary objectives
1. Measure the change in clinician-reported quality-of-life
2. Measure the change in patient-reported generic and disease-specific quality-of-life
3. Determine the rate of salvage treatment.

Eligibility criteria
Age 40-85 years, life expectancy >10 years, PSA <15 ng/ml, clinical stage T1c/T2a, PIRADS score 3-5 or suspicious lesion on PSMA-PET, imaging-

concordant ISUP 1 (≥10mm in ≥1 core) or ISUP 2 (any length) or ISUP 3 (longest core <10mm) prostate adenocarcinoma, and template biopsies of remaining gland showing either no cancer or clinically insignificant PCa (<10mm ISUP 1).

All patients will undergo initial mpMRI or PSMA-PET, followed by targeted and template transperineal prostate biopsy.

Oncological outcomes will be assessed by performing PSA testing at six weeks, followed by three-monthly. Repeat mpMRI and/or PSMA-PET will be performed per-protocol 18 months post-treatment, or earlier if indicated.

Functional outcomes will be assessed with CTCAE and quality-of-life questionnaires at baseline, six weeks, followed by six-monthly.

Results
Ethics approval has been received. Patient recruitment opened in March 2025, with a target of 100 patients. Statistical analyses will include: comparisons between patients with pathological progression and control, multivariable logistic regression analysis to identify predictors of pathological progression, and Kaplan-Meier analyses to evaluate freedom from pathological progression and salvage treatment.

Conclusions
This is the first registry exploring focal IRE treatment in an Australian public hospital. It aims to contribute to the growing body assessing the feasibility/safety of focal IRE treatment and its oncological/functional outcomes.

#abs21 | Comparison of 18F-based PSMA radiotracers with [68Ga]Ga-PSMA-11 in PET/CT imaging of prostate cancer-a systematic review and meta-analysis

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Introduction and objectives
Prostate-specific membrane antigen (PSMA) positron emission tomography (PET)/computed tomography (CT) has become an increasingly established imaging modality in the staging of prostate cancer (PCa). Numerous PSMA-based tracers are currently available, however, there is a lack of consensus on the optimal radiotracer(s) for PSMA PET/CT. This study aims to investigate whether Fluorine-18 (18F)-labelled PSMA PET/CT is significantly different from Gallium-68 (68Ga) in primary diagnosis and/or secondary staging of prostate cancer following biochemical recurrence.

Methods
A critical review of MEDLINE, EMBASE, PubMed and Web of Science databases was performed in May 2023 according to the Preferred Reporting Items for Systematic Review and Meta-analysis (PRISMA) statement. Studies that directly compared 18F-based PSMA radiotracers and [68Ga]Ga-PSMA-11 in terms of the normal organ SUV or the lesion SUV or the detection rate were assessed. Quality was assessed using the Quality Assessment of Diagnostic Accuracy Studies-2 (QUADAS-2).

Results
Twenty-four studies were analysed. [18F]DCFPyL and [18F]PSMA-1007 were the two most commonly studied 18F based PSMA tracers. [18F]JK-PSMA-7, [18F]rhPSMA-7, [18F]AlF-PSMA-11 were the new tracers evaluated in a limited number of studies. Overall, [18F]DCFPyL was observed to have a similar lesion detection rate to [68Ga]Ga-PSMA-11 with no increase in false positive rates. [18F]PSMA-1007 was found to have a greater local lesion detection rate because of its predominant hepatobiliary excretory route. However, [68Ga]Ga-PSMA-11 was observed to have a similar local lesion detection rate in studies that administer patients with furosemide prior to the scan. In addition, [18F]PSMA-1007 was found to have a significant number of benign bone uptakes.

Conclusions
[18F]DCFPyL was observed to be similar to [68Ga]Ga-PSMA-11. [18F]PSMA-1007 was observed to be less preferrable to [68Ga]Ga-PSMA-11 due to its high benign bone uptakes. Overall, there was not enough evidence in differentiating the radiotracers based on their clinical impacts.

#abs22 | Cystoscopic application of a haemostatic agent - RADA16 Self-assembling peptide (Purastat®) for refractory haematuria from radiation cystitis: a novel surgical technique.

Dr Jonathan Kam[1,2,3], Francesco Del Guidice[2], Yasmin ABU-GHANEM[2], Elsie MENSAH[2], Rajesh NAIR[2], Muhammad Shamim KHAN[2], Ramesh THURAIRAJA[2,4]

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Introduction
Haematuria from radiation cystitis following radiation therapy for prostate cancer can be very difficult to manage. RADA16 (Purastat®) has an established use in radiation proctitis causing regression of radiation induced telangiectasia in the bowel.

We describe our initial experience using cystoscopic application of RADA16 for radiation cystitis in patients with refractory haematuria referred to our specialist radiation cystitis service.

Methods
Patients referred to our specialist radiation cystitis service with refractory haematuria were offered this novel treatment option. All these patients had already failed standard management requiring hospital admissions, bladder irrigation and/or endoscopic management with diathermy or laser.

Patients were taken to operating theatres under general anaesthesia where a standard cystoscopy was performed. Active bleeding was controlled with either diathermy or laser ablation. Fluid was evacuated from the bladder and the bladder insufflated with CO2 to a pressure of 8-15mmH2O to obtain adequate visualisation of the radiation affected regions of the lower urinary tract. RADA16 was then applied to the affected regions via a ureteric catheter. This was left for 5 minutes after which the bladder was emptied. A catheter was left at the discretion of the operating surgeon.

Results
A total of 17 RADA16 peptide treatments were administered to 15 patients between Feb to Oct 2024. Median age was 75 (Range 54-91years) and median time from radiotherapy 7 years (1.5-17). All patients were male and had radiation therapy for prostate cancer (47% primary and 53% adjuvant/salvage treatment). 5 (33%) patients required prior blood transfusions, and 1 patient had 16 units transfused prior to transfer to our centre. 7 (47%) had previous surgical intervention for haematuria.

14 (93%) patients had significant reduction in their haematuria at 6 weeks while 7 (47%) having complete resolution of haematuria. Clavien-Dindo 90-day complications were 1 (7%) - Grade 1 retention, 3 (20%) – Grade 2 blood transfusion, 4 (27%)- Grade 3 Surgical intervention under general anaesthetic. 1 patient required cystodiathermy to bleeding from the prostatic fossa from a concurrent TURP performed at time of RADA16 application. 2 patients required repeat applicaiton of RADA16 and 1 patient required salvage cystectomy for ongoing bleeding. No other patients required readmissions to hospital.

Conclusion
Cystoscopic application of RADA16 for radiation cystitis is a promising treatment for patients with refractory haematuria. Further study is required to assess its long-term outcomes and whether repetitive applications (which are used for radiation proctitis) can improve durability of these results.

#abs23 | DARO-LIPID (ANZUP2205): A randomised phase 2 study of sphingosine kinase inhibitor (opaganib) with darolutamide in poor prognostic metastatic castration resistant prostate cancer (mCRPC) based on a circulating lipid biomarker, PCPro

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Introduction and objectives
Metastatic castration resistant prostate cancer (mCRPC) may exhibit intrinsic resistance to various therapies, or develop resistance over time. Our previous studies have shown that elevated circulating sphingolipids, including ceramides, are associated with shorter progression free survival (PFS) and shorter overall survival (OS) in mCRPC after treatment with docetaxel or androgen receptor pathway inhibitors (ARPI). We have developed a NATA-compliant plasma lipid biomarker (PCPro), including ceramides, that can identify people with mCRPC who have a poor prognosis and resistance to ARPIs.

Ceramides are metabolised into sphingosine-1-phosphate, which promotes cancer growth, metastasis and drug resistance through regulation of cell proliferation, survival and immune processes. Inhibition of the ceramide-Sphingosine-1-Phosphate axis, through the sphingosine kinase inhibitor opaganib, suppresses prostate cancer growth in vitro and ex vivo and overcomes ARPI resistance. Opaganib is orally bioavailable and well-tolerated.

We hypothesise that patients with mCRPC with de novo ARPI resistance, as indicated by PCPro positivity at baseline, will benefit from the addition of a sphingosine kinase inhibitor to their ARPI.

Method
Participants with treatment naïve mCRPC will be screened for PCPro. PCPro positive participants will be randomised 1:1 to receive darolutamide with opaganib or placebo, in combination with androgen deprivation therapy/bilateral orchidectomy (n=60). Treatment will continue until progression. There will be a pharmacokinetic study of the initial 20 randomised participants. The primary objective is 12-month radiographic-PFS. The secondary objectives are PSA PFS, OS and quality-of-life changes. Translational outcomes include changes in the circulating lipidome and drug-drug interactions between opaganib and darolutamide.

Results
The study has HREC approval and drug delivery is expected in April. We are planning to open all 15 sites in Australia and New Zealand during 2025.

Conclusion
The DARO-LIPID study will evaluate a novel strategy of lipid targeted therapy in a metabolically selected population, to address de novo ARPI resistance.

#abs24 | De-escalation Therapy in Metastatic Prostate Cancer: A Retrospective Study on Intermittent ARPI Treatment

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Background
Androgen deprivation therapy (ADT)1 in combination with Androgen receptor pathway inhibitors (ARPI)s are the initial approach for treating metastatic prostate cancer (mPCa)2–9.

ARPIs used in the treatment of prostate cancer can have several life changing adverse effects including cardiovascular events, bone health issues, metabolic changes, sexual dysfunction, vasomotor symptoms cognitive and emotional changes10. Currently, all the studies that established the practice of ARPI and ADT combinations have continued treatment until disease progression. However, this approach incurs both significant clinical and financial toxicity11,12.

One established approach for decreasing toxicity is intermittent drug treatment13.

Our study primary objective was to examine the clinical outcomes of patients who underwent a treatment break due to non-progressive disease.

Methods
This retrospective, single-centre study included 60 mPCa patients treated with ADT+ARPI for ≥12 months. Treatment breaks were initiated based on favourable response: PSA decline, clinical assessment, PET/PSMA scan.

At progression, patients were offered re-challenge,

surveillance, or focal radiation treatment.
Primary outcome was treatment-free survival (TFS). Rechallenge response was assessed upon progression. All patients had a treatment-free follow-up of at least 6 months.

Results

Patients (median age 69; 75% metastatic hormone-sensitive mPCa) received initial ARPI (80% abiraterone) for median 26 months. Following treatment break, mTFS was 25 months (95% CI 20.8–28.8). Significantly longer TFS was associated with testosterone recovery (p=0.016), Prostate-Specific Antigen (PSA) nadir <8 months (median 35 vs 15 mo, p=0.007), PET PSMA complete response (CR) (median NR) vs 20.5 mo, p=0.028), and prior prostate radiotherapy (RT) (median 35 vs 19 mo, p=0.007). Upon progression, rechallenge response rate was high at 95% (19/20 patients).

Conclusions

Intermittent ADT+ARPI therapy appears feasible in selected mPCa patients. Selection may be guided by predictors of longer TFS (testosterone recovery, rapid PSA nadir, PET PSMA CR, prior prostate RT). This strategy could potentially reduce treatment burden and toxicity.

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#abs25 | Developing a Targeted Plasma DNA Methylation Panel for Early Prostate Cancer Detection

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Introduction

Prostate cancer (PCa) represents a major health burden globally, with over 1.4 million annual diagnoses and almost 400,000 PCa-related deaths. Current approaches to PCa screening and diagnosis are suboptimal, creating challenges for the accurate detection of clinically important PCa. Hence, there is an urgent need for novel, accessible, and clinically deployable biomarkers to optimise PCa care. Circulating tumour DNA (ctDNA) is a minimally invasive, highly specific technology that identifies the presence of a tumour using plasma-derived cell-free DNA (cfDNA). DNA methylation changes are a universal hallmark of cancer that dynamically influence gene expression. We, and others, have shown that ctDNA-based epigenetic alterations are higher in number, potentially enabling earlier tumour detection than genetic mutation analysis. Analysis of the cell-free DNA methylome, therefore, represents an exciting avenue for the development of highly accurate biomarkers for early PCa detection.

Methods

In this multicentre, prospective discovery study, we have performed whole-genome scale DNA methylation profiling of matched patient blood and prostate biopsy tissue samples. Men scheduled to undergo prostate biopsy for clinical suspicion of PCa were recruited from several localities across New Zealand, with matched pre-biopsy peripheral blood samples and prostate biopsy tissue collected for molecular profiling. Unbiased, whole-genome scale DNA methylation profiling for both plasma cfDNA and tissue samples was performed using cell-free reduced representation bisulfite sequencing (cfRRBS).

Results
Over 200 differentially methylated regions (DMRs) differentiating malignant from benign and healthy samples have been identified from early profiling results of cfDNA samples, demonstrating significant discriminatory power for PCa detection at very early-stage disease. PCa-specific DMRs have also been identified from prostate tissue samples – interestingly, however, the most predictive tissue-derived DMRs cluster distinctly from those detected in cfDNA, even in matched patient samples.

Conclusions
Early profiling results show promise for cfRRBS as a discovery approach for cell-free DNA-based methylation biomarkers, with high prospective utility in the setting of PCa detection. Profiling results will be further refined and correlated to clinical and histopathological features of disease severity to generate a blood-based, targeted methylation panel for early and accurate PCa detection.

#abs26 | Early Implementation of a Digital Care Model in Prostate Cancer Management

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Introduction & Objectives
Prostate cancer (PCa) survivorship requires long-term management involving multiple healthcare providers. Digital health tools offer an opportunity to streamline care and enhance patient outcomes. This study reports the early experience with a digital care model at a single site, focusing on the development and implementation of a nurse-led post-surgical surveillance protocol and an active surveillance (AS) algorithm for patients with low to intermediate-risk PCa. The primary objective was to evaluate the feasibility and usability of the model using the User Version of the Mobile Application Rating Scale (uMARS). Secondary outcomes include treatment adherence, anxiety (PCFA distress thermometer, GAD7), and treatment escalation.

Methods
The Steera digital platform was integrated into two care models: an established nurse-led post-operative surveillance protocol and a newly developed digital AS protocol. The platform enabled seamless communication between patients, general practitioners (GPs), and specialists. Usability and patient engagement were assessed via the uMARS and PROMs, while clinician satisfaction was measured using the System Usability Scale (SUS). Data on platform usage, technical integration, and feedback from multidisciplinary team assessments were also collected.

Results
A total of 55 patients were enrolled (30 post-operative, 25 AS). The platform demonstrated high usability scores. The AS protocol effectively generated patient treatment plans improving monitoring efficiency and patient experience. Urology clinic workload was reduced by 50% due to shared care between clinicians.

Conclusions
This initial experience highlights the feasibility and usability of a digital care model for PCa management at a single site. The platform enhances care coordination and supports both post-surgical surveillance and AS models. Further evaluation is required to assess scalability and long-term outcomes.

#abs27 | EORTC GUCG 2418: "Strategies for Treatment Adaptation following Re-evaluation of the Bladder after using pRimary neoadjuvant Systemic Therapies" (STARBURST-1): an EORTC platform trial

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Introduction and objectives
The standard treatment for patient with muscle-invasive bladder cancer (MIBC) consists of neoadjuvant systemic therapy (NAT) followed by radical cystectomy (RC) or trimodal therapy (TMT).

Currently, patients are not routinely reassessed after NAT and proceed directly to local treatment, leading to a missed opportunity for patients with complete or near complete response to benefit from bladder sparing strategies. On the other hand, for the non-responders, it is a missed opportunity for escalation strategy with systemic treatment. Unfortunately, several studies have shown an insufficient concordance between the clinical and pathological staging of MIBC, unraveling the inadequacy of the current methods for clinical staging post-NAT.

