

Poster Session 7: Oncology–Bladder, Renal, Testes (Part 2)

Saturday, October 11, 2025 • 7:00–8:00 am

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Abstract #86

TAR-200 monotherapy in patients with bacillus Calmette-Guérin-unresponsive high-risk non-muscle-invasive bladder cancer carcinoma in situ: 1-year durability and patient-reported outcomes from SunRISe-I

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Introduction: Patients (pts) with bacillus Calmette-Guérin (BCG)-unresponsive high-risk non-muscle-invasive bladder cancer (HR NMIBC) have a high risk of disease progression and limited treatment (tx) options. TAR-200 is an intravesical drug-releasing system designed to provide sustained delivery of gemcitabine in the bladder. SunRISe-I (NCT04640623) is an ongoing phase 2b study assessing TAR-200 in pts with BCG-unresponsive HR NMIBC, ineligible for/refused radical cystectomy. Cohorts 1–3 enrolled pts with carcinoma in situ (CIS) ± papillary disease. We report one-year duration of response (DOR) and patient-reported outcomes (PRO) in pts receiving TAR-200 monotherapy (cohort 2).

Methods: Pts (≥18 y; ECOG PS 0–2) had histologically confirmed CIS ± papillary disease (high- grade Ta, any T1) with last dose of adequate BCG ≤12 months of CIS diagnosis. TAR-200 was dosed Q3W to W24 then Q12W to W96. No re-induction for non-responders was allowed. Primary Endpoint was overall complete response (CR) rate. Secondary endpoints were DOR, overall survival, PROs, and safety. Response assessments included cystoscopy, centrally assessed urine cytology (Q12W), centrally assessed biopsy (W24/48), and local imaging (Q24W). Change from baseline in global health status (GHS) and physical functioning (PF) scores (0 [worse]–100 [better]) on EORTC- QLQ-C30, completed at W0, 6, 12, Q12W on tx, and at safety follow-up, was assessed.

Results: On the September 4, 2024 data cutoff, 85 pts (median age, 71 y [range 40–88]; 80% male; 33% with concurrent papillary disease) received tx, with a median followup 14 mo (range 2–41). Centrally confirmed and investigator-assessed CR rates were both 84% (95% CI 74–91). Estimated 12-month CR rate was 50% (95% CI 36–62). Estimated median DOR and one-year DOR rate were 26 months (95% CI 9–NE) and 55% (95% CI 40–68), respectively. Nine pts completed two years of tx; seven remain in response. Mean GHS (75 [SD 16.7]) and PF (86 [SD 17.3]) scores were high at baseline and stable on tx (did not exceed clinically meaningful change threshold of ≥10 points); 71 pts (84%) had tx-related adverse events (TRAEs); most were low-grade lower urinary tract AEs. Ten pts (12%) had

grade ≥3 TRAEs; five (6%) had serious TRAEs; three (4%) had TRAEs leading to tx discontinuation. No tx-related deaths occurred.

Conclusions: TAR-200 monotherapy was well-tolerated, with the highest CR rate reported in BCG-unresponsive HR NMIBC. Responses were highly durable, and most responders were disease-free at one year. Clinical benefit of TAR-200 was achieved with sustained overall health status and high PF. Data will be updated after final results in April.

Funding: Janssen Research and Development, LLC, a Johnson and Johnson company.

Abstract #87

TAR-200 monotherapy in patients with bacillus Calmette-Guérin-unresponsive papillary disease-only high-risk non-muscle-invasive bladder cancer: First results from cohort 4 of SunRISe-I

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Introduction: Treatment options are limited for patients with bacillus Calmette-Guérin (BCG)-unresponsive high-risk non-muscle-invasive bladder cancer (HR NMIBC) with papillary disease only. TAR-200 is an intravesical drug-releasing system designed to provide sustained delivery of gemcitabine in the bladder. The ongoing phase 2b SunRISe-I study (NCT04640623) is assessing TAR-200 in patients with BCG-unresponsive HR NMIBC who are ineligible for or refused radical cystectomy. Cohorts 1–3 enrolled patients with carcinoma in situ (CIS) ± papillary disease. Cohort 4 is assessing TAR-200 monotherapy in patients with BCG-unresponsive papillary-only HR NMIBC. We report interim analysis data from cohort 4.

Methods: Eligible patients (≥18 years; ECOG performance status 0–2) with histologically confirmed papillary-only HR NMIBC (high-grade Ta, any T1, and absence of CIS) diagnosed ≤12

months of last dose of adequate BCG were enrolled in cohort 4. All visible papillary disease was fully resected. TAR-200 was dosed every three weeks through week 24, then every 12 weeks until week 96. Response assessments included cystoscopy and centrally assessed urine cytology every 12 weeks, local imaging every 24 weeks, and centrally assessed biopsy, as clinically indicated. The primary endpoint was disease-free survival (DFS) rate at 12 months. Key secondary endpoints included safety and tolerability.

Results: On the September 4, 2024 data cutoff, with a median followup of 6.2 months (range 4–10), 52 patients (median age, 71 years [range 42–88]; 71% male; papillary disease [T1], 40%) received TAR-200 monotherapy. The six-month DFS

rate was 94.4% (95% CI 67–99); 12-month DFS rate was not estimable. Thirty-nine patients (75%) had treatment-related adverse events (TRAEs); most were low-grade lower urinary tract events, including dysuria (35%), pollakiuria (25%), micturition urgency (23%), and urinary tract infection (19%). Seven patients (14%) had grade ≥ 3 TRAEs; most common was bladder pain (6%). Three patients (6%) had serious TRAEs; four (8%) had TRAEs leading to TAR-200 discontinuation. No treatment-related deaths occurred.

Conclusions: First results of TAR-200 monotherapy in patients with BCG-unresponsive papillary disease-only HR NMIBC in SunRISe-I demonstrated the highest DFS rates reported in this setting. TAR-200 monotherapy was well-tolerated, with a favorable safety profile. These results support ongoing development of TAR-200 monotherapy for treatment of BCG-unresponsive papillary disease-only HR NMIBC. Updated results will be available in April with additional followup. Abstract will be revised to include updated data.

Funding: Janssen Research and Development, LLC, a Johnson and Johnson company.

