enucleation is employed quite frequently even at institutions that do not support its ubiquitous use. These data lay the groundwork for determining whether RT is a modifiable variable for functional and oncologic outcomes in patients who undergo NSS.

86 ENDOSCOPIC ROBOT-ASSISTED SIMPLE ENucleATION (ERASE) VS. OPEN SIMPLE ENucleATION (OSE) FOR THE TREATMENT OF CLINICAL T1 RENAL MASSES: ANALYSIS OF PREDICTORS OF TRIFECTA OUTCOME

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Aim: The aim of this study was to analyse the intra- and post-operative complications, as well as the predictive factors of Trifecta outcome in patients submitted to endoscopic robot-assisted simple enucleation (ERASE) and open simple enucleation (OSE) for clinical T1 renal masses. Materials and Methods: Overall, 634 cases treated with OSE (n=290) and ERASE (n=344) were prospectively recorded in our Department between 2006 and 2014. Trifecta was defined as simultaneous ischemia time <25 min, no surgical complication and negative surgical margin. A univariate analysis and multivariate logistic regression were performed for Trifecta. Results: The two groups were comparable for body mass index (BMI), comorbidity, tumor side, clinical T score, tumor diameter, surgical indication, pre-operative renal function, pre-operative hemoglobin and hematocrit. A significant difference was found between the OSE and the ERASE groups in operative time (115 (96-130) vs. 150 (120-180) minutes, p<0.0001), pedicle clamping (93.8% vs. 69.2%, p<0.0001), estimated blood loss (EBL) (150 (100-200) vs. 100 (100-143) cc, p<0.0001) and intraoperative complications (3.4% vs. 1.7%, p=0.02). The two groups were comparable for warm ischemia time (WIT) ≥25 min. A significant difference was found between OSE and ERASE in overall (16.6% vs. 5.5%, p<0.0001), Clavien 2 (11.7% vs. 4.4%, p=0.02) and Clavien 3 (3.1% vs. 1.7%, p=0.04) post-operative surgical complications, length of stay (6.0 (5.0-7.0) vs. 5.0 (4.0-6.0) days, p<0.0001), pre-operative 1st day delta creatinine (0.3 (0.2-0.4) vs. 0.15 (0.1-0.2) mg/dl, p<0.0001), positive surgical margins (2.1% vs. 1.5%, p=0.04), and Trifecta achievement (73.8% vs. 85.5%, p<0.0001). At univariate analysis, a higher median clinical diameter, a higher mean age, a higher median Charlson comorbidity index (CCI), endophytic tumor growth pattern, renal sinus and calyceal dislocation of the tumor, a higher median PADUA score and OSE were predictive factors of Trifecta achievement. At multivariate analysis, CCI lost significance (p=0.26), while age (odds ratio (OR)=1.02, 95% confidence interval (CI)=1.00-1.04, p=0.001), clinical diameter (OR=1.22, CI=1.05-1.42, p=0.008), PADUA score (OR=1.23, CI=1.07-1.41, p=0.004) and OSE (OR=1.74, CI=1.13-2.68, p=0.01) were confirmed predictive factors for Trifecta failure. Conclusion: The ERASE is a feasible and safe technique, which shows a comparable WIT, together with a significantly lower EBL, surgical complications’ rate, length of stay and a significantly higher Trifecta achievement compared to OSE. Age, comorbidity, tumor diameter and PADUA score, in association with surgical approach, represent significant predictive factors of Trifecta failure.