The STARBURST project aims to refine the bladder cancer treatment landscape in two successive steps. First, SB-1 study aims to develop and validate a clinical multimodal signature to enhance the prediction of the systemic treatment response. Second, SB-2 will be developed as a risk-adapted strategies trial based on the response post NAT.

Here below, we present the methodology of SB-1.

Methods

SB-1 is a prospective, phase II, single arm cohort of 237 patients with newly diagnosed MIBC (pT2-pT4a N0-1 M0).

- All patients will be treated with standard of care NAT followed by RC.
- All patients will be assessed before NAT by a cystoscopy, urine cytology, bladder multiparametric MRI (mpMRI) (Vi-RADS score), blood and urine samples (ctDNA,utDNA and multiplex urine molecular biomarkers).
- After completing the NAT, every patient will be reassessed by a cystoscopy (+/- biopsy), a bladder mpMRI (NAcVI-RADS score) and by urinary and blood markers.

The primary endpoints of SB-1 is to prospectively validate:

- The accuracy of the NacVI-RADS score to predict the pathological complete or near complete response defined as the absence of residual disease or the absence of muscle invasive disease on the cystectomy specimen (ypT0 or ypTa/1)
- To predict the absence of muscle invasive disease (ypT2 vs ypT0/a/1) assessed by the negative predictive value (NPV), the positive predictive value (PPV) and the receiver operating curves (ROC).

Secondary endpoints include the assessment of new biomarkers including blood circulating tumor DNA (ctDNA) and urine tumor DNA (utDNA), urines multiplex biomarkers, pathomics, radiomics and molecular alterations that could predict the pathological response.

Conclusions

The EORTC GUCG 2418 STARBURST-1 project offers a unique opportunity to define and validate a clinical multimodal signature of response to NAT properly and further offer patients downstream risk-adapted strategies.

NCT02834884

#abs28 | Evexomostat (SDX-7320), a methionine aminopeptidase-2 inhibitor, potently suppresses cell cycle and plasticity regulators in castrate-resistant prostate cancer.

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Metastatic prostate cancer (mPCa) is treated with androgen receptor-targeted therapies that provide incremental improvements in survival, but resistance remains a serious clinical issue. Methionine aminopeptidase-2 (MetAP2) is a multi-functional metalloprotease responsible for N-methionine excision, whose expression has been linked to both grade and stage of prostate cancer [1]. We have previously demonstrated that the MetAP2 inhibitor, SDX-7320 (evexomostat), developed by SynDevRx [2] potently suppressed tumour growth in a range of preclinical models of androgen-sensitive, castrate-resistant (CRPC), enzalutamide-resistant and neuroendocrine PCa (NEPC). However, the tumour-specific mechanisms underpinning tumour growth suppression across these disease stages are largely unknown. We aimed to identify the mechanisms of action of MetAP2 inhibition, to inform utilization of evexomostat as sequential or combination therapy, guide patient selection and expand our knowledge of PCa biology.

Tumours from treated animals from 5 preclinical models, including LNCaP models of androgen-

sensitive PCa and CRPC, LUCaP.35CR models of CRPC and enzalutamide-resistant CRPC, and LTL545 model of NEPC, were collected for analysis. Tumour tissues underwent RNA sequencing to identify differentially expressed gene signatures with evexomostat treatment, subsequently validated through western blotting.

We found a significant reduction in early region 2 binding factor (E2F) signalling in LNCaP and LuCaP.35CR models, likely mediated by a reduction in phospho-retinoblastoma (p-Rb) protein. Furthermore, we found significant reductions in the oncogenic drivers C-Myc and the enhancer of zeste homolog 2 (EZH2). The canonical function of EZH2, marked by the trimethylation of H3K27, was also reduced. Remarkably, the downregulation of C-Myc and EZH2 was also observed in our NEPC model, suggesting a consistent effect of MetAP2 inhibition. Our work propounds that suppression of proliferation, mediated through inhibition of p-Rb/E2F signalling, may account for CRPC tumour suppression with evexomostat. Downregulation of c-Myc and EZH2 indicates alterations in plasticity signalling, which have important implications in disease progression and treatment resistance.

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#abs29 | Evolocumab in Metastatic Castration-Resistant Prostate Cancer – preliminary results

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Introduction

PCPro is a clinically accessible, NATA-compliant plasma lipid biomarker of poor overall survival (OS) in metastatic castration-resistant prostate cancer (mCRPC)1 and metastatic hormone-sensitive prostate cancer (mHSPC)2. It is also predictive for lack of OS benefit from enzalutamide in mHSPC2. We hypothesise that modulating PCPro with lipid-targeted therapy may improve OS in metastatic prostate cancer. This study aims to evaluate whether PCPro can be modulated using the PCSK9-inhibitor evolocumab in mCRPC.

Methods

In this multi-centre, open label phase 2 trial, men with mCRPC commencing standard-of-care anti-cancer therapy for disease progression were screened for PCPro status. Those who tested positive (poor prognosis) received a 12-week course of evolocumab concurrent with their standard therapy. Evolocumab dosage was as per cardiovascular guidelines (420mg subcutaneously every 4 weeks). PCPro status was re-evaluated after evolocumab treatment. Primary endpoint is alteration of PCPro from a positive to a negative status. Secondary endpoints are study feasibility and safety.

Preliminary results

To date, 56 participants were screened, of whom 12 were positive for PCPro (21%). A pre-specified two-week turnaround between screening and dissemination of results was met in 55 of the 56 participants (98%; median time: 8 days, range 1-18). Of the 12 who were PCPro-positive, 3 died prior to commencement of evolocumab and 1 died after cycle 1, all due to progressive mCRPC. Three remain on evolocumab. Five completed evolocumab treatment, of whom 4 remained PCPro-positive after treatment. Five serious adverse events requiring hospitalisation were reported, all of which were related to the concurrent standard-of-care therapy.

Conclusion
It is feasible to use PCPro to prospectively select participants for lipid-targeted therapy. PCPro status was modulated in 1/5 participants after a 12-week course of evolocumab. An interim analysis to determine clinical benefit from addition of evolocumab is planned after 10 participants have completed treatment.

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#abs30 | Final overall survival with talazoparib plus enzalutamide as first-line treatment in patients with homologous recombination repair–deficient metastatic castration-resistant prostate cancer in the Phase 3 TALAPRO-2 trial

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Introduction and objectives
Approximately one-quarter of advanced prostate cancers have alterations in DNA damage response genes directly or indirectly involved with homologous recombination repair (HRR) that can sensitize them to treatment with poly(ADP-ribose) polymerase inhibitors. TALAPRO-2 (NCT03395197) demonstrated significantly improved radiographic progression-free survival (rPFS) for first-line talazoparib plus enzalutamide vs placebo plus enzalutamide in HRR-deficient patients with metastatic castration-resistant prostate cancer (mCRPC). We report final overall survival (OS), a descriptive rPFS update, and extended safety data in the HRR-deficient cohort.

Methods
Patients with HRR-deficient tumors were randomized 1:1 to talazoparib 0.5 mg or placebo, plus enzalutamide 160 mg/day, stratified by prior abiraterone/docetaxel. Primary endpoint was rPFS by blinded independent central review. OS was an alpha-protected key secondary endpoint (alpha-threshold 0.024 [two-sided]).

Results
At median follow-up of 44.2 months (cutoff Sept 3, 2024), OS was significantly improved with talazoparib plus enzalutamide (n=200) vs placebo plus enzalutamide (n=199) (hazard ratio [HR]=0.622; 95% CI, 0.475–0.814; P=0.0005; median 45.1 vs 31.1 months). In exploratory analyses, OS favored talazoparib plus enzalutamide in patients with BRCA1/2 alterations (n=155; HR=0.497; 95% CI, 0.318–0.776; P=0.0017) and patients without BRCA1/2 alterations (n=244; HR=0.727; 95% CI, 0.516–1.024; P=0.0665). Updated rPFS favored talazoparib plus enzalutamide (HR=0.468; 95% CI, 0.359–0.612; P<0.0001; median 30.7 vs 12.3 months). Consistent with primary results, common grade 3–4 adverse events with talazoparib plus enzalutamide were anemia (43%) and neutropenia (20%). Adverse events were generally manageable; 26 patients (13%) discontinued talazoparib due to adverse events.

Conclusions
Combining talazoparib with enzalutamide significantly improved OS in patients with HRR-deficient mCRPC. rPFS continued to favor talazoparib plus enzalutamide. No new safety signals were identified.

#abs31 | Final overall survival with talazoparib plus enzalutamide as first-line treatment in unselected patients with metastatic castration-resistant prostate cancer in the Phase 3 TALAPRO-2 trial

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Introduction and objectives
TALAPRO-2 (NCT03395197) demonstrated significantly improved radiographic progression-free survival (rPFS) for first-line talazoparib plus enzalutamide vs placebo plus enzalutamide in patients with metastatic castration-resistant prostate cancer (mCRPC) unselected for homologous recombination repair (HRR) gene alterations. We now report final overall survival (OS), a descriptive rPFS update, and extended safety in the unselected cohort.

Methods
Patients were randomized 1:1 to talazoparib 0.5 mg or placebo, plus enzalutamide 160 mg/day, stratified by prior abiraterone/docetaxel and HRR status. Primary endpoint was rPFS by blinded independent central review. OS was an alpha-protected key secondary endpoint (alpha-threshold 0.022 [two-sided]).

Results
At a median follow-up of 52.5 months (cutoff Sept 3, 2024), OS was significantly improved in unselected patients receiving talazoparib plus enzalutamide (n=402) vs placebo plus enzalutamide (n=403) (hazard ratio [HR]=0.796; 95% CI, 0.661–0.958; P=0.0155; median 45.8 vs 37.0 months). OS favored talazoparib plus enzalutamide in HRR-deficient (n=169; HR=0.549; 95% CI, 0.364–0.826; P=0.0035) or HRR–non-deficient/unknown (n=636; HR=0.878; 95% CI, 0.713–1.080; P=0.218) subgroups. In exploratory analyses of patients with both circulating tumor DNA and tumor tissue results, OS favored talazoparib plus enzalutamide in patients without BRCA1/2 alterations (n=439; HR=0.749; 95% CI, 0.582–0.963; P=0.024) and in patients without HRR alterations (n=314; HR=0.782; 95% CI, 0.582–1.050; P=0.101). Updated rPFS favored talazoparib plus enzalutamide (HR=0.667; 95% CI, 0.551–0.807; P<0.0001; median 33.1 vs 19.5 months). Consistent with primary results, common grade ≥3 adverse events with talazoparib plus enzalutamide were anemia (49%) and neutropenia (19%).

Conclusions
Combining talazoparib with enzalutamide significantly improved OS in patients with mCRPC unselected for HRR gene alterations. rPFS continued to favor talazoparib plus enzalutamide. No new safety signals were identified.

#abs32 | Five-year follow-up results from the phase 3 KEYNOTE-564 study of adjuvant pembrolizumab for the treatment of clear cell renal cell carcinoma (ccRCC)

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Background
We present results from the fourth prespecified interim analysis of KEYNOTE-564 (NCT03142334) with a minimum follow-up of 5 years.

Methods
KEYNOTE-564 is a randomized, double-blind, placebo-controlled, phase 3 study, which enrolled adults with ccRCC with intermediate-high or high recurrence risk or M1 with no evidence of disease who had nephrectomy and/or metastasectomy ≤12 weeks before 1:1 randomization to pembrolizumab 200 mg or placebo IV Q3W. Treatment continued for ~1 year (17 cycles) or until recurrence, intolerable AEs, or physician decision to discontinue treatment. The primary endpoint was DFS by investigator; the key secondary endpoint was OS. The study met its DFS and OS objectives at earlier analyses; no subsequent formal statistical testing occurred. AEs were collected for 30-90 days after treatment cessation depending on severity, with serious treatment-related AEs collected regardless of timing.

Results
994 participants were randomized to pembrolizumab (n=496) or placebo (n=498). Median follow-up time to data cutoff date (25 Sept 2024) was 69.5 months (range, 60.2–86.9). All participants completed or discontinued study treatment ≥3 years earlier. Median DFS was not reached (NR) for the pembrolizumab group vs 68.3 months for the placebo group (HR 0.71, 95% CI 0.59–0.86); estimated DFS rate at 5 years was 60.9% vs 52.2%, respectively. 68 OS events in the pembrolizumab group and 99 in the placebo group had occurred. Median OS was NR in both arms (HR 0.66, 95% CI 0.48–0.90); estimated OS rate at 5 years was 87.7% vs 82.3%, respectively. DFS and OS outcomes were consistent across key subgroups. No new serious treatment-related AEs have been reported for ≥3 years.

Conclusions
With ≥5 years of follow-up, the benefits observed with adjuvant pembrolizumab vs placebo are consistent with prior analyses. No new serious treatment-related safety signals occurred. Adjuvant pembrolizumab remains a standard-of-care for participants with ccRCC at increased recurrence risk.

#abs33 | Focal Laser Ablation in Prostate Cancer: A systematic review and meta-analysis

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Introduction
Management of localised prostate cancer ranges from active surveillance, which carries risks of disease progression, to whole-gland treatment, which is associated with significant functional morbidity. Focal laser ablation (FLA) offers a targeted approach to tumour destruction while preserving surrounding tissue. This review aimed to evaluate the oncological control and functional outcomes of FLA in prostate cancer.

Materials and Methods
This systematic review and meta-analysis was conducted in accordance with the Preferred Reporting Items for Systematic Review and Meta-Analysis (PRISMA) guidelines. An electronic literature search was conducted to identify all relevant studies evaluating FLA for localised prostate cancer. The primary outcome was oncological control, assessed through recurrence at follow-up biopsy and reduction in PSA. Secondary outcomes included functional outcomes, specifically sexual function and urinary symptoms, which were assessed by the Sexual Health Inventory For Men (SHIM) score and International Prostate Symptom Score (IPSS).

Results
The search identified 12 studies for inclusion. A total of 421 patients underwent FLA for localised prostate cancer. The rate of recurrence of clinically significant cancer (ISUP ≥2) on initial biopsy following FLA (range 3-12 months) was 15% (95% CI 11% to 21%). The mean reduction in PSA at 12-months post-FLA was 2.3 ng/ml (95% CI 1.5 to 3.2). There was a change in SHIM scores post-operatively of -1.9 (95% CI -2.9 to -0.88), which was statistically significant (p <0.001), but not clinically significant (Cohens d = 0.29). There was no statistically significant change in urinary function following FLA.

Conclusion
The present systematic review and meta-analysis found that FLA provides oncological control comparable to other focal therapies while preserving functional outcomes. However, the limited availability of high-quality comparative studies highlights the need for further robust studies to validate these findings.

#abs34 | From hormone blockade to cardiac blockage: The risk of myocardial infarction on abiraterone acetate

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Introduction
Abiraterone acetate (AAP), an androgen biosynthesis inhibitor, has shown survival benefits in high-risk prostate cancer when added to androgen deprivation therapy (ADT), as demonstrated in the STAMPEDE trial. However, both ADT and AAP are associated with cardiovascular toxicities, particularly in patients with underlying comorbidities. We report a case of significant coronary artery disease in a patient treated with AAP and ADT for high-risk prostate cancer.