Abstract #88

Duration of alvimopan for prevention of postoperative ileus in patients undergoing cystectomy

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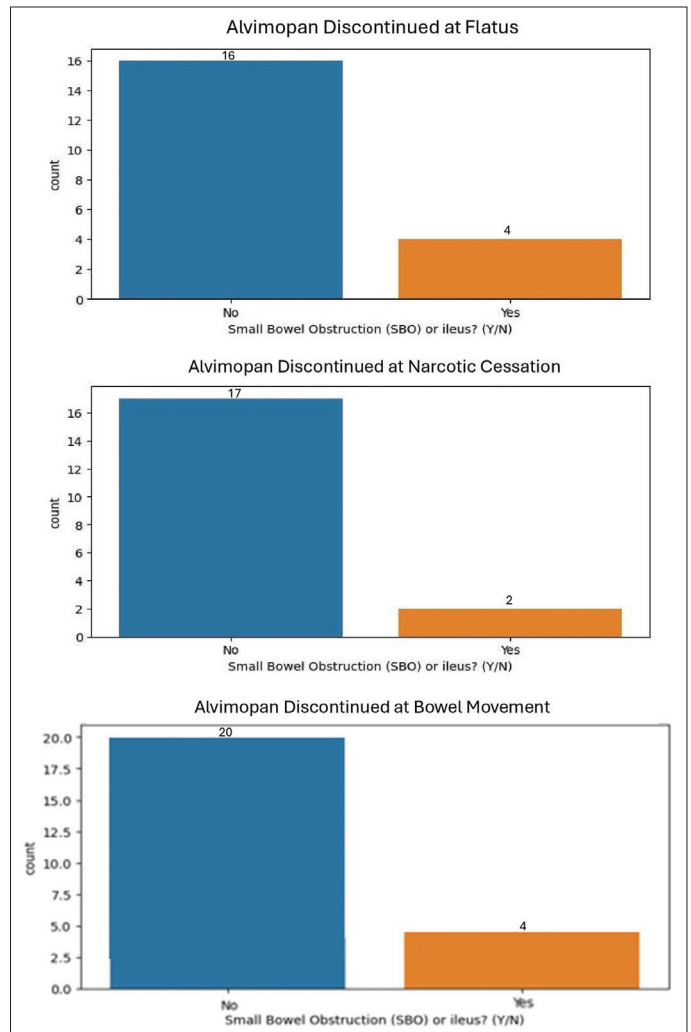
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Introduction: Postoperative ileus (POI) and small bowel obstruction (SBO) are common complications after cystectomy, contributing to extended hospital stays, increased healthcare costs, and patient discomfort. These conditions are often caused by extensive surgical manipulation and opioid use, which slow gastrointestinal recovery. Alvimopan, a μ -opioid receptor antagonist, is frequently used to mitigate these effects, but there is no consensus on the optimal duration of treatment. Hospitals use different criteria for discontinuing alvimopan, including diet as tolerated, passing flatus, having a bowel movement, or stopping narcotics. This study aimed to determine the most effective time to discontinue alvimopan while maintaining favorable outcomes and reducing unnecessary medication use.

Methods: This retrospective study analyzed data from 63 patients who underwent radical or simple cystectomy, either robotic or open, at hospitals in Buffalo, NY, between January 2019 and January 2024. Patients were categorized into three groups based on when alvimopan was discontinued: upon passing flatus, upon passing a bowel movement, or at the cessation of narcotic use. A 3x2 Chi-squared test of independence was conducted to compare SBO and POI rates among the groups. Additional subgroup analysis examined whether surgical approach (robotic vs. open) influenced outcomes.

Results: The study included 62 radical cystectomies and one simple cystectomy, with 40 robotic and 23 open procedures. No statistically significant differences were observed in SBO/POI rates among the three discontinuation groups (χ^2 (2, N=63)=0.67, p=0.71). Further stratification by surgical approach also showed no significant differences (χ^2 (2, N=40)=0.67, p=0.72 for open; χ^2 (2, N=23)=0.05, p=0.98 for robotic). The SBO/POI rates for each discontinuation group were flatus (20%), narcotic cessation (11.5%), and bowel movement (16.7%) (Figures 1, 2).

Conclusions: Discontinuing alvimopan when a patient passes flatus does not increase the risk of POI or SBO compared to continuing treatment until a bowel movement or narcotic cessation. Since there is no clear advantage to prolonged use, stopping alvimopan at flatus may help reduce unnecessary medication exposure and healthcare costs while maintaining positive postoperative outcomes. These findings support a more streamlined approach to alvimopan use following cystectomy.



Abstract #88. Figure 1. SBO/ileus incidence by alvimopan stoppage milestone.

Abstract #89

A quality assurance review of diagnostic delays and stage presentation of upper tract urothelial cell carcinoma during the COVID-19 pandemic

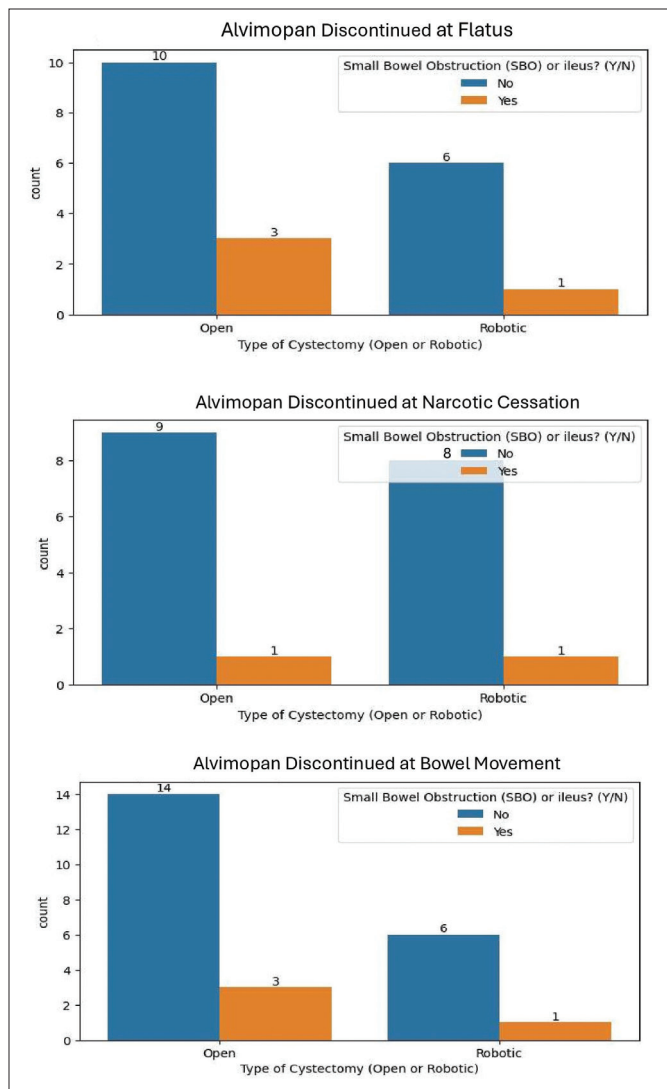
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Introduction: The COVID-19 pandemic presented a major impediment to global healthcare, and subsequent negative influence on the diagnosis and treatment of many malignancies. We aimed to further examine COVID-19's impact on upper tract urothelial cell carcinoma (UTUCC) prognosis and diagnosis in Newfoundland and Labrador (NL).

