

tumors, keratin, EMA, vimentin and CEA and, sometimes, hCG. Additional immunohistochemistry was adopted when required to improve the pathological diagnosis. Candidate patients to cystectomy, for reason other than large bladder tumor with radiologic imaging suggestive of bladder wall infiltration, *i.e.* Tis, multiple and/or recurrent non muscle invasive and patients submitted to TURBT at other centers, were excluded. Inferential statistical analysis was performed. **Results:** Out of 340 patients, 35 (10.3%) showed rare histotypes of bladder cancer, *i.e.* in 30 cases (32%) out of 94 radical cystectomies and in 5 (2%) out of 246 TURBTs. The rare histotypes were distributed as follows: squamous carcinoma 11 (31%), sarcomatoid 8 (23%), undifferentiated 6 (17%), neuroendocrine 3 (9%), micropapillary 2 (6%), adenocarcinoma 1 (3%), mixed 4 (11%). TCCB with histological rare variants showed at cystectomy considerable size (average diameter=7.7×6.7 cm; range=4.5×5-11×9 cm), while 13 (43%) were pT4 category. In 13 patients (37%), the uncommon histotype was detected at the pre-operative TURBT, while, in 22 (63%), it was recognized only in the cystectomy specimen. Regarding the correlation between TURBT and re-TUR, rare histotypes were not identified at the first TURBT in 9 patients (26%) but found at re-TURBT in 4 patients (44%) and at cystectomy in 5 patients (56%) (Figure 1). Conversely, an atypical component diagnosed at first TURBT was not confirmed by a subsequent re-TUR in only 1 patient (3%). **Discussion:** Although the important prognostic role of rare histologic variants of bladder cancer is well-recognized, TURBT is not standardized in relation to tumor size. Unrecognized rare histotypes might have important therapeutic implications since they are probably less responsive to neoadjuvant chemotherapy or bladder-sparing approaches, thus benefiting early cystectomy. The inaccuracy of TUR in everyday clinical practice in detecting uncommon variants could be explained by the inadequacy of sampling of large tumors. The “pre-cystectomy” TUR is often considered a limited biopsy to confirm the tumor and to demonstrate the infiltration of the muscular layer. As a matter of fact, pathologists often do not analyze a sufficient amount of tissue to identify different histological components. Standardization of the TURBT strategy, including sampling of different areas of bulky tumors, could be of clinical value.

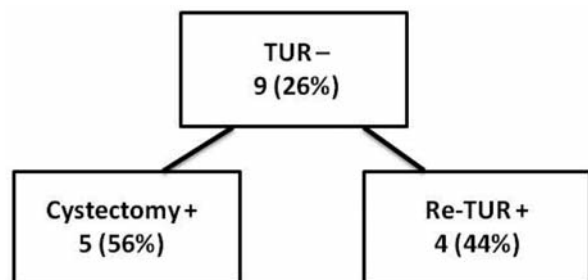


Figure 1. Flow chart showing the correlation between TURBT, re-TUR and cystectomy.

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**PREDICTIVE FACTORS OF RESECTION TECHNIQUES DURING PARTIAL NEPHRECTOMY IN A COHORT OF “ENUCLEORESECTIVE” CENTERS: INSIGHTS FROM THE SURFACE-INTERMEDIATE-BASE (SIB) MARGIN SCORE INTERNATIONAL CONSORTIUM**

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**Introduction:** Detailed reporting of resection strategies (RS) and resection techniques (RT) for tumor excision during partial nephrectomy (PN) is lacking in the current literature. The aim of the study was to evaluate (i) possible correlations between patients' and/or tumors' characteristics and RT performed and (ii) whether the type of RT does influence perioperative outcomes after PN, harnessing the newly proposed Surface-Intermediate-Base (SIB) margin score as a standardized reporting system. **Materials and Methods:** After Institutional Review Board's approval, data were prospectively collected from a cohort of 507 patients undergoing NSS at 16 high-volume Centers across the U.S. and Europe over a 6-month enrollment period. RT was classified according to the SIB score. RS was classified as "enucleative", "enucleoresective" or "resective" according to the most prevalent RT performed in each centre's cohort. Descriptive and comparative analyses were performed in the six enucleoresective RS centres (ERC). **Results:** Overall, 507 patients were finally enrolled in the study. The RT was classified as pure or hybrid enucleation (E, SIB 0-2), pure or hybrid enucleoresection (ER, SIB 3-4) and resection (R, SIB 5) in 266 (52.5%), 150 (29.6%) and 91 (17.9%) patients, respectively, in the overall cohort, while in 53 (33.1%), 83 (51.9%) and 24 (15.0%) patients in the ERC. Demographic data, comorbidity scores, surgical indication and approach and PADUA score did not significantly differ between the E, ER and R groups in the ERC. Tumors >4.0 cm were 21 (40.4%), 41 (49.4%) and 4 (16.7%) in the E, ER and R groups ( $p=0.02$ ), respectively. A clampless strategy was used in 19.2%, 13.2% and 8.3% of patients ( $p>0.05$ ). Median warm ischemia time (WIT) was 19 (15-24), 17 (14-23) and 17 (15-21) minutes in the E, ER and R groups ( $p>0.05$ ). Surgical post-operative complications were recorded in 7.5%, 13.2% and 4.2% of patients ( $p=0.05$ ). Positive surgical margin rate was 7.0%, 13.4% and 0% of patients, respectively ( $p>0.05$ ). Trifecta outcome was achieved in 67.2%, 71.6% and 73.7% of patients for the E, ER and R groups ( $p>0.05$ ). **Discussion and Conclusions:** This is the first study evaluating pre-operative predictive factors of RTs performed during PN and whether the type of RT significantly impacts on NSS outcomes using a standardized instrument of reporting. Overall, in ERC, ER represents less than 52%. ER and E are performed in a significantly higher proportion of tumors >4 cm compared to R. Relating to surgical outcomes, ER was associated with a significantly higher rate of post-operative surgical complication compared to E and R. However, Trifecta achievement was comparable among the three techniques.

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**RESECTION TECHNIQUES FOR NEPHRON SPARING SURGERY VARY: INSIGHTS FROM A PROSPECTIVELY COLLECTED MULTI-INSTITUTIONAL COHORT HARNESSING THE**

**SURFACE-INTERMEDIATE-BASE (SIB) MARGIN SCORE (SIB INTERNATIONAL CONSORTIUM)**

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**Introduction/Aim:** Resection methodology is rarely reported in current nephron-sparing surgery (NSS) literature. Yet, a