Case summary
A 68-year-old man with a history of hypertension, diabetes mellitus, and dyslipidaemia was found to have a raised prostate-specific antigen (PSA) of 13 ng/mL. Magnetic resonance imaging revealed bilateral PIRADS 5 lesions with seminal vesicle involvement. Biopsy confirmed Gleason 4+3 prostate adenocarcinoma. He was staged as non-metastatic based on computed tomography and bone scan. Multidisciplinary consensus recommended curative-intent treatment with ADT, radiotherapy to the prostate (60 Gy in 20 fractions), and AAP for two years.

Results
ADT commenced in December 2022, followed by AAP in January 2023 and radiotherapy in June 2023. PSA declined to undetectable levels by May 2023. In September 2024, he developed reduced effort tolerance and was diagnosed with unstable angina. Coronary angiography revealed triple-vessel disease, requiring coronary artery bypass grafting in January 2025. AAP and ADT were discontinued in October 2024 after 22 months. PSA remained undetectable as of March 2025.

Discussion & Conclusion
Both ADT and AAP are associated with increased cardiovascular risk. Meta-analyses show AAP increases the risk of high-grade cardiac events by 84% and nearly doubles the risk of hypertension. ADT independently increases myocardial infarction risk by up to 31%. This case underscores the importance of baseline cardiovascular risk stratification and proactive monitoring during treatment with combined hormonal and intensification strategies.

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#abs35 | Genitourinary toxicity following radiation therapy is not just about haematuria- lessons from 7 years of a specialist radiation cystitis clinic.

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Introduction
Radiation therapy for treatment of various pelvic cancers in both genders is being widely utilized. With improved survivorship, a significant number of these patients experience genitourinary toxicity which more commonly manifests as radiation cystitis/visible haematuria. However, non-haematuria symptoms of toxicity are often overlooked and are difficult to manage.

We aimed to investigate the incidence of non-haematuria genito-urinary toxicity symptoms in patients presenting to our specialist radiation cystitis service and analyse if these were more prevalent in specific treatment groups.

Methods
We analysed our prospectively maintained specialist radiation cystitis clinic database for patients treated at our centre between January 2016-Sept 2024. Demographic data was collated and additional information on non-haematuria related symptoms were collected from patient charts. Data was analysed using SPSS 29.

Results
219 patients were identified for analysis. 169 (77%) were male with a median age of 72 (Range 26-96). The mean time from radiation treatment to symptoms of genitourinary toxicity was 3 years (Range <1 year to 17 years). The primary diagnosis for radiation treatment were bladder cancer 13 (6%), prostate cancer 157 (72%), colorectal cancer 4 (2%), cervical cancer 36 (16%) and endometrial cancer 9 (4%).

Non-haematuria symptoms were highly prevalent in this patient cohort. Symptoms included incontinence (54.3%), urinary tract infections (21.9%), chronic pelvic pain (32.4%), concurrent bowel symptoms (24.2%), hydronephrosis (14%), urethral strictures (9.1%) and fistulas (7.3%). Sub-analysis of the patients with prostate cancer showed no difference in the incidence of non-haematuria genitourinary toxicity in between patients undergoing brachytherapy, primary external beam radiotherapy or adjuvant/salvage radiotherapy. 17 of these patients ultimately required salvage cystectomy for non-haematuria genitourinary toxicity indications.

Conclusion
Non-haematuria symptoms are very common in patients suffering from genitourinary toxicity from radiotherapy. Addressing these in conjunction with treatment for visible haematuria is important in providing patients with improved quality of life.

#abs36 | Immune and Genomic Profiling to Inform Risk Stratification in Muscle-Invasive Bladder Cancer

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Introduction and objectives
Muscle-invasive bladder cancer (MIBC) remains clinically heterogeneous, with variable outcomes despite standard perioperative chemotherapy. The COMBAT study investigated tissue biomarkers across genomic, immune, and transcriptomic domains in a real-world MIBC cohort.

Methods
Tumour samples from MIBC patients undergoing curative intent treatment in the BLADDA registry underwent multimodal molecular profiling. DNA was sequenced using Illumina TSO500 to assess somatic alterations and tumour mutational burden (TMB). PD-L1 was assessed by immunohistochemistry (SP263), and T-cell infiltration quantified using multiplex chromogenic immunohistochemistry(1). RNA sequencing enabled molecular subtyping per the MIBC consensus classification(2). Survival associations were evaluated using Kaplan–Meier analysis and Cox regression.

Results
The cohort comprised 105 patients (median age 70 [IQR 63–75]; 72% male), most with lower tract primaries (76%). Surgery was performed in 87%, with 45% receiving perioperative chemotherapy. Consistent with prior studies, frequent mutations were observed in driver genes, including TP53 (58%), ARID1A (20%), PIK3CA (19%), ATM (17%), and FGFR3 (15%). High TMB (≥10 mut/Mb) was observed in 46% of tumours and correlated with longer disease-free survival (DFS; HR 0.42, p=0.002) and overall survival (OS; HR 0.48, p=0.012), though TMB status did not predict differential benefit from perioperative chemotherapy. Among patients who received neoadjuvant chemotherapy, alterations in ATM, RB1,

or FANCC were associated with favourable DFS (log-rank p=0.061) and OS (p=0.036). High infiltration of CD3+, CD8+, and FOXP3+ T cells was linked to better DFS and OS (all $p < 0.01$). Neither PD-L1 expression nor molecular subtypes were associated with clinical outcomes.

Conclusions

High TMB and intratumoural T-cell infiltration correlated with improved survival, while PD-L1 expression and RNA subtypes were non-informative. These findings support immune and genomic profiling to refine risk stratification as novel immunotherapy and antibody–drug conjugate strategies enter the perioperative setting.

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#abs37 | Impact of tumor burden at progression and changes in risk scores from baseline in patients with advanced renal cell carcinoma treated with lenvatinib + pembrolizumab: phase 3 CLEAR trial

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Introduction and Objectives

Lenvatinib+pembrolizumab (L+P) significantly improved efficacy versus sunitinib in treatment-naïve patients with advanced renal cell carcinoma (aRCC) in the CLEAR trial. We report analyses on the impact of tumor burden at time of progression and shifts in International Metastatic RCC Database Consortium (IMDC) scores in the L+P arm of CLEAR.

Methods

Study design of CLEAR has been reported. Data cutoff for analyses herein is 31July2022 (median follow-up: ~4 years). Medians for survival (from progression and randomization) were estimated by Kaplan-Meier method; 95% CIs were estimated via generalized Brookmeyer and Crowley method. Patients (on L+P) were grouped into tertiles by percent changes from baseline in their target lesion diameters at progression (T1:≤-61%; T2:>-61%-≤-34%; T3:>-34%) for survival analyses. 6-month IMDC score changes from baseline were reported.

Results

Patients with larger percentage decreases in tumor size at progression had longer median survival (months [95% CI]) from progression vs patients with smaller tumor-size decreases (T1[n=59], 35.6 [28.4-39.2]; T2[n=58], 24.4 [15.5-34.5]; T3[n=59], 20.2 [16.4-26.9]).

Similar trends were observed for overall survival (months [95% CI] from randomization; T1, not estimable[NE] [49.9-NE]; T2, 43.0 [33.0-NE]; T3, 31.5 [22.4-34.4]).

Most patients, irrespective of tumor shrinkage at progression, received subsequent systemic anticancer medication during survival follow-up (T1:63%; T2:59%; T3:71%). Patients received an anti-VEGF therapy (46%;45%;59%) as their first subsequent medication more frequently than other medications. The most frequently used anti-VEGF therapy was cabozantinib (22%;29%;29%).

At 6 months, IMDC score stayed the same/decreased from baseline in 76% of patients; 7.6% of patients had increases in IMDC score and 16% were missing IMDC scores.

Conclusions
Patients in the L+P arm with lower tumor burden at progression showed improved prognosis, highlighting the importance of deep tumor response when considering treatment sequence. IMDC risk scores were typically constant/improved in patients treated with L+P; analyses were limited by patients' missing IMDC data.

#abs38 | Impacts of Sarcopenia on Prostate Cancer Patients Undergoing Docetaxel Chemotherapy

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Background
Sarcopenia is an important prognostic factor in cancer patients due to its known association with increased treatment-related toxicity, morbidity, and mortality. This study examines how sarcopenia affects chemotherapy outcomes in Australian prostate cancer patients.

Methods
This retrospective study examined the impact of sarcopenia on patients receiving docetaxel chemotherapy in the CCLHD between 2013-2022. The presence of sarcopenia was determined by measuring the cross-sectional area of the psoas muscle at L3 level to calculate the Psoas Muscle Index (PMI) on CT scan. Sarcopenia was predefined as PMI<5.7cm²/m² and additional data was obtained from patient records. Statistical analysis was used to determine the impact of sarcopenia on median overall survival (mOS) using Kaplan-Meier and Cox-proportional hazards methods. Additional comparisons were also drawn between castrate-sensitive prostate cancer (CSPC) and castrate-resistant prostate cancer (CRPC) groups.

Results
In this study, 104 patients were identified in which 50% (n=52) were determined to have sarcopenia. Sarcopenic patients had higher mortality risk than non-sarcopenic patients (HR 1.61 CI 1.12-2.32, p= 0.010). The CRPC group was more likely to have sarcopenia than the CSPC group (57% versus 34%, p=0.022) and had a significantly lower body mass index (BMI) (p=0.010). Sarcopenic patients demonstrated significantly shorter mOS (416 vs 682 days, p=0.009). When analysed by castrate sensitivity, the CSPC group showed no difference in mOS based on sarcopenia status (633 vs 706 days, p=0.095). However, the CRPC group showed significantly shorter mOS in those with sarcopenia (380 vs 642 days p=0.049). There was no difference in hospitalisation on chemotherapy between sarcopenic and non-sarcopenic groups (n=26 vs 27, p=0.845).

Conclusion
Sarcopenia is a significant prognostic factor for OS in prostate cancer patients receiving docetaxel chemotherapy, specifically in those with CRPC. This highlights the need for larger-scale prospective studies and interventional strategies to address sarcopenia to improve treatment outcomes.

#abs39 | Index and Composite Biopsy ISUP Grade Group: Implications for Prediction of Radical Prostatectomy Outcomes and Biochemical Recurrence in Localised Prostate Cancer

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Introduction
The ISUP grade group (GG), derived from the Gleason score, stratifies prostate cancer risk. However, prostate cancer's multifocal nature contributes to discrepancies between biopsy and radical prostatectomy (RP) histology. It remains unclear whether index (highest-

grade) or composite (aggregate) GG at biopsy better predicts RP pathology and biochemical recurrence (BCR). We evaluated concordance, upgrading, and downgrading rates of index versus composite GG at biopsy in predicting RP histology and biochemical recurrence (BCR) in clinically localised prostate cancer.

Methods
We retrospectively analysed a prospective cohort of patients undergoing RP for clinically localised prostate cancer (2009–2021). Biopsies were assigned both index and composite GG. Concordance with RP GG, upgrading/downgrading rates, and BCR outcomes were compared. Subgroup analyses assessed predictive value of MRI and biopsy parameters.

Results
Of 2084 patients, 85% had concordant index and composite biopsy GG; 15% were discordant. In concordant cases, index GG predicted RP histology with 69.5% concordance (22.1% upgraded, 8.4% downgraded). In discordant cases, index GG concordance was 39.1% (10.9% upgraded, 50.5% downgraded). Composite GG in discordant cases yielded 41.8% concordance, (53.3% upgraded, 4.9% downgraded).

In patients with biopsy composite GG 2, discordance with index GG was associated with increased BCR risk (HR 2.06, p=0.022). We evaluated patients with pre-operative MRIs: PIRADS ≥4, maximum cancer core length ≥6.7 mm, and ≥4 cores sampled from the index lesion region independently predicted concordance with final histology (p<0.01 for all). Patients meeting all three criteria had significantly higher concordance (79.2% vs 41.3%, p<0.01).

Conclusions
In discordant biopsies, composite GG may underestimate final pathology and BCR risk, while index GG may overestimate this. Index GG better reflects the dominant pathology in patients with PIRADS ≥4 lesions, longer cancer core length, and sufficient lesion-targeted sampling. Incorporating radiological and histological features can improve biopsy interpretation and management in localised prostate cancer.

#abs40 | Is PSA Testing Beneficial for Men with Low-Grade Prostate Cancer on Watchful Waiting?

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Watchful waiting is a management approach for prostate cancer, typically used for patients deemed too frail for curative treatment. This strategy involves monitoring the cancer until it metastasizes or causes symptoms such as pain or urinary obstruction, at which point treatment is considered to control the disease.

We evaluated patients from North Shore Hospital who transitioned from active surveillance for Grade Group 1 (GG1) prostate cancer to watchful waiting. These patients were discharged to their general practitioners with a recommendation for annual PSA testing and referral back to our care if PSA levels exceeded 20 ng/mL or if symptoms such as bone pain or urinary obstruction developed.

Our objective was to assess adherence to PSA surveillance, referral rates, and the proportion of patients requiring treatment. We reviewed records of 56 patients who transitioned to watchful waiting, primarily due to comorbidities, with six opting for this approach due to personal preference or declining treatment. Records were reviewed in August 2024, with follow-up calculated from the time of transition until August 2024 or death.

Of the 56 patients, 53 had GG1 disease, two had GG2, and one had GG3. The average follow-up was 44.7 months (median: 43 months, range: 4–87 months), totaling 208.5 person-years. PSA surveillance was maintained by 54 patients (96.3%).

At review:
44 patients (81.4%) had PSA levels below 10 ng/mL

10 patients (18.5%) had PSA levels between 10 and 20 ng/mL

6 patients (11.1%) had PSA levels above 20 ng/mL

Six patients (11.1%) were referred back to our department, and four (7.4%) underwent imaging for metastatic disease, all of which were negative. One patient declined further investigations, and one patient had a known 200cc prostate and did not progress to further imaging. No patients developed symptomatic metastatic disease or required

treatment, including androgen deprivation therapy. Seven patients (13%) died during the study period from causes unrelated to prostate cancer.

These findings suggest that over 208.5 person-years of watchful waiting with regular PSA testing, no patients required treatment. These findings support a less intensive monitoring approach, potentially basing referrals solely on symptom development. Further research is needed to refine these recommendations.

#abs41 | Management of complex Large renal masses (>70mm) by a single surgeon; Robotic and Laparoscopic partial nephrectomy

Mr Sepehr Miran[1,2], Dr Anne Hong[3], Dr Homayoun Zargar[3,4,5]

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Introduction
In this study, we retrospectively reviewed data analysing perioperative and postoperative outcomes in patients with a large renal mass >70mm. Trifecta and "Optimal outcome" were defined, and rates of achieving each were evaluated in patients undergoing either Robotic partial nephrectomy (RPN) or Laparoscopic partial nephrectomy (LPN).

Methods
In total, 10 patients underwent partial nephrectomy by a single surgeon from 2019 to 2024. Trifecta was defined by three components: Warm Ischemia time (WIT)<25min, Zero postoperative copmplications, Negative surgical margin. Optimal outcome was defined as achieving trifecta and short-term (3 months) eGFR preservation of more than 90%. Postoperative complications were classified using the Clavien-Dindo system. Statistical analysis was carried out using GraphPad Prism V10.4.

Results
10 patients met the inclusion criteria for this case series. The mean age was 61.70, and the average tumour size was 87.10mm. The mean warm ischemia time was 15.25 mins, and the median renal score was 11. Negative surgical margins were achieved in 88.89% of cases, no postoperative complications were recorded, and eGFR preservation >90% was achieved in 80% of the patients. Patients were monitored for an average of 24 weeks, and no incidents of recurrence were recorded.