Methods: A retrospective chart review was conducted on all cases of UTUCC managed surgically at our center from January 1, 2018, to November 30, 2024. Patients were categorized into pre-, during-, and post-COVID-19 pandemic cohorts.

Results: The study identified 65 cases that fit within the inclusion criteria. The mean age of the cohort at diagnosis was 70.86 years (standard deviation \pm 9.64). Demographics did not vary across timeframes, and 55.38% of patients were male. Before the pandemic, pathologic stage 3 (pT3) disease was reported in 73.33% of cases. This decreased through pandemic and post-pandemic cohorts to 30.4% and 33.3%, respectively. Surgical wait times remained stable across cohorts (p=0.571).



Abstract #88. Figure 2. SBO/ileus incidence by alvimopan stoppage and cystectomy type.

Conclusions: There was an observed 40% decrease in pT3 disease presentation at our center from the pre-COVID-19 to COVID-19 cohort. This was followed by a 3% increase in pT3 disease presentation from COVID-19 to post-COVID-19 cohort. These findings directly contrast recent prevalent research that has found later detection of various GU malignancies post-pandemic. Further study is necessary to determine if shifts in diagnostic priorities during this period contributed to earlier-stage UTUCC detection.

Abstract #90
Early thrombocytopenia following pelvic radiation in pediatric GU rhabdomyosarcoma: A secondary analysis of ARST0531

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Introduction: Hematologic toxicities, such as cytopenias, are a known sequelae of radiation therapy (RT), and contribute to complications such as bleeding and infection in the already vulnerable pediatric population. Pelvic RT is of particular concern, as pelvic region marrow comprises nearly 50% of total body hema-

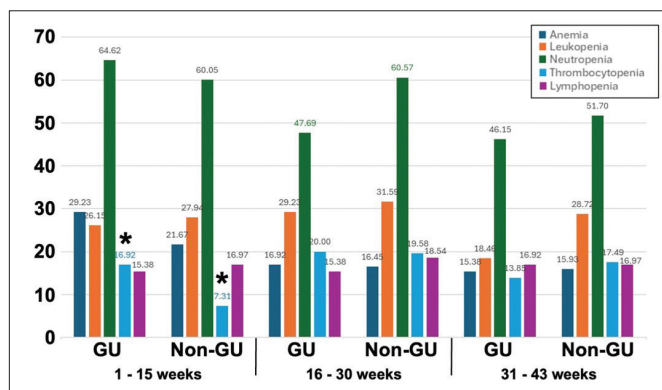
topoiesis. This study aimed to evaluate the relationship between pelvic RT and cytopenia, including associated complications, in patients with genitourinary (GU) rhabdomyosarcoma (RMS) enrolled in a large clinical trial.

Methods: Data were obtained from ARST0531, a Children’s Oncology Group clinical trial, which enrolled patients with intermediate-risk RMS, the vast majority being pediatric. All subjects received RT and chemotherapy regimens, and in secondary analysis, we separated them by GU and non-GU tumor sites. Non-pelvic GU cases were excluded, allowing GU to act as a proxy for pelvic RT exposure. Multivariable logistic regression was used to assess the odds of developing cytopenias during the 43-week treatment period, adjusting for age, race, tumor size, and chemotherapy regimen. Secondary analyses explored complications of cytopenia, such as infections and febrile neutropenia, as well as the timing at which cytopenias or complications occurred.

Results: Of 488 subjects with RMS, 65 (15%) were pelvic GU cases and 383 (85%) were non-GU (Table 1). No significant differences were observed between GU and non-GU subjects in risk of developing various cytopenias across the overall treatment period (Table 1). Neutropenia was most prevalent, at 79% overall. When the RT treatment period was split into thirds, thrombocytopenia was significantly more common during the first 15 weeks for GU RMS (OR 2.79, p=0.01) compared to non-GU subjects, with no differences thereafter (Figure 1). Complications, including febrile neutropenia and infections, were comparable between GU and non-GU in each treatment period and across the overall study.

Conclusions: In intermediate-risk RMS, pelvic RT was associated with an early increased risk of thrombocytopenia for GU RMS patients, compared to non-GU patients undergoing RT. No differences were seen in overall cytopenias or in complications such as febrile neutropenia.

Understanding these toxicities is key to improving the management of pediatric RMS, and these findings may inspire future research to improve RT tolerability and oncologic outcomes for GU RMS patients.



Abstract #90. Figure 1. Thrombocytopenia was significantly more common in GU vs non-GU patients during the first treatment period (p=0.01).