87 PROSPECTIVE ANALYSIS OF COMPLICATIONS AND THEIR PREDICTIVE FACTORS AFTER PARTIAL NEPHRECTOMY IN A MULTICENTER COMPARATIVE ITALIAN STUDY (RECORDI)

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Introduction/Aim: Absence of surgical complications represents an important perioperative goal of partial nephrectomy (PN). The aim of this study was to analyse intra and post-operative complications related to nephron-sparing surgery (NSS) in clinical T1 renal tumors in a wide Italian multicentre dataset and search for possible predictive factors. Materials and Methods: Overall, 1,075 patients treated with NSS for clinical renal tumors, between January 2009 and December 2012, were prospectively recorded. Overall, X patients had open NSS, Y a laparoscopic and Z a robotic approach. Centres were divided in high- and low-volume according to the threshold of 50 interventions per year. A description of cT1 cases (n=965) and a uni- and multivariate analysis for surgical complication were performed. Results: Overall, 965 patients were analyzed. 4.9% had intraoperative complications (3% for pleural injuries, 1% for vascular injuries, 0.3% for spleen injuries and 0.6% for other causes). Overall, in 13.3% of patients, post-operative surgical complications were recoded (7.6% surgical Clavien 2 and 3.8% surgical Clavien 3). Overall, 6.4% of patients had post-operative medical complications (3.2% were respiratory, 1.9% cardiologic, 0.2% thromboembolisms and 1.1% for other causes). At multivariate analysis, ECOG score ≥1 (odds ratio (OR)=1.9, 95% confidence interval (CI)=1.21-3.10, p=0.01), clinical diameter (OR=1.42, CI=1.07-1.90, p=0.02), open approach (OR=3.2, CI=1.11-9.30, p=0.03) and estimated blood loss (EBL) (OR=1.01, CI=1.00-1.01, p=0.01) were significant predictive factor of surgical post-operative complications. Intra-operative complications, at univariate analysis, were predictive factors for surgical post-operative complications (p=0.0001); however, they did not achieve significance at multivariate analysis (OR=2.08, CI=0.94-4.59, p=0.07). Conclusion: In this study, comorbidity status (ECOG score) and clinical diameter of the tumor were the only pre-operative significant predictive factors of surgical complications, along with higher EBL and the open approach.

DEFINITIVE RADIOTHERAPY IN THE TREATMENT OF BLADDER CANCER IN ≥80-YEAR-OLD PATIENTS: ANALYSIS OF TOXICITY AND OUTCOMES
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Aim: The aim of this study was to evaluate toxicities and survival rates of exclusive radiation therapy (RT) in the treatment of elderly patients with bladder cancer. Matherial and Methods: Between May 2011 and January 2016, 20 patients with bladder cancer previously submitted to transurethral resection (TURB) with diagnosis of high-grade transitional cell carcinoma, were treated with exclusive RT. Age ranged from 80 to 87 years (median=81). Five patients (25%) presented stage II disease, 10 (50%) stage II and 5 (25%) stage IV (M0). A 3-dimensional conformal treatment (3D-CRT) with a four-field box technique was planned delivering to the pelvis 45 Gy in 25 fractions with a sequential boost of 22 Gy in 11 fractions to the bladder and positive nodes for a total dose of 67 Gy. Acute and late toxicities were evaluated according to RTOG scale. Results: The median follow-up was 10 months (range=3-44). Acute genitourinary (GU) toxicity rates were 75%: grade 1/2 and grade 3 were, respectively, 70% and 5%. Grade 1-2 gastrointestinal (GI) toxicity rate was 25%. Grade 1/2 GI late toxicity rates was 10%. No grade ≥3 toxicity was recorded. Grade 1 and grade 2 GU late toxicity rate was 35% and 10%, respectively. No grade ≥3 toxicity was recorded. Overall survival (OS) was 100% at 2 years and 56% at 3 years. Four patients died because of systemic disease progression. Five patients died from intercurrent disease without evidence of bladder cancer. The actuarial 1-year and 2-year disease-free survival (DFS) were 59.8% and 33.7%, respectively. Conclusion: This study demonstrated that in ≥80-year-old patients, not candidate to surgery or to concomitant radio-chemotherapy for age and general conditions, exclusive definitive radiotherapy represents a valid alternative, after TURB, with acceptable toxicity profile.

A SNAPSHOT OF NEPHRON SPARING SURGERY IN ITALY: A PROSPECTIVE, MULTICENTER REPORT ON CLINICAL AND PEROOPERATIVE OUTCOMES
(THE RECORD 1 PROJECT)
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