The defined trifecta was met in 60% of cases while optimal outcome was achieved in 50%.

Conclusion
In this single surgeon case series, partial nephrectomy showed favourable outcomes in terms of perioperative and postoperative stats. safe and effective management option for large and complex renal masses. Achievement of trifecta and "optimal outcome" supports its feasibility and safety as a surgical management option for large complex renal masses.. However, due to the limited number of cases, further controlled studies are warranted to confirm its broader applicability.

#abs42 | OMAHA-004: Phase 3 trial of CYP11A1 inhibitor opevesostat versus next-generation hormonal agent (NHA) switch in participants with metastatic castration-resistant prostate cancer (mCRPC) after 1 prior NHA

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Background
Opevesostat (MK-5684; ODM-208) is an oral, nonsteroidal inhibitor of cytochrome P450 11A1 (CYP11A1), a catalyst of the first and rate-limiting step of steroid biosynthesis. Opevesostat showed antitumor activity in participants with heavily pretreated mCRPC in the phase 1/2 CYPIDES trial (Fizazi K et al. NEJM Evid. 2024;3:EVIDoa2300171). The randomized, open-label, phase 3 OMAHA-004 trial (NCT06136650) is designed to evaluate the efficacy and safety of opevesostat in participants with molecularly-unselected mCRPC after 1 prior NHA.

Methods
Eligible participants have mCRPC that progressed during androgen deprivation therapy ≤6 months before screening and on or after 1 NHA for hormone-sensitive prostate cancer (HSPC) or nonmetastatic CRPC for ≥8 weeks (≥14 weeks with bone progression). Prior NHA plus docetaxel for HSPC is

permitted if patients received ≤6 cycles of docetaxel without radiographic disease progression.

Approximately 1500 participants will be randomized 1:1 to opevesostat 5 mg orally twice-daily plus dexamethasone 1.5 mg and fludrocortisone 0.1 mg orally once daily or abiraterone acetate 1000 mg orally once daily plus prednisone 5 mg orally twice daily (if prior enzalutamide, darolutamide, or apalutamide) or enzalutamide 160 mg orally once-daily (if prior abiraterone). Primary end points are radiographic progression-free survival per Prostate Cancer Working Group 3 (PCWG3)-modified RECIST v1.1 by blinded independent central review (BICR) and overall survival, analyzed separately in participants 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. Enrollment is ongoing.

Funding: This study is supported by Merck Sharp & Dohme LLC, a subsidiary of Merck & Co., Inc., Rahway, NJ, USA, and Orion Corporation, who are codeveloping opevesostat (MK-5684; ODM-208).

#abs43 | Oncological and functional outcomes of apical prostate cancers treated with focal laser ablation (ProFocal®)

Dr Jonathan Kam[1,2], Mohan ARIANAYAGAM[1], Bertram CANAGASINGHAM[1], Ahmed Saeed GOOLAM[1], Nicola JEFFERY[1], Mohamed KHADRA[1,2], Raymond KO[1,2], Nicholas MEHAN[1], Isaac THANGASAMY[1,2], Celi Varol[3]

[1]Nepean Urology Research Group, [2]University of Sydney, [3]Medlogical Innovations

Objectives

ProFocal® (Medlogical Innovations, 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. The aim of this study is to report the oncological, functional and safety outcomes of the treatment of apical prostate cancers using the ProFocal® system.

Methods

Patients with apical cancers treated were extracted from the prospective, PFLT-PC (ProFocal Laser Therapy for Prostate Tissue Ablation) trial (Australian New Zealand Clinical Trials Registry ID: ACTRN12618001774213p) evaluating the novel ProFocal® device (Medlogical Innovations, Sydney, Australia) 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. Following ProFocal treatment, patients underwent a post-treatment MRI within 72 hours, and a 3-month follow-up transperineal prostate biopsy to assess treatment efficacy. Functional (urinary, sexual and bowel) outcomes were measured using validated questionnaires (IPSS, SHIM, EPIC, SF-12) at baseline, 3, 6, and 12 months. Statistical analysis was performed using SPSS 29.0. The Friedman test was performed to analyse differences between related non-parametric variables across multiple time points.

Results

From the original PFLT_PC trial cohort of 100 men, 32 patients were identified as having apical tumours treated and were included in the analysis. All cases were completed as day only procedures, with no significant peri- or post-operative complications (Clavien-Dindo 3+). On 3-month surveillance biopsy, 4 (12.5%) had ISUP ≥2 prostate cancer. Of these, 1 patient had infield ISUP 2 disease only, 1 had outfield ISUP 2 disease and 2 patients had ISUP ≥2 disease on both infield and outfield biopsies. Patient reported functional outcomes were excellent with no significant changes across all domains through 3-6 and 12 months.

Conclusions

Treatment of apical prostate cancers with the ProFocal® system demonstrated excellent oncological, functional outcomes and safety profile. On surveillance biopsy, 96.9% of patients demonstrated successful infield treatment of disease, and functional outcomes were excellent across all domains, with no significant worsening in urinary, bowel, quality of life or sexual reported outcome measures.

#abs44 | Oncological and functional outcomes of apical prostate cancers treated with focal laser ablation (ProFocal®)

Dr Jonathan Kam[1, 2, 3], Mohan ARIANAYAGAM[1 2, 3], Bertram CANAGASINGHAM[1, 2, 3], Ahmed GOOLAM[1], [2, 3], Nicola JEFFERY[1, 2, 3], Mohamed KHADRA[1], [2, 3], Raymond KO[1, 2, 3], Nicholas MEHAN[1, 3], Isaac THANGASAMY[1, 2, 3], Celi VAROL[4]

[1]Nepean Urology Research Group, [2]Sydney Medical School, University of Sydney, [3]Nepean Hospital, [4]Medlogical Innovations

Objectives

ProFocal® (Medlogical Innovations, 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. The aim of this study is to report the oncological, functional and safety outcomes of the treatment of apical prostate cancers using the ProFocal® system.

Methods

Patients with apical cancers treated were extracted from the prospective, PFLT-PC (ProFocal Laser Therapy for Prostate Tissue Ablation) trial (Australian New Zealand Clinical Trials Registry ID: ACTRN12618001774213p) evaluating the novel ProFocal® device (Medlogical Innovations, Sydney, Australia) 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. Following ProFocal treatment, patients underwent a post-treatment MRI within 72 hours, and a 3-month follow-up transperineal prostate biopsy to assess treatment efficacy. Functional (urinary, sexual and bowel) outcomes were measured using validated questionnaires (IPSS, SHIM, EPIC, SF-12) at baseline, 3, 6, and 12 months. Statistical analysis was performed using SPSS 29.0. The Friedman test was performed to analyse differences between related non-parametric variables across multiple time points.

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From the original PFLT_PC trial cohort of 100 men, 32 patients were identified as having apical tumours treated and were included in the analysis. All cases were completed as day only procedures, with no significant peri- or post-operative complications (Clavien-Dindo 3+). On 3-month surveillance biopsy, 4 (12.5%) had ISUP ≥2 prostate cancer. Of these, 1 patient had infield ISUP 2 disease only, 1 had outfield ISUP 2 disease and 2 patients had ISUP ≥2 disease on both infield and outfield biopsies. Patient reported functional outcomes were excellent with no significant changes across all domains through 3-6 and 12 months.

Conclusions

Treatment of apical prostate cancers with the ProFocal® system demonstrated excellent oncological, functional outcomes and safety profile. On surveillance biopsy, 96.9% of patients demonstrated successful infield treatment of disease, and functional outcomes were excellent across all domains, with no significant worsening in urinary, bowel, quality of life or sexual reported outcome measures.

#abs45 | Outcomes of focal laser ablation (ProFocal®) treatment in clinically localised prostate cancer: a stratified analysis by tumour anatomical location

Dr Jonathan Kam[1,2], Mohan ARIANAYAGAM[1], Bertram CANAGASINGHAM[1], Ahmed Saeed GOOLAM[1], Nicola JEFFERY, Mohamed KHADRA[1,2], Raymond KO[1,2], Nicholas MEHAN[1], Isaac THANGASAMY[1,2], Celi VAROL[3]

[1]Nepean Urology Research Group, [2]University of Sydney, [3]Medlogical Innovations

Objectives

ProFocal® (Medlogical Innovations, Sydney) is a focal laser ablation (FLA) treatment for localised prostate cancer. The ProFocal® Laser Therapy for Prostate Cancer Tissue Ablation (Australian New Zealand Clinical Trials Registry ID: ACTRN12618001774213p), was designed as an open-label, single-arm, safety and efficacy trial. In this study, we evaluate the oncological outcomes of ProFocal® treatment stratified by the anatomical location of the prostate cancer foci.

Methods

Between October 2020 to April 2023, 100 patients who met trial inclusion criteria were enrolled for ProFocal® treatment at Nepean Hospital, Sydney, Australia. Study Inclusion criteria were males over

the age of 18 with biopsy confirmed intermediate risk prostate cancer, PSA≤15, Gleason score ≤7, clinical stage ≤T2c, and up to three tumour suspicious regions on multiparametric MRI. Patients were excluded if they had received prior treatment for their prostate cancer. The study protocol included a post-treatment MRI within the first week, and surveillance prostate biopsy at 3 months. Tumours were stratified by anatomical location from apex to base, and anterior to posterior.

Results

The median age was 66 years (IQR 60-72), PSA 5.9 ng/mL (3.9-7.6), prostate volume 39cc (30-51 and the MRI lesion volume 0.84 (0.57-1.2cc). Sixteen patients were found to have ISUP ≥2 infield disease on their 3-month surveillance biopsy. An initial learning curve is evident, with 12 of these cases in the first 50 cases decreasing to 4 cases in the subsequent 50 cases. When stratifying oncological outcomes by tumour location, 26 patients (26%) had anteriorly located cancer foci, with clinically significant in-field recurrences observed in 3 patients (11.5%). Among the 64 patients (64%) with posteriorly located cancer foci, 10 patients (15.6%) experienced clinically significant in-field recurrences.

Conclusions

ProFocal® Treatment for Intermediate Risk Prostate Cancer is a promising treatment modality within the field of Focal Therapy. Following the initial learning curve associated with treatment delivery, detection of in-field clinically significant disease reduced to 4%. Stratified by tumour location, the recurrence rates was 11.5% for anterior tumours and 15.6% initially for posterior tumours.

#abs46 | Patient Outcomes On Alternative-dose Abiraterone Acetate Compared To Standard-dose In A Real-World Southeast Asian Cohort

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Introduction

Abiraterone acetate (AA) is a standard treatment for metastatic castration-resistant prostate cancer (mCRPC), but its relatively high cost limits access in many low- and middle-income countries. Alternative-dose AA (250 mg with low-fat food) has demonstrated comparable pharmacokinetics and efficacy to the standard-dose AA (1000 mg fasting state) in clinical trials [1,2]. However, real-world survival data from Southeast Asia are scarce.

Methods

This retrospective study included mCRPC patients treated at Universiti Malaya Medical Centre (2013–2024) with alternative-dose AA (250 mg with low-fat food) or standard-dose AA (1000 mg fasting state). Primary endpoints were overall survival (OS) and biochemical progression-free survival (bPFS). Secondary endpoints included PSA response (≥50% reduction at 3 months), depth of PSA response (≥90% at 3 months), and treatment-related toxicities.

Results

Among 146 patients (95 alternative-dose, 51 standard-dose), the alternative-dose group had significantly longer OS (median not reached vs 21.0 months, p=0.007). bPFS was also longer (21.0 vs 12.0 months), though not statistically significant (p=0.178). Depth of PSA response was significantly higher in the alternative-dose group (78.4% vs 21.6%, p=0.049). Across both groups, patients with ≥90% PSA decline had significantly longer OS (median 23.0 vs 15.0 months, p=0.004). This correlation remained significant in the alternative-dose group (24.5 vs 15.0 months, p=0.039) and the standard-dose group (21.5 vs 9.0 months, p=0.035). Toxicities were mostly grade 1, including ankle oedema, hypertension, and hypokalaemia. Grade 3 toxicity (hypertension) occurs <5% and in both groups.

Discussion

The survival outcomes of alternative-dose AA shown in this study confirms its therapeutic efficacy in real-world mCRPC setting. The regimen is well tolerated and more affordable. Although retrospective in nature, this study benefits from a large sample size, clearly defined endpoints, and real-world relevance.

Conclusion
Alternative-dose AA is a clinically effective and economically sustainable option for mCRPC treatment. This real-world findings advocate for broader use in cost-constrained healthcare systems.

Keywords
Prostate cancer, Abiraterone, Alternative dose, Real-world evidence, mCRPC, PSA response, Survival

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#abs47 | Phase 1/2 OMAHA-U01 substudy 01A: Oral CYP11A1 inhibitor opevesostat alone or in combination with other therapies in participants with metastatic castration-resistant prostate cancer

Arif Hussain[1], Chris Garratt[2], Nan Li[3], Dr. Yingjie Liu[4], Christian Poehlein[4], **A/Prof Peter C. C. Fong**5

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Background
Current treatments for patients with metastatic castration-resistant prostate cancer (mCRPC) are associated with hormone dependence and the development of resistance. Therapeutic agents with novel mechanisms of action are needed for this patient population. Opevesostat (MK-5684; ODM-208) is an oral, nonsteroidal inhibitor of cytochrome P450 11A1 (CYP11A1), a catalyst of the first and rate-limiting step of steroid biosynthesis. In the phase 1/2 CYPIDES study, opevesostat showed antitumor activity in patients with heavily pretreated mCRPC (Fizazi et al. NEJM Evid. 2024;3:EVIDoa2300171). OMAHA-U01 is an adaptive, open-label, rolling-arm, multicenter, phase 1/2 umbrella study designed to evaluate opevesostat-based investigational therapies in participants with prostate cancer. Substudy 01A (NCT06353386) will evaluate the safety and efficacy of opevesostat alone or in combination with other therapies in participants with previously treated mCRPC.

Methods
Eligible participants have mCRPC that progressed during androgen deprivation therapy ≤6 months before screening, and on or after 1-2 androgen receptor pathway inhibitors for metastatic or nonmetastatic hormone-sensitive prostate cancer and nonmetastatic or mCRPC. Prior treatment with ≤1 taxane-based chemotherapy regimen for mCRPC is allowed. A safety lead-in phase for all opevesostat-based experimental combinations (~10 participants in each arm) will establish the recommended phase 2 dose (RP2D), followed by an efficacy phase (opevesostat alone, ≤100 participants; opevesostat-based combinations, ~40 participants each). Participants will be randomly assigned 1:1:1:1 to receive opevesostat 5 mg PO BID, opevesostat 5 mg PO BID plus olaparib (RP2D), opevesostat 5 mg PO BID plus docetaxel (RP2D), or opevesostat 5 mg PO BID plus cabazitaxel (RP2D). The primary end point for the safety lead-in phase is safety and tolerability. Primary end points for the efficacy phase are safety and prostate-specific antigen response rate per Prostate Cancer Clinical Trials Working Group criteria. Enrollment is ongoing.

Previously presented at ESMO Congress 2024, FPN: 1663TiP, Arif Hussain et al. – Reused with permission.

Funding
This study is supported by Merck Sharp & Dohme LLC, a subsidiary of Merck & Co., Inc., Rahway, NJ, USA, and Orion Corporation, who are codeveloping opevesostat (MK-5684; ODM-208).