Abstract #90. Table 1. Patient characteristics and cytopenia rates

| Parameter, N (%) | Overall Cohort N = 488 | Genitourinary N = 65 (15%) | Non-GU N = 383 (85%) | P value |
|-------------------------|---------------------------|-------------------------------|-------------------------|-----------------------------|
| Age, < 10 years | 306 (68.30) | 56 (86.15) | 250 (65.27) | 0.001 |
| Sex, Male | 241 (53.79) | 48 (73.85) | 193 (50.39) | <0.001 |
| Race, White | 319 (71.21) | 48 (73.85) | 271 (70.76) | 0.487 |
| Cytopenia, N (%) | | | | OR (95% CI, P value) |
| Anemia | 159 (35.5) | 24 (36.9) | 135 (35.2) | 0.96 (0.54 - 1.70, 0.89) |
| Thrombocytopenia | 131 (29.2) | 22 (33.8) | 109 (28.4) | 1.49 (0.81 - 2.73, 0.20) |
| Leukopenia | 196 (43.8) | 26 (40.0) | 170 (44.4) | 0.73 (0.42 - 1.27, 0.27) |
| Neutropenia | 356 (79.4) | 48 (73.8) | 308 (80.4) | 0.64 (0.34 - 1.19, 0.16) |
| Lymphopenia | 105 (23.4) | 15 (23.1) | 90 (23.5) | 0.85 (0.45 - 1.61, 0.61) |

Abstract #91

Teamwork makes the dream work: The impact of industry collaboration on FDA approval success in genitourinary oncology

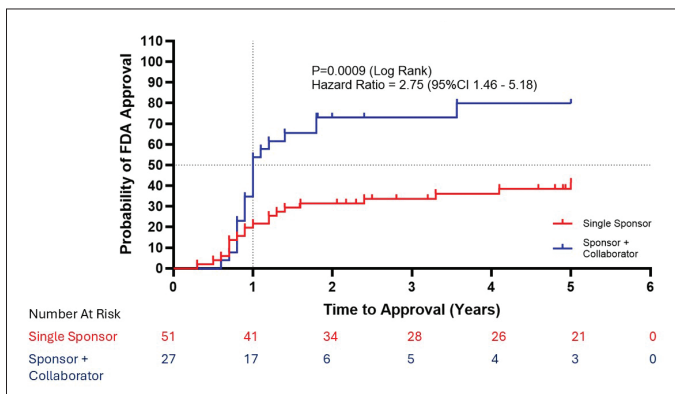
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Introduction: Collaboration among trial sponsors pools expertise and resources, potentially enhancing drug development success. This study assessed the impact of collaborations between drug sponsors on Food and Drug Administration (FDA) approval rates for phase 3 clinical trials in genitourinary (GU) cancers.

Methods: We queried ClinicalTrials.gov to create a dataset of all interventional trials in GU malignancies sponsored by industry and successfully completed between January 1, 2010, and October 1, 2024. Drugs indicated for supportive purposes, non-therapeutic agents, and therapeutic equivalence studies were excluded. The primary analysis compared time to FDA approval between single sponsors (SS) and sponsor-collaborator (S-C) groups using Kaplan-Meier curves with log-rank p-values. Cox regression analysis was performed to adjust for potential confounders and estimate the hazard ratios (HRs) for FDA approval associated with collaboration status. Secondary analyses evaluated the influence of collaboration within different trial factors, such as primary disease site and localized vs. metastatic status, using stratified Cox regression models. Additionally, the influence of collaboration was compared among trials that met their primary endpoints.

Results: A total of 183 phase 3 clinical trials were identified, of which 78 (42.6%) met the eligibility criteria. Of the eligible trials, 51 (65.4%) were led by SS, while 27 (34.6%) were in the S-C group. Collaboration significantly accelerated FDA approval rates, with 20 of 27 S-C trials approved vs. 20 of 57 SS trials (HR 2.75, 95% confidence interval [CI] 1.46–5.18, $p=0.0009$). The one- and two-year FDA approval rates were 50% and 73.6% for the S-C group, respectively, compared to 19.6% and 31.4%, respectively, for the SS group. Stratified Cox regression confirmed a consistent benefit in subgroups, including metastatic disease, prostate cancer, and previously approved drugs. Among trials that met their primary endpoints (50 [64.1%]), S-C trials had a significantly higher approval likelihood, with an HR of 2.23 (95% CI 1.13–4.38, $p=0.013$) (Figure 1).

Conclusions: Collaboration between sponsors significantly accelerates FDA approval for phase 3 GU cancer trials, with S-C trials achieving higher approval rates and faster timelines. This advantage was consistent across various trial variables, including trials that met their primary endpoints.



Abstract #91. Figure 1. Time to FDA approval.

Abstract #92

Outcomes of immunotherapy vs. chemotherapy in metastatic bladder cancer: A systematic review and meta-analysis of phase 3 randomized controlled trials

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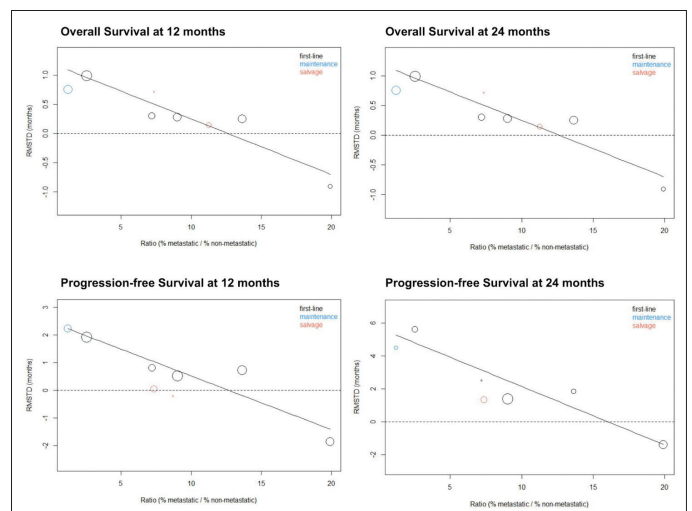
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Introduction: Randomized controlled trials (RCTs) between immune checkpoint inhibitors (ICIs) and chemotherapy have varying proportions of patients with visceral and non-visceral metastases. We conducted a systematic review and meta-analysis of RCTs to compare outcomes between ICIs and chemotherapy in metastatic bladder cancer.

Methods: A systematic review was performed using EBSCO MEDLINE for phase 3 RCTs comparing ICIs to chemotherapy in metastatic bladder cancer. Search terms included 'urothelial carcinoma' OR 'urothelial cancer' OR 'bladder cancer' AND 'immunotherapy' from 2018–2024. Trials that reported on overall survival (OS) and progression-free survival (PFS) via Kaplan-Meier (KM) curves were included. We excluded articles that were single-arm studies, studies without direct treatment comparisons, and with mean followup time <6 months. The proportions of patients with visceral vs. non-visceral metastases were extracted, and individual patient data (IPD) were reconstructed from KM curves. IPD was used to calculate the restricted mean survival time differences (RMSTD) between treatment and control arms for OS and PFS at 12 and 24 months. Meta-regression was performed to estimate the change in RMSTD based on the ratio of visceral metastatic to non-visceral metastatic patients.

Results: A total of 143 abstracts fit our search criteria to undergo screening by two blinded reviewers (interrater reliability 96%). Thirteen articles were included for full-text screening. Eight articles ($n=6922$ patients) met the inclusion criteria. The proportion of patients with non-visceral metastases ranged from 4.8–45%. Meta-regression showed a decline in RMSTDs as the ratio of metastatic to non-metastatic patients increased (Figure 1). RMSTD significantly decreased per-unit increase in the metastatic to non-metastatic ratio for OS at both 12 months (-0.10, 95% CI -0.15, -0.05, $p=0.006$) and 24 months (-0.23, 95% CI -0.4, -0.07, $p=0.014$). RMSTD for PFS showed similar results at 12 months (-0.20, 95% CI -0.31, -0.08, $p=0.009$) and 24 months (-0.36, 95% CI -0.60, -0.11, $p=0.020$).

Conclusions: We show that the survival benefit of ICI may vary based on the proportion of patients with visceral metastatic bladder cancer. Our meta-analysis demonstrates higher proportions of visceral metastatic patients dampens ICI's survival benefit relative to chemotherapy.



Abstract #92. Figure 1. Meta-regression of restricted mean survival time difference (RMSTD) for overall survival and progression-free survival at 12 and 24 months for trials in the first-line, maintenance, and salvage settings.

Abstract #93

Utilization of telemedicine for first postoperative followup visits in renal tumor surgery: A single-center experience

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Introduction: The COVID-19 pandemic reshaped healthcare delivery, accelerating the adoption of telehealth across medical specialties. In urology, postoperative followup visits are critical for reviewing pathology, initiating surveillance, and evaluating for complications. In this study, we focused on telemedicine, defined specifically as synchronous, real-time video or telephone encounters conducted by physicians. Our objective was to evaluate the use of telemedicine for first postoperative followup visits among patients undergoing renal tumor surgeries within a large, integrated urology practice during and after the COVID-19 pandemic.

Methods: We conducted a retrospective analysis using electronic health record data from a large healthcare delivery system between January 1, 2020, and November 30, 2023. We identified new patients who established care with a urologist and underwent either partial or radical nephrectomy. For each patient, we assessed the modality of their first postoperative followup visit — telemedicine or in-person. To ensure clinical relevance and data completeness, we excluded patients whose first followup occurred more than 100 days after surgery. Visits conducted by phone or through outside clinics not captured in our data system were also excluded.

Results: A total of 1056 new patients underwent renal tumor surgery between 2020 and 2023. Of these, 640 patients (60.6%) had a documented first postoperative followup visit within 100 days of surgery. Among those, 63 patients (9.8%) received their first followup visit via telemedicine. The number of telemedicine visits increased over time, with 11 patients (8.9%) using telemedicine in 2020, 15 (8.0%) in 2021, and 22 (13.6%) in 2022. In 2023, 15 patients (9.0%) received telemedicine followups; however, this figure may underestimate the total due to incomplete data for patients who had surgery late in the year. While the overall proportion of telemedicine visits remained modest, the upward trend suggests increasing adoption of telemedicine for postoperative care in urology.

Conclusions: Although use of telemedicine for first postoperative followup after renal tumor surgery was limited, its gradual increase over the study period reflects evolving practice patterns in the post-pandemic healthcare landscape. Further research is needed to assess outcomes, patient and provider satisfaction, and barriers to broader integration of telemedicine in surgical followup care.

Abstract #94

Do centralized hospitals have improved failure-to-rescue rates after major cancer surgery?

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Introduction: Centralization is the process by which major cancer surgery is preferentially performed at high-volume regional referral centers. While treatment at referral centers is generally associated with improved postoperative complication rates, it is less clear whether these hospitals are more effective at managing complications after they arise. To better understand these nuances in centralized care delivery, we compared failure-to-rescue (FTR) rates among patients treated

at referral and non-referral centers. FTR is a quality metric that captures whether hospitals can prevent death by promptly recognizing and responding to patient complications.

Methods: We used data from the Pennsylvania Cancer Registry linked to all-payer statewide inpatient discharge records to identify patients who had surgery for bladder, brain, esophageal, liver, lung, or pancreatic cancer from 2013–2019. We developed 11 postoperative complication groups using ICD-10 codes. We defined FTR as the rate of death among patients who had at least one postoperative complication within 90 days of surgery. We defined referral centers as National Cancer Institute-designated cancer centers or American College of Surgeons Commission on Cancer-accredited academic comprehensive cancer programs. In a post-hoc analysis limited to lung cancer patients, we used inverse probability weighting to derive an adjusted estimate of FTR by controlling for patient-level confounding factors.

Results: Of 29 544 patients with major cancer surgery, 40% (n=11 900) developed a complication within 90 days of surgery. Overall FTR rates varied from 11.8% for lung cancer to 15.6% for esophageal cancer. FTR rates were significantly lower at referral vs. non-referral centers for brain (13.0% vs. 16.1%, p=0.01) and pancreatic (10.3% vs. 14.0%, p=0.04) cancers. There were no significant differences in FTR rates at referral vs. non-referral centers for esophageal, liver, or bladder cancers (Table 1). After inverse probability weighting, there was no significant difference in adjusted odds of FTR when lung cancer patients were treated at referral vs. non-referral centers (odds ratio 1.01; 95% confidence interval 0.99–1.02).

Conclusions: While referral centers are generally thought to offer superior surgical outcomes, we found that their relationship with FTR varies depending on cancer type. Our results suggest that the overall benefits of centralization may be more strongly linked to preventing complications rather than responding to complications after they occur.

Funding: National Cancer Institute R37CA262366.

Abstract # 94. Table 1. 90-day unadjusted failure to rescue rates stratified by cancer type

| Cancer type | 90-day failure to rescue rates | | |
|-------------|--------------------------------|--------------------------|------|
| | Non-regional referral center | Regional referral center | p |
| Bladder | 10.9% | 13.1% | 0.03 |
| Brain | 14.1% | 15.1% | 0.64 |
| Esophageal | 16.1% | 13.0% | 0.01 |
| Liver | 13.7% | 16.8% | 0.37 |
| Lung | 11.7% | 14.2% | 0.64 |
| Pancreatic | 14.0% | 10.3% | 0.04 |

Abstract #95

Impact of geographic and socioeconomic factors on non-adherence rates for surveillance cystoscopy in patients with non-muscle-invasive bladder cancer

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Introduction: Surveillance cystoscopy is crucial for managing non-muscle-invasive bladder cancer (NMIBC). Non-adherence to AUA surveillance guidelines has been linked to worsened outcomes, such as cancer progression. This study examined the influence of demographic, geographic, and socioeconomic factors — including distance to clinic, income, race, insurance type, age, gender, and rurality — on non-adherence among NMIBC patients.