#abs48 | Phase 1b/2 KEYNOTE-365 cohort I: Pembrolizumab plus carboplatin and etoposide chemotherapy (pembrolizumab–chemotherapy) or chemotherapy alone for metastatic neuroendocrine prostate cancer (NEPC)

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Introduction and objectives
Patients with NEPC are often treated with platinum-based chemotherapy but novel efficacious therapies are needed. We report preliminary results from cohort I of the phase 1b/2 KEYNOTE-365 study (NCT02861573) evaluating pembrolizumab–chemotherapy versus chemotherapy for NEPC.

Methods: Adults with pathologically confirmed treatment-emergent or de novo metastatic NEPC, disease progression ≤6 months before screening, and ECOG PS of 0/1, with/without prior androgen deprivation therapy are eligible. Participants are randomized 1:1 to receive 4-6 cycles of chemotherapy (carboplatin AUC-5 intravenously Q3W plus etoposide 100 mg/m2 intravenously on days 1-3 Q3W) with/without pembrolizumab 200 mg intravenously Q3W for ≤35 cycles. Primary endpoints are safety, ORR per RECIST v1.1 by blinded independent central review (BICR), and prostate-specific antigen (PSA) response rate (≥50% decrease from baseline). Secondary endpoints include rPFS per PCWG3-modified RECIST v1.1 by BICR and OS. No formal hypothesis testing was performed.

Results
As of February 3, 2025, 25 participants received ≥1 dose of pembrolizumab–chemotherapy and 23 participants ≥1 dose of chemotherapy. Median (range) follow-up was 14.3 months (0.2-34.0) in the pembrolizumab–chemotherapy arm and 13.8 months (1.2-27.4) in the chemotherapy arm. For pembrolizumab–chemotherapy versus chemotherapy, confirmed ORR was 25% (6/24; 95% CI, 10-47) versus 10% (2/21; 1-30) among participants with RECIST-measurable disease. Confirmed PSA response rate was 35% (8/23; 95% CI, 16-57) versus 28% (5/18; 10-54) among participants with baseline PSA. In all treated participants, median rPFS was 5.1 months (95% CI, 4.1-8.0) versus 4.0 months (2.1-5.0); median OS was 10.3 months (8.0-13.2) versus 7.8 months (4.0-8.5). Grade 3-5 treatment-related AEs occurred in 48% of participants with pembrolizumab–chemotherapy versus 78% with chemotherapy (grade 5, 0% vs 4%).

Conclusions
Based on these preliminary data in participants with NEPC, pembrolizumab–chemotherapy is associated with promising efficacy outcomes versus chemotherapy and does not result in new safety signals.

Funding
Merck Sharp & Dohme LLC, a subsidiary of Merck & Co., Inc., Rahway, NJ, USA

#abs49| Phase Ib/IIa dose escalation and expansion study of 212Pb-ADVC001 in metastatic castration-resistant prostate cancer (mCRPC): TheraPb – Phase I/II Trial in Progress

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Introduction and objectives
Prostate-specific membrane antigen (PSMA)-directed radioligand therapies (RLT) are evolving to meet unmet patient needs in mCRPC. Traditional dose-finding study designs used for systemic anti-neoplastic agents, however, fail to leverage unique aspects of RLT, and the optimal dosing regimens for even established RLTs have not been fully explored. Adaptive design elements and dose optimization

have rarely been included in RLT clinical trials to date. The TheraPb study design incorporates adaptive design and dose optimization to rigorously and efficiently evaluate optimal dosing strategies of ^{212}Pb-ADVC001 in mCRPC.

Methods

This is an ongoing prospective, Phase 1b/2a open-label, non-randomized, dose escalation, dose optimization and expansion study of ^{212}Pb-ADVC001 – a novel PSMA-targeted radioligand labelled with the potent alpha-emitting payload ^{212}Pb. Primary objectives are selection of the recommended Phase 2 dose and schedule (Phase 1b) and efficacy (Phase 2a) of ^{212}Pb-ADVC001 in patients with PSMA-positive mCRPC who have had exposure to at least one androgen receptor pathway inhibitor.

The Phase 1b dose escalation follows an interval 3+3 design, incorporating Bayesian decision-making and additional design elements that can be modified based on emerging study data to evaluate dosing intervals of ^{212}Pb-ADVC001 administered every 6, 4 or 2 weeks. Number of cycles are tailored to patient response on molecular imaging. Efficient dose escalation leverages routine biodistribution imaging and dosimetry assessment, limiting the number of patients exposed to subtherapeutic doses. If the Phase 1b demonstrates multiple dosing regimens with similar safety, tolerability and anti-tumour activity, the protocol provides the option to include adaptive randomization in Phase 2a expansion to identify an optimized dose and schedule. Phase 2a further includes evaluation of biomarker-driven adaptive dosing regimens in three pre-defined cohorts of patients with PSMA-positive mCRPC proceeding in parallel, characterizing the drug profile and development potential in specific indications.

Results

Phase 1b of the trial is currently enrolling at two clinical sites (Princess Alexandra Hospital and Royal Brisbane and Women's Hospital) in Australia (NCT05720130).

Conclusions

The adaptive design and dose optimization elements of the study aim to identify optimal RLT dosing regimens, while reducing subject exposure to subtherapeutic doses or suboptimal schedules and improving patient safety, ultimately enabling faster patient access to this novel and potentially effective treatment.

#abs50 | Physical and cognitive training, fatigue and wellbeing in men with prostate cancer: a pilot investigation

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Introduction

Physical activity is a well-accepted intervention to improve quality of life and wellbeing in men with prostate cancer, in particular, physical fatigue (1). Cognitive fatigue also continues to impact this population, with some preliminary research demonstrating acceptability of cognitive activity (2). However, little is known about how physical activity can be simultaneously combined with cognitive activity to create a layered, more holistic intervention to influence fatigue and wellbeing in men with prostate cancer.

Objectives

To determine whether a moderate intensity aerobic physical training intervention with or without cognitive training improves fatigue and wellbeing in men with prostate cancer when compared to a control group.

Methods

The physical training group (n=7) cycled at 60-70% of heart rate maximum for up to 60 minutes, twice per week for 8 weeks. The concurrent cognitive and physical training group (n=5) completed cognitive activity on Brain HQ in the domains of executive function, reaction time and spatial awareness, whilst simultaneously cycling. The control group (n=6) continued with their normal routine. Standardized quality of life and fatigue measures were completed

pre- and post- intervention period. Kruskal-Wallis testing identified effect sizes between groups post-intervention.

Results
There were small effect sizes post- intervention for most wellbeing measures including fatigue (ε^2 = 0-0.025), suggesting that group allocation accounted for minimal variance, except in functional wellbeing and urinary symptomology where a medium effect size was observed (ε^2 = 0.07) (95% CI [-0.042, 0.52], [-0.039, 0.60]).

Conclusion
There were medium effects in functional and physical wellbeing post- intervention between groups. This suggests that physical and cognitive training should continue to be encouraged for their other known physiological benefits and potential effects on aspects of perceived physical wellbeing. Further investigation is required regarding the effect of combined interventions on fatigue and wellbeing in this population when compared to physical training alone.

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#abs51 | Predictors of Progression in Grade Group 1 Prostate Cancer: Outcomes from a New Zealand Centre

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Active surveillance (AS) is a management strategy for men with low-risk prostate cancer, aimed at avoiding overtreatment while monitoring for disease progression. Initially described in 2002, AS involves regular monitoring with the intent to intervene only if progression occurs. However, optimal criteria for identifying patients at risk of progression and the best surveillance strategy remain uncertain.

We conducted a retrospective cohort study of 296 men with Gleason Grade Group (GG) 1 prostate cancer enrolled in an AS program at a large metropolitan hospital in Auckland, New Zealand, from its inception in 2014 to December 2020. Patients were enrolled following a single biopsy confirming GG1 disease and a discussion regarding AS.

The initial AS protocol included:

PSA testing every 3 months 1 year, then every 6 months
MRI at 6–12 months
Confirmation biopsy at 12 months
Surveillance biopsy every 3-5 years

More than 25 clinicopathologic variables were independently collected by two authors in 2024, with cross-analysis ensuring internal validity. The primary outcome was histological progression to GG2 or higher. Predictive factors were analyzed using logistic regression, X^2 tests (or Fisher exact tests when necessary), and t-tests (or Wilcoxon rank-sum tests when appropriate).

Results
Of the 296 patients, 108 (36.5%) experienced cancer progression while on AS. The median follow-up period was 57 months (range: 6–176), and the median age at diagnosis was 65 years (range: 42–76).

Baseline characteristics associated with increased progression risk
PIRADS ≥3 lesion on initial MRI: OR = 3.86 (95% CI: 2.6–6.5, P < 0.0001)
PIRADS ≥4: OR = 5.0 (95% CI: 2.8–9.0, P < 0.0001)
PIRADS 5: OR = 12.76 (95% CI: 3.4–47.7, P < 0.002)
PSA density ≥0.15: OR = 4.68 (95% CI: 2.8–8.0, P < 0.0001)
Percentage of positive cores at diagnosis:
≥17%: OR = 2.2 (95% CI: 1.3–3.8, P = 0.0026)
≥33%: OR = 2.8 (95% CI: 1.4–5.8, P = 0.0043)
Age at diagnosis: OR = 0.96 per year increase (95% CI: 0.92–0.99)

Conclusions
Predictors of prostate cancer progression during AS include PSA density >0.15, the presence of PIRADS ≥3 lesions on MRI, and a higher percentage of positive biopsy cores at diagnosis. The observed progression rates align with existing AS protocols in

the literature. These findings contribute to a better understanding of baseline risk factors, allowing clinicians to refine AS protocols and provide more personalized risk assessments for patients.

#abs52 | Preliminary Analysis of HPV Genotypes in Australian Penile Cancer

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Introduction & Objectives
Penile cancer, though rare, is an aggressive malignancy with significant morbidity. Human papillomavirus (HPV) is a known aetiological factor in penile cancer, especially in p16-positive cases. This study aims to assess the prevalence and distribution of HPV genotypes in p16-positive penile cancers within Australia, to better inform public health strategies, vaccination policies, and clinical management.

Methods
Tissue was retrospective accessed for histopathological staining and genotyping from penile cancer patients within the Australian Penile Cancer Registry. Penile cancer tissue was stained with p16 by immunohistochemistry (IHC). HPV genotyping was performed on p16-positive penile cancer samples. The primary outcome was the HPV genotype distribution.

Results
A total of 51 cases were reviewed, with 37 cases meeting the inclusion criteria. Of these, 19 cases (51%) were positive for p16 by immunohistochemistry (IHC). Among the p16-positive cases, HPV genotyping revealed the following distribution: HPV 16 in 7 cases, HPV 18 in 1 case, multi-strain HPV infection in 3 cases, and 6 cases were HPV negative. The remaining 18 cases (49%) were p16-negative. This distribution highlights the heterogeneity of HPV involvement in p16-positive penile cancers.

Conclusions
This study contributes valuable insights into the epidemiology of penile cancer in the Australian context, with implications for public health policy and patient care.

#abs53 | Prescribing trends across Australia for metastatic renal cell carcinoma

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Introduction
A number of novel treatments have emerged for metastatic renal cell carcinoma in recent years. Previous literature on prescribing trends for metastatic renal cell carcinoma has demonstrated disparities in prescribing rates across Australia. This study was conducted to examine whether this remains ongoing, as well as to explore whether prescribing trends are consistent across Australia.

Methods
A search of the PBS registry was performed. For each therapeutic agent, the relevant codes for treatment of metastatic RCC were noted, and the number of PBS scripts filled on a monthly basis by state from January 2014 to December 2024 was recorded for each code. Population data was obtained from the Australian Bureau of Statistics.

Results
Across Australia, prescribing rates per capita have increased 3.5 fold over the past 10 years, from 20 to 70 scripts per month per 100,000 people. The highest prescribing rates per capita are in the smaller states of Western Australia, South Australia, and Tasmania, with rates last year hovering at 85 to 90 scripts per month per 100,000 people. These are followed by the larger states of New South Wales, Victoria, and Queensland, which averaged 65 to 70 scripts per month per 100,000 people. The lowest prescribing rates per capita are the territories, Australian Capital Territory and Northern Territory, at 40 and 20 scripts per month per 100,000 people last year respectively. Prescribing patterns of different therapeutic agents were comparable across the states, with nivolumab, cabozantinib, and pembrolizumab-lenvatinib representing the majority of scripts in recent years.

Prescribing trends were difficult to interpret for the territories due to the smaller number of scripts.

Conclusion
There remain prescribing disparities within Australia between the states and the territories for reasons that remain unclear. Within the states, there are comparable prescribing patterns.

#abs54 | Primary Squamous Cell Carcinoma of the Prostate: A Rare Entity – Case Report and Literature Review

Dr Gerald Mak[1], Dr Kenneth Chew[1], Dr Dale Wood[1], Dr Shannon Mcgrath[1], A/Prof James Thompson[1]

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Introduction
Primary squamous cell carcinoma (SCC) of the prostate is a rare, aggressive malignancy comprising approximately 0.5% of prostate cancers. It is frequently diagnosed at an advanced stage, due to non-specific urinary symptoms and typically normal PSA levels. This study presents a case of metastatic metastatic prostatic SCC and reviews the current literature.

Methods
A 61-year-old man presented with urinary frequency, poor flow, and urge incontinence, with a previous episode of urinary retention and UTI. PSA was 0.98ng/ml, DRE revealed benign moderate enlargement, and prostate volume was 67ml. CT revealed a low-attenuation prostatic lesion, a liver lesion, and bilateral pelvic lymphadenopathy. Nodal biopsy confirmed moderately differentiated keratinising SCC. TURP was performed for symptom relief.

TURP histopathology showed infiltrating moderately differentiated, focally keratinising SCC involving 80% of 66g of tissue, with necrosis and lymphovascular invasion. Cells stained positively for cytokeratin CAM5.2, CK5/6, p63, and p40; weakly for GATA3; focally for CK7; and were negative for PSA, PEEP, NKX3.1, TTF-1, and CK20. FDG PET-CT confirmed pelvic nodal and hepatic metastases and persistent prostatic avidity. The patient received palliative carboplatin/paclitaxel and pelvic radiotherapy, then further palliative radiotherapy to metastatic sites. He died 11 months after diagnosis.

Results
Up to 50% have metastatic spread of prostate SCC at diagnosis. Urinary obstruction is the most common presenting symptom. Treatment is stage-dependent, and includes radiotherapy, chemotherapy, and surgery. Cisplatin-based regimens are most established. Prostatectomy may be associated with better outcomes, but likely reflects earlier stage at presentation. Five-year survival is estimated at 33%, significantly lower than for acinar adenocarcinoma.

Conclusion
Primary prostatic SCC is rare and often diagnosed late due to non-specific symptoms and low PSA. Prognosis remains poor. Further research is needed to develop earlier diagnostic methods and more effective treatment options.

#abs55 | Primary Testicular Lymphoblastic Lymphoma: A Case Report and Literature Review of Diagnosis and Staging Investigations, Treatment, and Prognosis

Dr Gerald Mak[1], Dr Kenneth Chew[1], Dr Dale Wood[1], Dr Shannon Mcgrath[1], Dr Dominic Lee[1]

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Introduction
Lymphoblastic lymphoma (LBL) is a rare malignancy of precursor lymphoid cells, typically presenting with mediastinal or nodal disease. Isolated testicular involvement is exceptionally uncommon, with limited guidance on diagnostic workup, staging, treatment, and follow-up. We present a case of bilateral primary testicular lymphoblastic lymphoma in an adult and review the current evidence on its management.