Methods: We retrospectively analyzed 261 NMIBC patients from 2016–2021 at an academic medical center, affiliated private practices, and regional clinics. Adherence to AUA surveillance cystoscopy guidelines was evaluated over five years. A “non-adherence rate” was created for each patient based on the ratio of missed visits to expected total visits (higher rate equating to less adherence). Distance to clinic was calculated using ZIP code centroids, and income was estimated using 2020 U.S. Census data for average ZIP code income. Rurality was classified using 2010 Rural-Urban Commuting Area (RUCA) codes. Logistic regression and Chi-

squared tests were used to assess associations, with significance set at $p < 0.05$. IRB approval was obtained.

Results: The average non-adherence rate was 25.4%. Distance showed a small positive correlation with non-adherence (0.11% per mile), but it was not statistically significant ($p=0.29$). Patients living more than 40 miles from the clinic had a 35.6% non-adherence rate, compared to 24.9% for those living within 40 miles ($p=0.23$). While income was not significantly associated with non-adherence as a continuous variable ($p=0.93$), those in ZIP codes with income greater than \$115,000 had a statistically significantly lower non-adherence rate (16.6%) than those below that cutoff (26.9%, $p=0.02$). Insurance type was associated with adherence — patients with private insurance had a 21.7% non-adherence rate, compared to 34.5% for those with Medicare and 23.8% for those with both Medicare and private insurance ($p=0.02$). Rural patients had a higher non-adherence rate (27.6%) than urban residents (25.2%), but this was not statistically significant ($p=0.77$). Race did not show significant differences. Multivariate analysis, including income, distance, age, gender, race, and insurance, did not reveal significant trends.

Conclusions: Although distance from the clinic was not statistically significant, a trend of higher non-adherence among rural and geographically distant patients suggests access to care remains a barrier. Lower income was also significantly associated with higher non-adherence. Insurance type and clinical risk category also influenced adherence. These findings highlight the need for targeted interventions, such as patient navigation or tele-cystoscopy programs — especially for socioeconomically disadvantaged and rural populations — to address structural barriers and eliminate disparities in NMIBC followup care.

Abstract #96

Serum osmolality reveals predominance of isotonic dehydration in post-cystectomy readmissions

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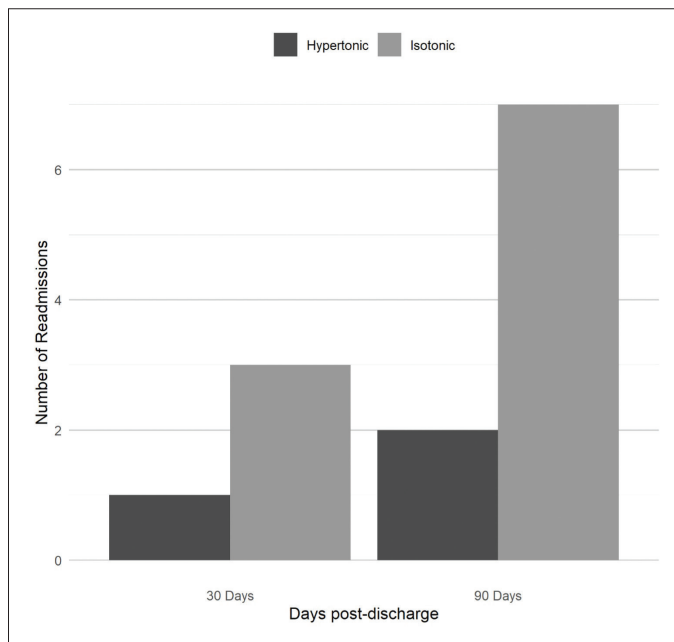
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Introduction: Readmission following cystectomy is common, with dehydration being one of the most frequently reported causes for readmission. Dehydration can be classified into low-intake (hypertonic) dehydration, caused by decreased oral fluid intake, and salt-loss (isotonic) dehydration, which results from fluid shifts and gastrointestinal losses after surgery. Low-intake dehydration may be preventable through outpatient strategies such as monitoring and promoting hydration, while isotonic dehydration often requires higher acuity monitoring and intervention. In this study, we aimed to quantify the proportion of patients readmitted following dehydration with hypertonic and isotonic dehydration to better guide post-cystectomy hydration strategies and research.

Methods: We conducted a retrospective review of 100 cystectomy patients within a large integrated healthcare system, spanning from June 2020 to November 2021. Dehydration was determined by clinical signs or symptoms of volume depletion not attributable to other postoperative complications. The threshold for hypertonic dehydration was defined as a serum osmolality >300 mOsm/kg, while isotonic was defined within the range of 275–300 mOsm/kg. These values were calculated from routine lab tests measuring sodium, blood urea nitrogen, and glucose. Patients without available laboratory data or those with conditions affecting osmolality interpretation (e.g., alcohol intoxication) were excluded from the analysis.

Results: At 30 days post-discharge, there were 42 unplanned encounters involving 34 patients leading to 31 readmissions among 28 patients. Of these, seven encounters (17%) were attributed to dehydration, all of which resulted in readmission. Dehydration accounted for 23% of all readmissions within 30 days (Figure 1). One readmission was due to hypertonic dehydration and three were linked to isotonic dehydration. At 90 days, a total of 75 unplanned encounters occurred among 46 patients, leading to 50 readmissions among 36 patients. Thirteen encounters (17%) were associated with dehydration, with 11 leading to readmission. At 90 days, dehydration represented 22% of all readmissions. Two readmissions were linked to hypertonic dehydration, and seven to isotonic dehydration.

Conclusions: Most readmissions related to dehydration following cystectomy were associated with isotonic (salt-loss) rather than low-intake dehydration. These findings suggest that non-selective outpatient hydration protocols may be insufficient for preventing dehydration-related complications, highlighting the need for more targeted hydration strategies.