Materials
A literature review was performed using PubMed and Google Scholar to identify cases of B- and T-cell isolated testicular LBL. Data were extracted on presentation, diagnostic investigations, treatment, and outcomes. These findings were integrated with an illustrative case of bilateral primary testicular LBL in an adult.

Results
Nine cases of localised primary testicular lymphoblastic lymphoma were identified- two T-cell and seven B-cell. Presenting symptoms included

testicular swelling (n=7), pain (n=5) and constitutional symptoms (n=1). Eight cases were unilateral; only our case demonstrated bilateral involvement. Ages ranged from 3 to 39 years (five paediatric, four adult).

Diagnosis investigations involved ultrasound (n=7), CT (n=7), bone marrow biopsy (all), lumbar puncture (n=6), and FDG-PET (n=3). Local control was achieved with orchidectomy in seven cases, including one bilateral (this case); one was managed with biopsy alone and one did not specify. Two cases had radiotherapy to the contralateral testis.

All patients received systemic and intrathecal chemotherapy, usually based on Acute Lymphoblastic Leukaemia protocols, despite no confirmed CNS involvement. Follow-up ranged from 3 to 36 months. One patient experienced relapse at 3 months; others remained disease-free.

Conclusion

Testicular lymphoblastic lymphoma is a rare entity requiring accurate histopathological diagnosis and staging. Orchidectomy is most common for local control, with systemic and CNS-directed chemotherapy. Early consideration of sperm preservation and potential testosterone replacement is needed particularly when bilateral disease is suspected or when radiotherapy to the contralateral testis is planned. Further multicentre studies are needed to guide optimal management strategies.

#abs56 | Prostate cancer in transgender women: what the evidence means for healthcare providers in Australia & New Zealand

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Introduction and objectives

Male to female transition via gender affirming hormone therapy (GAHT) and/or gender affirming surgery (GAS) is increasing. Transgender women (TGW) are at risk of prostate cancer (PCa) and there are no resources available to guide screening or management. We aim to review the evidence and present the findings.

Methods

We conducted a literature review of PCa in TGW to compile a list of doctor-patient considerations.

Results

4 studies with 606 cases of PCa in TGW were reviewed. PCa incidence is up to five times lower for TGW than cisgender men (CGM) believed consequential to androgen deprivation therapy (ADT) in GAHT (1-3). Estrogen hormone therapy (EHT) without ADT increases the risk of PCa as this environment is hypothesized to initiate neoplastic transformation of epithelial cells and promote early progression to an invasive phenotype (4). TGW have higher rates of metastatic disease at presentation, death post diagnosis and biochemical recurrence (1-3). TGW have a lifetime PSA rate of 48% versus 66% for CGM (1). Key reasons for this disparity are inadequate education of patients/providers, pre-existing lesions, decreased access to healthcare and deficient prostate exam/biopsy via neovagina (3). There is no consensus on interpreting PSA levels in GAHT or MRI scans of the atrophic glandular prostate tissue created by GAHT. There is no clear way of identifying TGW or GAHT/GAS status in electronic medical records. International classification of diseases code of 'gender dysphoria' was recently replaced by 'gender incongruence' which still has poor sensitivity and specificity.

Conclusion

Our understanding of PCa in TGW is limited. Incidence appears to be lower when EHT and ADT are taken but the increased risks of EHT alone are concerning. Increased rates of advanced disease at presentation warrant efforts to improve our PSA understanding and surveillance. Prostate MRI pre-transition should be considered for high-risk patients. Appropriate revision of data collection is needed for future, sensitive transgender research.

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#abs57 | Prostate Cancer Screening Guidelines: Are They Inclusive of Gender Diverse Populations? A Systematic Rubric-Based Evaluation

Dr Opeyejesu Afolabi[2], Dr Isha Bagwe[1], Dr Alice Mistry[1]

[1]Cairns Hospital, [2]Gold Coast Hospital

Introduction and objectives

Prostate cancer is one of the most commonly diagnosed malignancies, accounting for 7.3% of cancer diagnoses worldwide and is one of the leading causes of cancer related mortality. Prostate cancer screening guidelines have traditionally been developed with "cisgender med" in mind, often neglecting the unique healthcare needs of gender-diverse individuals. The aim of this study was to assess the extent at which current international prostate cancer screening guidelines include or provide tailored recommendations for transgender women and non-binary individuals.

Method

Five major international prostate cancer screening guidelines (2020-2025) were selected based on recency, explicit focus on prostate cancer screening, availability in English and issuance by major professional bodies. These guidelines were then individually reviewed using a structured rubric assessing inclusivity towards transgender women and non-binary individuals across six domains; acknowledgement, adapted recommendations, hormone therapy, anatomy, language and research gaps. Each domain was scored individually (0-3 points) with a maximum total score of 16 points per guideline. Scores for each guideline were summarised into a comparative table and categorised as Poor (0-5), Moderate (6-11), or High (12-16) to evaluate current practices.

Results

Of the five guidelines reviewed, three (EUA 2025, CUA 2022 and Pan-Asian Adapted ESMO 2022) scored 0, indicating no inclusion of gender-diverse individuals. NICE guidelines 2021 scored 6 and AUA guidelines 2023 scored 9, both indicating moderate inclusivity. The AUA guideline alone openly mentions the effects of hormone therapy, future research needs, and acknowledged screening uncertainty in transgender women. No guideline provided adapted screening protocols based on anatomy or hormone status.

Conclusion

Overall, current prostate cancer screening guidelines have limited inclusivity with most offering no acknowledgement or guidance for screening in gender-diverse populations. The most inclusive guidelines reviewed stop short of providing adapted recommendations. This lack of inclusion risks perpetuating inequities in cancer detection and care.

#abs58 | Prostatic artery embolisation in New Zealand: audit of local cases

Dr Kain Xu[1], Dr Brendan Buckley[1]

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Objectives

Prostate artery embolization (PAE) is performed in small numbers in New Zealand, but its global adoption is increasing. The USANZ position statement has shifted from advising that it 'should not be performed outside of clinical trials' to stating that it 'must be done with proper patient selection and adequate informed consent. However, no published local data is available on its outcomes. Our aim was to assess the safety and efficacy of prostate artery embolization in the New Zealand setting.

Patients and method

All cases of prostate artery embolisation that were performed at Auckland City Hospital were identified and records analyzed retrospectively. A total of 25 patients were identified. Median age was 70, median prostate size was 161cc. The primary endpoints of this study were safety, feasibility and efficacy.
Safety was measured by adverse events
Feasibility was defined by technical success
Efficacy was defined by outcomes:
Indication of prostatic bleeding: successful discharge from hospital without significant haematuria and further acute hospital presentations.
Indication of lower urinary tract symptoms (LUTS): further procedures for LUTS

Results
19 patients received PAE for LUTS, and 6 for prostatic bleeding. 97% were technically successful. There were no complications of Clavien-Dindo grade III or above. 83% of patients were day-stays or discharged day 1 post-procedurally. The short term efficacy of PAE for LUTS was 83% at 12 months, longer term efficacy dropping to 58% at 36 months. The short term efficacy of PAE for prostatic bleeding was 100%, longer term efficacy was 60%, with 3/5 patients not requiring any further hospitalisation for haematuria. The 2 patients who required further hospitalisation were successfully treated with ward based measures and did not require further invasive intervention.

Conclusion
PAE is a technically feasible and safe procedure. It is effective in the setting of prostatic bleeding. PAE for LUTS caused by benign prostatic hypertrophy (BPH) shows good short-term efficacy up to 12 months, but medium-term symptom recurrence is significantly higher than previously reported in the literature. This is likely confounded by the larger prostate sizes.

#abs59 | Randomized controlled trial of perirectal space creation using an iodinated hydrogel spacer in subjects with intermediate-risk prostate cancer receiving stereotactic body radiotherapy (SABRE Trial)

Professor Suneil Jain[1], **Professor Jarad Martin**[2], Danielle Vannan[3], Erin Chaussee[3], Dr. Sean Collins[4], Professor Michael Zelefsky[5], Professor Pierre Blanchard[6]

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Introduction and Objective
Prostate stereotactic body radiotherapy (SBRT) is a standard treatment for intermediate risk prostate cancer. Evidence suggests whole prostate dose escalation increases cancer control with increased risk of late gastrointestinal (GI) toxicity. The main objective of the SABRE Trial is to demonstrate the effectiveness of a next generation radiopaque polyethylene glycol (PEG) hydrogel spacer in reducing late GI toxicity in subjects undergoing prostate SBRT. Here we present clinical characteristics and extent of spacing in subjects enrolled to date.

Methods
In this prospective, multi-center, multinational randomized controlled trial (NCT04905069), 500 planned subjects are being randomized 2:1 spacer:control. Spacer subjects receive transperineal injection of 10 mL of the iodinated PEG hydrogel. SBRT (40Gy, 5 fractions) is planned for all subjects. Over 5-year follow-up, subjects will be assessed for GI and genitourinary toxicity (CTCAE), quality-of-life (EQ-5D-5L, EPIC-26), tumor control (PSA), device deficiencies and concomitant medications. Complete enrollment is anticipated in 2025 with primary endpoint (late grade 2+ GI toxicity) results available 24 months post-SBRT initiation.

Results
Data is reported from 28 sites in Europe (19), USA (6), and Australia (3). As of April 1, 2025, 475 subjects have been randomized and 395 (270 spacer, 125 control) have completed SBRT planning. Baseline characteristics do not differ between arms. The majority (66%) of subjects have Gleason score 3+4, and approximately 48% were on hormone therapy at baseline. Median mid-gland separation post-spacer placement is 9.1mm (IQR: 7.0-11.0). 92% subjects have received SBRT on a linear accelerator.

Conclusion
SABRE is the largest randomized trial to date comparing perirectal spacing to no spacing in prostate SBRT. Space creation using the iodinated PEG hydrogel aligns with studies of non-iodinated PEG hydrogel spacers (meta-analysis: median 10.8mm).1 The reported separation with iodinated spacer will likely translate into dosimetric benefit with SBRT in patients with intermediate risk prostate cancer.

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#abs60 | Real world assessment of MRI predictors of rectal complications following transperineal SpaceOAR Hydrogel Insertion

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Objectives

SpaceOAR® hydrogel post-market surveillance suggests significant complications are much more common than suggested by the original SpaceOAR® PIVOTAL trial. We aimed to assess the rates of rectal wall infiltration, seen on MRI, during transperineal placement of prostate-rectum hydrogel spacers (SpaceOAR® for patients with prostate cancer and their association with significant rectal complications.

Methods

A retrospective audit of all men who underwent transperineal SpaceOAR® hydrogel insertion at 2 centres (Nepean Public Hospital and Nepean Private Hospital) from 1 January 2017 to 30 June 2021 prior to radiotherapy for prostate cancer was undertaken. Baseline demographics, procedural details and post-operative outcomes were collected. Post-insertion MRIs were assessed for symmetry and rectal wall infiltration (RWI) according to the PIVOTAL trial protocol. Rectal complications were assessed and correlated to MRI findings.

Results

In total 139 patients were identified of which 113 had post-insertion MRIs performed. The median age was 72 years (range: 51 – 84 years), median PSA was 8ng/mL (range: 3.1 – 23ng/mL). Proportions of prostate cancer grade group (GG) were GG2 48%; GG3 16%; GG4 23% and GG5 13%.

47 (42%) cases had rectal wall infiltration on the post-SpaceOAR® insertion MRI. 22 (19.4%) were grade 1, 12 (10.6%) grade 2 and 13 (11.5%) were grade 3. Three patients had significant rectal complications, 2 patients had a grade 2 rectal ulcer, and 1 patient developed a rectourethral fistula. All 3 cases had significant grade 3 RWI on MRI, suggesting that grade 3 RWI is a significant risk factor for rectal complications post-SpaceOAR® insertion. GI symptoms are not a good predictor of RWI, with only 2 of the 7 cases of grade 3 RWI having GI symptoms. For the 2 patients with rectal ulcers- 1 patient had their radiotherapy delayed by 3 months and the other patient proceeded to radical prostatectomy.

Conclusions

Our real-world data suggests SpaceOAR® hydrogel insertion results in a much higher RWI rate than suggested by the PIVOTAL trial (6% in PIVOTAL trial vs. 41% in our cohort). Grade 3 RWI was associated with a significant risk in significant rectal complications. Given that RWI could not be predicted by GI symptoms, SpaceOAR® insertion should be followed by an MRI to ensure there is no significant rectal wall infiltration. In cases with significant rectal wall infiltration delay of treatment and referral for colorectal assessment for the presence of rectal ulceration should be considered to prevent serious rectal complications.

#abs61 | Real-world Clinical Outcomes in Australian patients with Non-metastatic (M0) Castration-Resistant Prostate Cancer (CRPC)

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Introduction
Androgen receptor pathway inhibitors (ARPIs) improve metastasis-free survival (MFS) and overall survival (OS) in non-metastatic castrate-resistant prostate cancer (M0CRPC)1-3. Enzalutamide, apalutamide and darolutamide are available in Australia. This real-world study describes treatment patterns and outcomes in Australian M0CRPC patients.

Methods
Patients with M0CRPC were identified from the electronic Prostate Cancer Australian Database (ePAD), a multi-centre, prospective clinical registry. Patient characteristics and treatment patterns were analysed using descriptive statistics. MFS and OS were calculated through Kaplan-Meier methods.

Results
224 patients were diagnosed with M0CRPC between 30 June 2006 and 15 July 2024. Median age was 75 years (range 37-94). 38% had a Gleason score ≥8, 75% were ECOG 0-1, 76% had prior local therapies and 14% underwent prostate-specific membrane antigen positron emission tomography (PSMA- PET). Median follow-up was 56.6 months. Median time to CRPC was 43 months (range 0.9 – 303). 50% had a PSA-doubling time (PSADT) <7 months.

94 patients (42%) received systemic therapy other than first-generation anti-androgens (FGA), including enzalutamide (47%), darolutamide (39%), abiraterone (11%) and docetaxel (3%). Patients on systemic treatment were younger (median age 73 vs 78 years) and had a shorter median time to CRPC (38.5 vs 50.8 months). 48% had a PSADT <7 months.

After ARPIs first became available in Australia in September 2020, systemic therapy use increased from 38% (69/182) to 60% (25/42). FGA as sole therapy declined from 63% to 21%.

Median MFS was 19.8 months with no additional therapy, 51.6 months with enzalutamide, and not reached for darolutamide or abiraterone. Although data are immature, mOS was similar between groups.

Adverse events occurred in 57% on enzalutamide, 40% on abiraterone and 11% on darolutamide.

Conclusions
ARPIs have been rapidly adopted and used in Australia. MFS reflect pivotal trial results. OS findings remain immature. Ongoing survival and toxicity analyses will refine clinical practice.

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#abs62 | Renal PNET in young patients, uncommon entity: Results of long term follow up after multi modality treatment from tertiary cancer care centre

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Introduction and objectives
Renal-PNET is a rare, aggressive malignant tumor in young population with high recurrence and metastasis rate.[1,2] This study aim to review clinical profile, management and outcomes of patients with renalPNET after multi modality treatment from tertiary cancer care centre .

Methods
This retrospective study retrieved demographic and clinical data of 32-renalPNET patients treated at a tertiary cancer care centre in mumbai, India. Descriptive analysis was done for baseline characteristics. Kaplan-meier method was used to analyze overall survival(OS) and progression-free survival(PFS). Cox regression was used for univariate analysis.

Results

There were 25-male and 7-female patients, with median age of 27-years. At diagnosis, 23-patients were nonmetastatic and 9-patients were metastatic. Median follow up duration was 22 months. 30-patients were symptomatic, while 2-patients had incidental diagnosis. On immunohistochemistry, MIC2, FLI1 and synaptophysin were positive in 29, 18 and 12 patients. 22-patients underwent radical and 1-patient underwent partial nephrectomy. Out of thirty-two, 17-patients received first-line chemotherapy, 17.6%(n=3) received both neoadjuvant and adjuvant, 76.5%(n=13) received adjuvant and 23.5%(n=4) received palliative chemotherapy. Adjuvant radiotherapy was given to renal-bed in 8-patients and oligometastatic sites in 4-patients. 20-patients had disease progression, among which 14 had non-metastatic and 6 had metastatic disease at baseline. The overall median PFS and OS were, 11.6 months(95%CI-8.73-14.53) and 27.8 months(95%CI-14.72-40.9). Tumor size did not affect survival outcomes. Median OS with multi-modality treatment, in non-metastatic and metastatic disease were, 44.6 versus 7.6 months(p-value-0.033). Nephrectomy improves median OS significantly(36.4 versus 5.5 months)(p-value<0.001). Chemotherapy received in any line improves median OS by 27.8 versus 13.83 months(p-value-0.03). Multimodality treatment approach had better survival outcomes.

Conclusions

RenalPNET is an aggressive tumor which must be included in differential diagnosis in young patients with renal mass and should be treated with a multimodality approach. Denovo-metastatic disease carries poor prognosis. Tumor size did not affect survival outcomes.

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#abs63 | Review of relapse detection methods in stage 1 testicular germ cell tumours in patients after orchidectomy managed with active surveillance: Is Physical Examination required?

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Introduction and Objectives

Active surveillance (AS) is the preferred management strategy for most patients diagnosed with stage 1 testicular germ cell tumours (GCT) after orchidectomy based on data from large retrospective cohort studies. AS avoids chemotherapy in up to 85% of patients. Detection of relapse at the earliest possible stage increases chances of survival. International AS guidelines recommend a traditional face-face model of patient follow-up with a combination of imaging, serum tumour markers and physical examination. Reported optimal adherence to AS is only in the range of 55-80%. The aim of this review was to analyse the diagnostic yield for detecting relapse in patients with stage 1 GCTs managed with AS, particularly with regard to the role of routine physical examination.

Methods

Systematic review of the literature from 1976 to 2024 detailing method of relapse detection for patients with stage I GCT managed with AS. Studies commencing after 1990 were assigned to the 'Modern Cohort' and studies recruiting before this date were assigned to the 'Older Cohort'. Descriptive statistical analysis of discrete data was performed to determine recurrence and proportion of patients, where relevant. The chi squared test was used to determine statistical significance.

Results

Twenty relevant articles were identified representing 2232 (20%) relapses amongst 11,414 patients with stage 1 GCTs managed with AS following orchidectomy. Relapses were detected by imaging alone in 60%, tumour markers alone in 24%, imaging and markers in 15%, and physical examination in 1.5%. Comparing the Modern cohort (n=4771) to the Older

cohort (n=6643), there were fewer relapses detected by physical examination (0.3% vs 2%, p=0.01) and more relapses detected by imaging alone (71% vs 55%, p<0.00001).

Conclusions
Almost all relapses of patients managed with AS are detected by routine imaging, serum tumour markers or a combination of these methods. Physical examination alone rarely identified relapses, particularly in the Modern cohort which we hypothesise was primarily driven by improvement in computerised tomography (CT) imaging techniques. AS can be conducted safely without mandatory physical examination. Novel surveillance programs focusing on ensuring imaging and serum tumours markers are performed on schedule may lead to improved adherence to AS. These may include offsite telehealth or digital applications to increase engagement with AS and reduce potential delays in detecting relapse and associated worsening of prognostic factors.

#abs64 | Role of confirmation biopsy and surveillance biopsies in active surveillance of GG 1 prostate cancer

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Active surveillance (AS) is a management option for men with low-risk prostate cancer.

This study aimed to determine whether confirmation biopsies improve metastatic disease-free survival and treatment-free survival for men on AS.

We conducted a retrospective cohort study using prospectively collected data from 296 men with Gleason Grade Group (GG) 1 disease referred for AS at a large medical center between 2014 and December 2020. Data collection occurred around May 2024. Patients were divided into those who received a confirmation biopsy and those who did not, and their outcomes were analyzed.

Among the cohort:
1 patient (0.3%) had missed progression to metastatic disease and later died from prostate cancer.
11 patients (3.7%) experienced biochemical disease recurrence post-treatment.

5 patients had detectable and rising PSA post-prostatectomy but did not reach the 0.2 ng/mL threshold.

2 patients had PSA rises of >1 ng/mL over nadir but <2 ng/mL post-radiotherapy.

All 19 patients with disease progression or treatment failure had received a confirmation biopsy.

A total of 223 patients underwent a repeat biopsy within 24 months, while 51 patients did not.

Key findings
The missed progression/treatment failure rate was 8.5% for those with confirmation biopsies and 0% for those without.

The median age at diagnosis was similar between groups (64 years with confirmation biopsy vs. 66 years without, $p > 0.05$).

The median PSA at diagnosis was higher in those without confirmation biopsies (6.6 vs. 5.3, $p < 0.05$).

Patients with confirmation biopsies transitioned to treatment at a higher but statistically insignificant rate (odds ratio 0.65, 95% CI 0.3–1.3, $p = 0.21$), with a longer median time to treatment (64 months vs. 54 months).

Those who underwent confirmation biopsies had more intensive surveillance, with median surveillance biopsies every 2.8 years and MRI every 2.0 years, compared to every 5.7 years and 2.1 years, respectively, for those without a confirmation biopsy.

Conclusion
For men with GG1 disease over a minimum follow-up of 4.2 years, not having a confirmation biopsies was associated with fewer surveillance biopsies, lower conversion rates to treatment, and lower rates of treatment failure. Despite higher baseline PSAs in the non- confirmation biopsy group, confirmation biopsies and increased surveillance biopsies did not improve disease-related mortality, missed progression, or treatment failure rates. These findings suggest that less intensive surveillance and the omission of confirmation biopsy are not associated with adverse outcomes over 4.2 years of active surveillance for GG1 prostate cancer.

#abs65 | Secondary outcomes by prior definitive treatment in patients with high-risk biochemically recurrent prostate cancer treated with enzalutamide monotherapy: EMBARK post hoc analysis

Dr Stephen Freedland, Dr Ugo De Giorgi, Dr Ronald F. Tutrone, Dr Lawrence I. Karsh, Dr Miguel Ramirez-Backhaus, Dr Edward M. Uchio, Dr Yiyun Tang, Dr Ruslan Croitoru, Dr Matt Rosales, Dr Matko Kalac, Dr Fong Wang, Dr Neal D. Shore, **Dr Henry Woo**

Background
The EMBARK trial demonstrated clinically meaningful improvement in metastasis-free survival and secondary efficacy endpoints with enzalutamide monotherapy (enza mono) vs leuprolide alone. We descriptively report secondary endpoints for enza mono vs leuprolide alone across prior definitive treatment subgroups.

Methods
Eligible patients had high-risk biochemically recurrent prostate cancer (hrBCR), with a PSA doubling time ≤9 months. Patients were randomized 1:1:1 to enza + leuprolide, leuprolide alone, or enza mono. Secondary endpoints included time to PSA progression, first use of new antineoplastic treatment, distant metastasis, resumption of any hormonal therapy after treatment suspension, and symptomatic progression. Post hoc subgroup analyses descriptively compared secondary endpoints for enza mono vs leuprolide alone in patients with radical prostatectomy (RP) only, radiotherapy (RT) only, or RP+RT.

Results
In both treatment groups (enza mono [n=355] and leuprolide alone [n=358]), nearly half of patients had prior RP+RT (enza mono [n=166]; leuprolide alone [n=179]). In all prior definitive treatment subgroups (RP only, RT only, RP+RT), enza mono vs leuprolide alone numerically reduced the risk (hazard ratio, [95% CI]) of PSA progression: 0.62 (0.28–1.34), 0.53 (0.30–0.95), 0.14 (0.06–0.33); of first use of new antineoplastic treatment: 0.68 (0.38–1.22), 0.76 (0.48–1.20), 0.37 (0.23–0.58); of distant metastasis: 0.81 (0.32–2.08), 0.65 (0.31–1.34), 0.45 (0.24–0.85); and of symptomatic progression: 0.61 (0.36–1.03), 0.79 (0.52–1.22), 0.56 (0.39–0.80). Time to resumption of any hormonal therapy favored leuprolide alone vs enza mono across all prior definitive treatment subgroups.

Conclusions
Enza mono treatment showed improvements in all secondary endpoints except time to resumption of any hormonal therapy vs leuprolide alone, regardless of prior definitive treatment. Small sample size and event numbers should be considered when interpreting the results. Interaction analyses of secondary endpoints across prior definitive treatment subgroups will be reported in the presentation.

Clinical trial registration number: NCT02319837

Disclosure
Pfizer's generative AI tool, MAIA, was used to draft this abstract (accessed: 2024-10-01); the authors reviewed, edited, and take full responsibility for the content.

Funding
The study was sponsored by Pfizer Inc. and Astellas Pharma Inc., the co-developers of enzalutamide.

Acknowledgments
Medical writing and editorial support, funded by the sponsors, were provided by Roham Sadeghimakki and Rosie Henderson of Onyx, a division of Prime (London, UK), along with Mikaeel Valli, Olga Klibanov, and Nathaniel Grubbs from IQVIA.

#abs66 | Secondary outcomes by prior definitive treatment in patients with high-risk biochemically recurrent prostate cancer treated with enzalutamide plus leuprolide: EMBARK post hoc analysis

Dr Henry H. Woo, Dr Stephen J. Freedland, Dr Martin Gleave, Dr Ugo De Giorgi, Dr Antti Rannikko, Dr Swetha Sridharan, Dr Klaus Brasso, Dr Antonio Gómez Caamaño, Dr Luke T. Nordquist, Dr Yiyun Tang, Dr Ruslan Croitoru, Dr Matt Rosales, Dr Matko Kalac, Dr Olivier Peraud, Dr Fong Wang, Dr Neal Shore

Background
EMBARK showed enzalutamide plus leuprolide (combo) vs leuprolide alone improved metastasis-free survival and secondary efficacy endpoints. Secondary endpoints (S-EPs) for combo vs leuprolide alone are reported across prior definitive treatment subgroups.

Methods
EMBARK enrolled patients with high-risk biochemically recurrent prostate cancer (hrBCR; PSA doubling time ≤9 months). Patients were randomized 1:1:1 to combo, leuprolide alone, or enzalutamide monotherapy. S-Eps: time to PSA progression, first use of new antineoplastic treatment, distant metastasis, resumption of any hormonal therapy, and symptomatic progression. Post hoc subgroup analyses compared S-EPs for combo vs leuprolide alone in patients with prior radical prostatectomy (RP), radiotherapy (RT), or RP+RT.

Results
In both groups (combo [n=355], leuprolide alone [n=358]), nearly half of patients had prior RP+RT (combo [n=179]; leuprolide alone [n=179]). In all prior definitive treatment subgroups (RP only, RT only, RP+RT) combo vs leuprolide alone numerically reduced the risk (hazard ratio, [95% CI]) of PSA progression: 0.05 (0.01–0.41), 0.10 (0.03–0.27), 0.06 (0.02–0.21); first use of new antineoplastic treatment: 0.54 (0.28–1.02), 0.28 (0.15–0.52), 0.34 (0.21–0.53); distant metastasis: 0.51 (0.17–1.59), 0.47 (0.22–1.00), 0.34 (0.18–0.67); resumption of any hormonal therapy: 0.74 (0.51–1.08), 0.92 (0.61–1.39), 0.60 (0.46–0.79); and symptomatic progression: 0.76 (0.46–1.28), 0.55 (0.34–0.89), 0.46 (0.32–0.66). No significant interactions were observed for time to PSA progression (Pinteraction=0.79) and first use of new antineoplastic treatment (Pinteraction=0.57) across prior definitive treatment subgroups. P-interactions for other endpoints will be reported in the presentation.

Conclusions
Combo treatment improved all S-EPs vs leuprolide alone in all prior definitive treatment subgroups, suggesting its benefits for patients with hrBCR, supporting combo as the new standard of care for patients with hrBCR regardless of prior definitive treatment. Small sample sizes of the non-randomized subgroups and low event numbers should be considered when interpreting results.

Clinical trial registration number: NCT02319837

Disclosure
Pfizer's generative AI tool, MAIA, was used to draft this abstract (accessed: 2024-10-01); the authors reviewed, edited, and take full responsibility for the content.

Funding
The study was sponsored by Pfizer Inc. and Astellas Pharma Inc., the co-developers of enzalutamide.

Acknowledgments
Medical writing and editorial support, funded by the sponsors, were provided by Roham Sadeghimakki and Rosie Henderson of Onyx, a division of Prime (London, UK), along with Mikaeel Valli, Olga Klibanov, and Nathaniel Grubbs from IQVIA.

#abs67 | Subgroup analyses of patients with advanced urothelial carcinoma who had long-term progression-free survival or overall survival with avelumab first-line maintenance in the AVENANCE real-world study

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Background
Avelumab first-line maintenance (1LM) is approved worldwide for patients with advanced urothelial carcinoma (aUC) without progression after 1L platinum-based chemotherapy (PBC) based on the JAVELIN Bladder 100 phase 3 trial. AVENANCE, a noninterventional, ambispective study, showed the effectiveness and safety of avelumab 1LM in a real-world aUC population in France. Here, subgroups defined by duration of progression-free survival (PFS) or overall survival (OS) were analyzed.

Methods
Eligible patients had aUC without progression after 1L PBC, and previous, ongoing, or planned avelumab 1LM treatment. The primary endpoint is OS. Characteristics of subgroups with short or long PFS (≤3 or ≥12 months from avelumab start, respectively) or long OS (≥3 years from 1L PBC start) were analyzed.

Results
At data cutoff (July 15, 2024), median follow-up was 33.2 months. Of 595 patients (efficacy population), 187 (31.4%) had short PFS, 173 (29.1%) had long PFS, and 139 (23.4%) had long OS. Compared with the short PFS subgroup, long PFS and long OS subgroups had higher proportions with ECOG PS of 0 (25.6% vs 38.1% and 41.7%), prior 1L cisplatin (19.9% vs 34.1% and 36.7%), or complete response to 1L PBC (11.9% vs 22.7% and 26.6%). In the short PFS, long PFS, and long OS subgroups, respectively, second-line treatment after avelumab was received by 72.2%, 30.6%, and 41.0%, including enfortumab vedotin in 6.4%, 14.5%, and 13.7%; PBC in 10.7%, 6.9%, and 10.8%; and non-PBC in 49.2%, 4.6%, and 10.8%.

Conclusions
Subgroup analyses from AVENANCE show that long-term PFS and OS with avelumab 1LM treatment occurred in 29% and 23% of patients, respectively, including patients with varying characteristics and irrespective of 1L PBC regimen.