Abstract #96. Figure 1. Readmissions linked to isotonic and hypertonic dehydration.

Abstract #97

Comparison of same-admission vs. delayed reconstruction following surgical debridement for Fournier's gangrene: A single-institution pilot study

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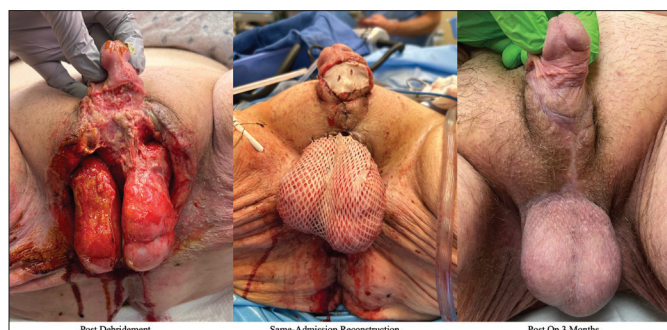
Introduction: Fournier's gangrene (FG) is a rare necrotizing fasciitis of the genitalia and perineum with up to 20% mortality requiring aggressive surgical debridement, often resulting in extensive soft tissue defects requiring reconstruction. While early surgical debridement is established as critical in management, current literature lacks consensus on timing and strategy of reconstruction. This pilot study compares same-admission reconstruction (SAR) vs. delayed reconstruction (DR) following FG debridement.

Methods: This pilot study evaluated the safety of SAR for FG at Allegheny Health Network. A prospective cohort undergoing SAR ($n=5$) after protocol initiation (patients undergoing reconstruction during the same hospitalization as debridement) in September 2024 was compared to a retrospective cohort undergoing DR ($n=6$) treated from January 2020 to August 2024. We collected demographics, comorbidities, Fournier's Gangrene Severity Index (FGSI) scores, reconstruction characteristics, hospital course details, and postoperative outcomes. Primary endpoints for this safety assessment included length of stay, readmission rates, and post-reconstructive complications. Our objective was to evaluate the safety of SAR in this initial cohort and assess non-inferiority to DR regarding key safety outcomes.

Results: Compared to the DR group, SAR patients were significantly older (Table 1) and had a much shorter time to reconstruction (Table 1). Baseline characteristics (sex, race, BMI, comorbidities, ASA, FGSI), debridement/ICU metrics, and hospitalization times (OR duration, LOS) were similar (Table 1). Reconstruction methods differed significantly: SAR exclusively used split-thickness skin grafts (Figure 1), while DR primarily used complex flaps or primary closure. SAR showed non-significant trends towards fewer readmissions and reoperations (Table 1).

Conclusions: This pilot study demonstrates promising SAR outcomes following FG, even in older patients, highlighting the value of interdisciplinary management with plastic surgery. Higher use of split-thickness skin grafts in the SAR group may reduce readmissions and complications. The absence of 30-day/90-day readmissions and reoperations in the SAR group suggests clinical benefits warranting further investigation. Comparable lengths of stay indicate early reconstruction does not prolong hospitalization while eliminating subsequent admissions. SAR may also eliminate the psychological burden of living with open wounds and reduce health-

care use. Future studies could develop protocols for patient selection and optimal timing of reconstruction while assessing quality-of-life and functional outcomes



Abstract #97. Figure 1. Example of same-admission reconstruction: perineal reconstruction with fasciocutaneous flaps and bilateral orchiopexy with split thickness skin graft to penile shaft and neoscrotum.

| Abstract #97. Table 1 | | | |
|---|---|-----------------------------------|--------|
| Metric | Same-admission reconstruction (SAR) (n=5) | Delayed reconstruction (DR) (n=6) | p |
| Demographics & baseline | | | |
| Age (mean ±SD) | 70±5.92 | 50±5.04 | <0.001 |
| HgbA1c (mean ±SD) | 6.9±2.30 | 9.9±2.87 | 0.14 |
| ASA Scores | 3.6±0.21 | 3±0.22 | 0.21 |
| Fournier's gangrene severity index | 5.33±3.35 | 5.8±2.80 | 0.81 |
| Debridement & ICU | | | |
| Surface area debrided | 240±65.7 cm ² | 334±369.8 cm ² | 0.57 |
| Number of debridements | 4±1.64 | 3±1.72 | 0.37 |
| ICU admission rates | 40% | 50% | 0.99 |
| ICU duration | 1.5±0.71 days | 2.3±1.53 days | 0.47 |
| Reconstruction & hospital course | | | |
| Time from debridement to recon. | 6±2.59 days | 94±54.8 days | <0.001 |
| Procedure duration | 186±74 minutes | 147±108 minutes | 0.50 |
| Total length of stay (LOS) | 20±11.2 days | 15±13.3 days | 0.55 |
| Post-reconstruction LOS | 3±3.04 days | 2±3.25 days | 0.18 |
| Split-thickness skin grafts use | 5/5 (100%) | 1/6 (17%) | 0.05 |
| Outcomes & complications | | | |
| 30-day readmission rate | 0/5 (0%) | 1/6 (17%) | 0.82 |
| 90-day readmission rate | 0/5 (0%) | 2/6 (33%) | 0.56 |
| Reoperation rate (complications) | 0/5 (0%) | 1/6 (17%) | 0.82 |

Abstract #98

Is bedrest necessary in the management of grade 1–3 renal injuries?

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Introduction: Renal trauma management has increasingly shifted toward non-operative approaches. The American Urological Association (AUA) urotrauma guideline recommends conservative treatment for hemodynamically stable patients with grade 1–3 renal injuries, which may include prolonged bedrest; however, there is limited evidence supporting bedrest, particularly in adults, and prolonged immobilization may increase hospital stay and risk of complications, such as deep vein thrombosis (DVT) and hospital-acquired infections. This study aimed to compare complication rates between patients managed with bedrest and those allowed early ambulation.

Methods: We conducted a pre- and post-intervention retrospective chart review of all patients ages >18 year admitted with an AAST grade 1–3 renal trauma and an injury severity score (ISS) <15 at Albany Medical Center from January 2020 through December 2024. In November 2023, we instituted a project where all stable, low-grade patients would not be put on bedrest. Patients who had other injuries that prevented early ambulation after the institutional recommendation change were excluded. Demographics, ISS, hospital length of stay (LOS), and need for transfusion were obtained. We collected all renal-related complications requiring any management or readmission amongst patients.