#abs68 | Systematic review of single use disposable sheaths for flexible cystoscopy

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Introduction
Flexible cystoscopy is a commonly performed urological procedure for workup and surveillance of bladder cancer. These have traditionally been performed using reusable cystoscopes that are disinfected between patients, but there has been a shift in recent years to single use cystoscopes, primarily to reduce costs. Single use disposable sheaths (SUDS) for cystoscopes are an alternative that have had poor uptake in Australia despite being cheaper and having a smaller environmental footprint. A review of the literature was conducted to explore the reasons behind this.

Methods
A systematic review of PubMed, CENTRAL, Google Scholar ("endosheath"; "sheath" AND "cystoscop*") was conducted, including studies from any year and any language. Abstracts were filtered for relevance, and 12 studies were included for final analysis.

Results
Several common themes emerged from comparing SUDS to disinfection of reusable cystoscopes. Five studies examining cost demonstrated SUDS was either cheaper or comparable to disinfection, with only one study indicating SUDS was more expensive. Across 7 studies, there was no increased risk of infection, very low risk of sheath breach, and no evidence of cystoscope contamination at the end of the case both macroscopically and microscopically. Patient-reported outcomes were either comparable or favoured SUDS across 3 studies. However, clinician-reported experience was less favourable, with only one study reporting comparable outcomes. The other 5 studies examining clinician-reported experience reported longer setup time in theatre and difficulty with setup, inability to insert a sheathed scope (5% in one study), difficulty with handling, poor visibility, and inability to remove the sheath at the end of the case (15% in one study).

Conclusion

Single use disposable sheaths for cystoscopes are a reasonable alternative from a financial, infection control, and patient experience perspective. However, there remain difficulties with clinician experiences with SUDS, which are likely contributing to poor uptake in Australia.

#abs69 | Translational Evaluation of a Novel Therapy for Anaplastic, Treatment Emergent Neuroendocrine Prostate Cancer

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Introduction and Objectives

Treatment-emergent neuroendocrine prostate cancer (tNEPC) is a highly aggressive, anaplastic form of prostate cancer with no effective curative treatments (1). Accordingly, there is an urgent clinical need to find novel therapeutic targets and/or strategies to improve the survival outcomes of men harbouring tNEPC. Recent studies have identified overexpression of the facilitates chromatin transcription (FACT) complex in anaplastic tumours, and in particular those possessing a neuroendocrine phenotype (2). Recently, a curaxin-based molecule, CBL0137, has been shown to be an effective targeted-agent for inhibiting FACT function (3). Therefore, this study aims to assess the effect of CBL0137 as a novel targeted treatment for tNEPC, both as a monotherapy and as a co-therapy alongside the standard platinum-based chemotherapy, cisplatin.

Methods

By taking advantage of several clinically relevant ex-vivo patient-derived xenograft organoid (PDXO) models, inhibitory concentrations of CBL0137 were evaluated and have further probed its therapeutic potential as a companion therapy with cisplatin. This project also conducts a comprehensive multi-omic investigation into the molecular mechanisms enacted by CBL0137.

Results

CBL0137 exhibits potent inhibitory effects across all the PDXO models tested, with calculated IC50 values in low micromolar ranges confirming its robust anti-tumour activity against tNEPC. Western blot analysis confirmed a marked reduction in tumour proliferation and enhanced apoptotic mechanisms following CBL0137 treatment. Notably, combination treatment with cisplatin and CBL0137 resulted in improved therapeutic efficacy compared to either drug alone, indicating a potential beneficial effect that enhances overall treatment response.

Conclusion

Our findings confirmed that CBL0137 is a promising treatment strategy for the tNEPC, capable of potentiating the effects of standard platinum-based chemotherapy. This study further explores the functional mechanisms and molecular consequences of CBL0137 treatment on the processes implicated in tNEPC pathogenesis, which will ultimately improve the clinical outcomes of the poorly differentiated, highly aggressive anaplastic prostate cancer.

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#abs70 | Treatment Expenditures and Survival Outcomes in Metastatic Castration-Resistant Prostate Cancer: Insights from a Resource-Constrained Environment

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Background

Metastatic castration-resistant prostate cancer (mCRPC) poses major clinical and economic challenges due to its aggressive course in a resource-constrained environment.

Methods

This was an IEC approved retrospective analysis which included metastatic CRPC patients treated between 2018 and 2022. The baseline characteristics, treatment, toxicities and outcomes (PFS and OS) were recorded.

Results

A total of 138 mCRPC patients were included. Median follow-up was 72.6 months. The median age was 62 years. Hypertension and Diabetes were seen in 47 (34.1%) and 38 (27.5%) respectively. Gleason score > 8 was seen in 103 (74.6%). At baseline, 92 (66.7%) had high-volume disease. In the hormone-sensitive phase, 56 (40.6%) received docetaxel and 29 (21%) received Androgen Receptor Pathway Inhibitor (ARPI). Surgical castration was done in 96 (69.6%). The median PFS1, PFS2, PFS3 and PFS4 were 8.5, 7.6, 5.8 and 5.7 months respectively. The median OS was 19.2 months. In first-line mCRPC, 82 (59.4%) received Abiraterone while 40 (29%) received Docetaxel. PFS1 was longer with ARPI vs chemotherapy(9.1 vs 6.6 months; p=0.426) while the median OS was similar (19.8 vs 19.1 months; p=0.128). Chemotherapy-related grade 3/4 hematological toxicities occurred in 32%, 18%, 36% and 44% in first, second, third and fourth-line respectively. ARPI-related heart failure occurred in 8%, 15%, 20% in first, second and fourth-line respectively. First-line chemotherapy had a lower mean cost of therapy per month of OS than ARPI (Rs 5080 (USD 60) vs Rs 7181 (USD 85)). Patients treated with Lu-PSMA had longer median OS (27.1 vs 18.5 months; p=0.270) albeit at a higher cost of therapy per month of OS (Rs 14625 (USD 173) vs Rs 5598 (USD 66)).

Conclusion

The median PFS and OS were similar regardless of whether chemotherapy or APRI was initiated first, but chemotherapy had lower mean total cost of therapy per month of OS.

#abs71 | Tumour-based epigenetic markers of prostate cancer aggressiveness: focus on the Gleason score

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Introduction and objectives
Biomarkers of prostate cancer aggressiveness may be valuable to better predict outcomes. Using a large set of prostate tumours (N=1495) with genome-wide DNA methylation measurements, we aimed to: 1) carry out an epigenome-wide association study of Gleason score: 2) develop and validate an epigenetic marker of aggressiveness.

Methods
Data included publicly available datasets: TCGA (N=491), FredHutchinson Cancer Centre (N=517), ICGC-PRADFR (N=129) - used for discovery; and two cohorts of Australian men with prostate tumour methylation measurements from radical prostatectomies (N=241) and diagnosing biopsies (N=117) - used for validation. An epigenome-wide association study of Gleason score (pseudocontinuous: 6, 7(3+4); 7(4+3); 8; 9(4+5); 9(5+4); 10) was carried out. Elastic net-penalised linear regression was used to derive an epigenetic signature of Gleason score (mGS), which was then assessed in the validation sets for association with PSA recurrence or prostate cancer-specific mortality beyond available clinical variables including Gleason score.

Results
A total of 310,485 CpG sites were available for analysis. Of these, 25,018 were associated ($P<10^{-7}$) with Gleason score in the discovery set, of which 24,059 (96%) were replicated ($P<0.05$). The most strongly implicated pathways were 'calcium signalling' and 'cell periphery'. mGS included 106 CpGs and was strongly correlated with Gleason score in the two validation sets (r=0.60 and r=0.59, respectively). mGS was independently associated with risk of PSA recurrence within 2 years after radical prostatectomy (N events=49, risk ratio per standard deviation=1.32, 95%CI: 1.02-1.71, P=0.03) and with prostate cancer death (N events=82, hazard ratio=2.24, 95%CI: 1.64-3.01, $P=4\times10^{-7}$).

Conclusions
This study revealed widespread, highly-replicable methylation markers of prostate cancer aggressiveness and validated an epigenetic signature that may enhance the Gleason score for prediction of prostate cancer outcomes. Evaluation of mGS or similar epigenetic signatures in liquid biopsies might offer greater clinical applicability for prostate cancer management.

#abs72 | Uncovering the mechanisms linking mitochondrial dysfunction and valine metabolism in the development of castrate-resistant prostate cancer.

Dr Charles Bidgood[1], Mr Jesse Travaini[1], Dr Lisa Philp[1], Dr Anja Rockstroh[1], Dr Melanie Lehman[1,2], Prof Colleen Nelson[1], Dr Jenni Gunter[1]

[1]APCRC-Q, Queensland University of Technology, [2]Vancouver Prostate Centre, UBC

Introduction and objectives
Androgen receptor pathway inhibitors (ARPIs) improve survival, but tumours eventually develop resistance and disease progresses rapidly. In studying ARPI resistance pathways, we discovered a unique reliance of PCa cells on the uptake and metabolism of the essential amino acid valine that emerges in response to ARPIs. Our studies showed the breakdown of valine is critical for maintaining high succinate levels in the mitochondria of PCa cells and blocking valine metabolism results in death of malignant, but not benign PCa cells (1).

A number of recent studies have reported elevated succinate levels in high-grade prostate tumours correlates to increased succinate respiration in the mitochondrial TCA cycle (2-5) and may be linked to mutations in the mitochondrial genome (mtDNA). We aimed to identify whether valine dependency is driven by mtDNA damage, to better understand the molecular mechanisms underpinning this metabolic rewiring.

Results
From our RNAseq studies of ARPI-treated PCa cell and tissues, we generated a gene signature 'MitoS' from the differentially expressed enzymes of valine and succinate metabolic pathways. MitoS is enriched in CRPC patient tissue and cell lines and is further upregulated in castrate resistant and enzalutamide-resistant experimental models showing

the co-expression of enzymes of valine degradation and succinate respiration in metastatic CRPC tissue (6). Using the Seahorse Bioanalyser, we measured succinate respiration in PCa cells ranging from benign (BPH1), CRPC (LNCaP, DUCaP), ENZ-resistant (MR49F, MR42D and V16D) and AR-null models (DU145, PC3) which indicated increased dependency on succinate respiration with disease progression from 6% to 20% (percentage of basal oxygen consumption rate). RNAseq has also been used to identify the frequency and distribution of mtDNA variants (against Nanopore DNA sequencing) linked to MitoS and valine metabolism.

Conclusions
Our results identify an irreversible metabolic dependency associated with mitochondrial dysfunction. This information provides a valuable predictive tool for valine and succinate-dependent tumours.

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#abs73 | Using Patient-Reported Outcome Measures in Cancer Clinical Trials: Perspectives For and Against a 'Modular Approach'

Dr Carrie-anne Ng[1,2], Dr Tim Luckett[1,2], A/Prof Brendan Mulhern[1,2]

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Background and aims
There is growing interest in customising patient-reported outcome measures (PROMs) by selecting specific subscales/domains that focus on the key health-related quality of life (HRQoL) outcomes most relevant to a particular trial or clinical trial context and omitting others – called the 'modular approach'. This approach has sparked ongoing debate, focusing on balancing the collection of data that is important from the patient perspective with minimising respondent burden. The aim of this presentation is to explore various perspectives for and against adopting a modular approach for PROM inclusion.

Methods
This presentation will examine the arguments for and against a modular approach. Key considerations, such as ensuring the inclusion of sufficient domains for economic evaluation purposes, will also be discussed.

Results
ANZUP investigators are invited to learn about the modular approach, weighing both its advantages and limitations, to support decision making regarding PROM inclusion in their studies. On one hand, including fewer items reduces respondent burden and allows for flexible assessment of different HRQoL constructs at specific frequencies or timepoints that are meaningful. On the other hand, this approach may overlook unknown HRQoL issues affecting patients and make comparability with other studies challenging. The Cancer Quality of Life Expert Service Team (CQUEST) can work collaboratively with investigators, assisting in the choice of PROMs and/or PROM subscales after key HRQoL concepts of interest have been identified.

Conclusion
CQUEST invites ANZUP members to engage with our presentation to inform decisions about the selection of PROMs in cancer clinical trials. This will ensure the trial objectives are directly addressed while considering participant burden and yielding results that are optimally informative for stakeholder needs.

#abs74 | Wombat Trial

Megan Crumbaker, **Barak Talmor**, Laurence Krieger, David Pook, Ian Davis, Antoinette Fontela, Christopher Oldmeadow, Josh Hurwitz, Andrisha Inderjeeth, Haryana Dhillon, Teesha Downton, Gavin Marx, Samantha Shekar, Emmanuel Antonarakis, Samuel Denmeade, Angelyn Anton, Thean Tan, Sharad Sharma, Jeffrey Goh, Lisa Horvath, Anthony Joshua

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Camperdown, Australia, Hunter Medical Research Institute, Newcastle, Australia, The Kinghorn Cancer Centre, Darlinghurst, Australia, South Metropolitan Health Campus Perth WA Australia, Perth, Australia, Faculty of Science, School of Psychology, Centre for Medical Psychology & Evidence-based Decision-making, Psycho-Oncology Cooperative Research Group, The University of Sydney, Sydney, NSW, Australia, Sydney Adventist Hospital, Sydney, NSW, Australia, The Kinghorn Cancer Centre, St Vincent's Hospital, Sydney, Australia, University of Minnesota, Masonic Cancer Center, Minneapolis, MN, Johns Hopkins University School of Medicine, Baltimore, MD, Eastern Health, Melbourne, VIC, Australia, Department of Medical Oncology, Royal Adelaide Hospital, Adelaide, Australia, Ballarat Regional Integrated Cancer Centre, Ballarat Health Services, Ballarat, VIC, Australia, Royal Brisbane and Women's Hospital, Herston, Australia, Chris O'Brien Lifehouse, University of Sydney, Sydney, NSW, Australia, The Kinghorn Cancer Centre, St Vincent's Hospital, Darlinghurst, Australia

Background

The backbone of prostate cancer systemic treatment is androgen deprivation therapy (ADT) increasingly with the use of androgen receptor pathway inhibitors (ARPIs). Mechanisms for ARPI resistance include amplification of the androgen receptor (AR), overexpression of AR variants, aberrant AR activity, and autocrine/paracrine androgen synthesis in tumour cells. Preclinical and clinical studies have identified that bipolar androgen therapy (BAT) may restore the sensitivity of prostate cancer to ARPIs. We plan to test this hypothesis in patients with PSA progression on darolutamide for non-metastatic castrate resistant prostate cancer.

Methods

WOMBAT (ANZUP 2201, NCT06594926, ACTRN12624000582550) is a single-arm phase 2 trial. The primary endpoint is to determine metastasis-free survival (MFS; time from commencing BAT to evidence of metastases or death, by conventional imaging as per PCWG3 criteria). Secondary endpoints include toxicity of BAT and darolutamide; effects on health-related quality of life; efficacy measures (PSA response rate; PSA progression-free survival); effects of BAT and darolutamide on bone turnover. Inclusion criteria include: PSA progression on darolutamide for nmCRPC; M0 on conventional imaging. Treatment consists of BAT (IM testosterone enanthate 500mg) day 1 and darolutamide 600mg bd days 29-56 (of a 56-day cycle) with ongoing ADT. The total sample size of 69 (with a first stage of enrolment of 44) is calculated to demonstrate an increase in the proportion of participants without detectable metastases at 6 months from 56.1% to 66.7% (corresponding to a median MFS improvement from 7.2 to 10.27 months, HR 0.6) with a one-sided type I error of $\alpha = 10\%$ and power of 80%, based on benchmarks from the ARAMIS trial of darolutamide in nmCRPC. Enrolment has commenced at 8 sites around Australia.

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