Results: A total of 62 patients were included in the analysis; 49 patients were managed with bedrest prior to the institutional protocol change in November 2023, while 13 patients were mobilized early thereafter. The median patient age did not differ significantly between groups (41 vs. 57 years, p=0.5). A majority (42%) had a grade 3 injury. Two of 49 patients (4.1%) in the bedrest group presented to the ED for flank pain post-initial discharge compared to none of the 13 patients (0%) in the early ambulation group (p=1.0). There were no readmissions for delayed hemorrhage or any interventional management required in either group. There was no statistically significant difference in median ISS scores (p=0.57) or initial transfusion requirements (p=0.79) between the two cohorts. The median LOS was four days for patients on bedrest and three days for those who ambulated early (p=0.75).

Conclusions: Since our institutional change of no bedrest requirement for low-grade renal trauma, there has not been a significant increase in complications between the groups. These preliminary findings suggest that early ambulation could be a safe and effective component of conservative management. Further randomized studies are warranted to validate these findings and inform future guideline recommendations.

Abstract #98a

What traits and skills do urology programs value in medical students? A cross-sectional survey of Canadian urology program selection committee members

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Introduction: Clerkship represents a pivotal phase when medical students explore various specialties and enhance their skills. It also serves as a period for residency programs to assess candidates. Surveys conducted within residency programs have shown that performance during an elective is considered the most significant factor in residency selection. We aimed to identify the traits and competencies most valued by urology programs, as they are frequently implied but seldom directly assessed.

Methods: By incorporating the Canadian Medical Education Directives for Specialists (CanMEDS) framework, we developed 21 attributes reflecting key competencies. We designed a best-worst scale survey using the Lighthouse Studio Software, where participants identified the best and worst choices from five options across 21 question sets. The survey was distributed to Canadian urology programs in February 2025 and closed in March following two reminders. We used the Hierarchical Bayes method to estimate the relative importance of each attribute, and the resulting scores were presented on a probability scale summing to 100 with 95% confidence intervals. Higher scores correlate to greater selection likelihood within the survey.

Results: The respondents included eight program directors, four urologists, and one resident (N=13). As shown in Table 1, the three highest-ranked attributes were “Demonstrating appropriate behavior” (12.43 [11.86, 13.00]), “Exhibiting reliability and independence” (9.66 [8.48, 10.86]), and “Seeking out responsibilities” (9.60 [7.87, 11.32]). Conversely, the three lowest-ranked attributes were “Effective presentation skills during journal clubs” (0.28 [0.00, 0.70]), “Incorporating evidence on health disparities” (0.093 [0.011, 0.18]), and “Discussing barriers to care and proposing solutions” (0.034 [0.0039, 0.064]). Among the CanMEDS roles, Professional and Leader were the highest-priority areas (9.86 and 8.13, respectively), whereas Scholar and Health Advocate ranked the lowest (0.17 and 1.79, respectively).

Conclusions: The findings underscore the significance of integrity, reliability, and initiative during urology electives while placing less emphasis on research and advocacy. The low ranking of advocacy suggests that it may not be a central component in clerkship evaluations, indicating an opportunity for better integration within medical education. Despite the small sample size, this study offers valuable insights into the selection criteria for urology programs and provides guidance for students preparing for clinical rotations and residency applications.

Abstract #98a. Table 1. Overall ranking of desirable traits and skills sorted by probability scores

| Traits and skills | Probability score | CanMEDS role |
|---|----------------------|-----------------|
| Demonstrating appropriate behaviour through honesty, integrity, punctuality, and respect | 12.43 [11.86, 13.00] | Professional |
| Seeking out responsibilities by helping with rounds, doing consults, and organizing patient handover and discharge | 9.66 [8.48, 10.85] | Leader |
| Exhibiting reliability and independence in performing clinical duties (e.g., consults, clinics, etc.) to support the team | 9.60 [7.87, 11.32] | Leader |
| Building positive relationships with the urology team to foster collaborative care | 9.01 [7.27, 10.75] | Collaborator |
| Exhibiting self-awareness by recognizing personal limitations and seeking guidance | 8.77 [6.59, 10.96] | Professional |
| Preparing thoroughly for clinical duties by learning about the patients and procedures in advance | 8.37 [6.53, 10.20] | Professional |
| Resolving conflicts and differences in a respectful and collaborative manner | 6.41 [4.44, 8.38] | Collaborator |
| Proficiency in history taking, performing physical exams, and proposing appropriate investigations relevant to urological conditions | 6.33 [3.87, 8.80] | Medical expert |
| Effectively managing time by balancing clinical duties (e.g., preparing for rounds and timely completion of tasks) | 5.14 [3.21, 7.06] | Leader |
| Appropriate clinical and biomedical knowledge of urological conditions | 4.91 [2.89, 6.93] | Medical expert |
| Effective documentation of clinical encounters (e.g., consults, progress notes, discharge summaries) and their presentation to the medical team | 4.45 [2.60, 6.31] | Communicator |
| Seeking regular feedback from supervisors and peers to identify areas of improvement | 4.40 [2.32, 6.47] | Scholar |
| Basic surgical proficiency (e.g., suturing, catheterization, etc.) | 4.24 [2.42, 6.06] | Medical expert |
| Collaborating with allied healthcare professionals (e.g., social workers, dietitians) to meet patients' comprehensive needs | 2.05 [0.12, 4.00] | Collaborator |
| Efficiently managing the flow of patient encounters (e.g., interviewing, obtaining consent, collecting collateral information) | 1.88 [0.67, 3.09] | Communicator |
| Interpreting and communicating the results of diagnostic and screening tests | 0.88 [0.49, 1.26] | Communicator |
| Engaging in urological research to further the understanding of the field | 0.68 [0.05, 1.31] | Scholar |
| Advising patients on modifiable risk factors that impact their urological health and treatment outcomes | 0.40 [0.00, 0.80] | Health advocate |
| Effective presentation skills during journal clubs and grand rounds to communicate research findings | 0.28 [0.00, 0.70] | Scholar |
| Incorporating evidence on health disparities in urology when presenting cases or research findings | 0.09 [0.01, 0.18] | Health advocate |
| Discussing barriers to care, such as cost and access, and proposing solutions during rounds when appropriate | 0.03 [0.00, 0.06] | Health advocate |