the absence of validated questionnaires and the relatively short follow up of the RARP group.

P017
Patient decision-making prior to radical prostatectomy: What is and is not involved and the role of the urologist

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Introduction & Objectives: It is essential to ensure that men have access to balanced information before choosing a particular therapy for localized prostate cancer to allow for maximum patient satisfaction. We assessed the decision-making process prior to surgery with emphasis on patient perspectives and enquired whether patients were satisfied with their physician’s approach during this tough period and the outcomes of surgery.

Material & Methods: Telephone interview was conducted with 162 consecutive patients who underwent radical prostatectomy with a diagnosis of clinical T1-3 prostate cancer. A database was established and analyzed on pre and post-operative patient variables and interview results.

Results: Of 145 patients evaluated, 23% were unaware of cancer diagnosis. Radiation and active surveillance was presented as alternative options to 39 and 14%, respectively. Difficulty during decision was reported by 18%. Decision for surgery was made by the urologist 42%, patient 30% and shared 28%. Patients’ definition of effective treatment was satisfied with their physician’s approach during this tough period and the outcomes of surgery.

Conclusions: Urologists should be mindful of the prospects of prostate cancer patients in their community and devote more effort to fulfill their expectations. There seems to be room for improvement on topics such as moving from paternalism to more shared-decision making and informing patients in more detail on management alternatives along with side effects and complications.

P018
To what extent urologists embrace active surveillance for low risk localized prostate cancer at an academic center

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Introduction & Objectives: EAU, AUA and NCCN guidelines suggest that active surveillance is a viable management option which should be offered to patients diagnosed with low risk localized prostate cancer (LRPC). We reviewed data on patients who were diagnosed with LRPC and underwent radical prostatectomy. We assessed whether they recalled being offered active surveillance as an option.

Material & Methods: All patients who underwent radical prostatectomy with a diagnosis of localized prostate cancer between April 2009 and September 2013 were contacted by telephone by a neurologist (same person) who was not involved in the patients’ management. He asked each patient the same set of questions. A database was established on pre and post-operative variables and responses to telephone interview. LRPC was defined as cT1-2a, Gleason score ≤6, PSA ≤10, ≤3 cores positive for cancer and ≤50% core involvement. LRPC patients were analyzed regarding having been offered active surveillance as an option during the process of decision for management.

Results: A total of 162 surgeries were performed; 17 were excluded from analysis (unable to reach 8, Alzheimer 1, pre-op urethral catheter 4, renal transplant nominee 1, very recent surgery 2, deceased with colon cancer 1). Of the remaining 145, 36 fulfilled LRPC criteria. Mean age was 60.5 years, PSA 5.4 ng/ml, and time after surgery 14.1 months. Seven (19%) patients recalled having been offered active surveillance as an option. Regret for having undergone surgery was reported by 14%. An additional 5% reported ambivalent feelings on regret about their decision for surgery.

Conclusions: These results suggest that urologists do not appear to have readily embraced active surveillance as a management option for patients with low risk localized prostate cancer. These results reflect the practice at a university hospital in Istanbul and may not necessarily be generalized.

P019
Multi-variable models predicting specific patient-reported acute urinary symptoms after radiotherapy for prostate cancer: Ad interim results of a cohort study

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Introduction & Objectives: A multi-centric cohort study started in 2010 with the goal of developing predictive models of genito-urinary (GU) toxicity and of erectile dysfunction after high dose radiotherapy for prostate cancer. The aim of this ad-interim analysis was to assess correlations between clinical/dosimetric risk factors and acute urinary symptoms as measured by the International Prostate Symptom Score (IPSS).

Material & Methods: IPSS was prospectively filled in before and at the end of radiotherapy; relying on previous studies, absolute (cm²) weekly bladder dose-surface histograms (DSHWs) were chosen as dosimetric descriptors. Relevant clinical factors were prospectively collected including concomitant morbidities/drugs, androgen deprivation (AD); previous abdominal surgery, smoking, alcohol, age and BMI. Backward feature selection based on prediction optimization (minimization of residual) was used to select variables to be included in seven logistic models predictive of symptoms corresponding to each of the IPSS questions: moderate-severe symptoms (scores ≥4) were considered as end-points.

Results: Complete data of 262 patients (120 treated with conventional fractionation (1.8Gy/fr, median:78Gy) and 142 with hypofractionation (2.5–2.65Gy/fr, 71.4Gy, HYPO) were available. Smoking was a predictor for feeling of incomplete emptying (OR=6.20), frequency (OR=2.94), intermittency (OR=2.71), urgency (OR=2.81) and straining (OR=2.37); AD and use of anti-hypertensive drugs were risk factors for intermittency (OR=4.3) and weak stream (OR=1.95) respectively. The baseline score (ranging between 0 and 5) was a major predictor for all symptoms apart intermittency (ORs=1.50–2.59). DSHW parameters were correlated to an increased risk of frequency, intermittency, urgency and nocturia. Models showed moderate-high discriminative power (AUC: 0.62–0.85) and were sufficiently robust
Abstract P019

Figure 1

Bootstrap-based optimism: 2–6%). Dose-response relationships as a function of clinical risk factors is shown in figure. Main results were confirmed even when excluding patients with severe baseline symptoms; the impact of DSHw was stronger for HYPO.

Conclusions: Smoking and other clinical and dosimetry factors predict for specific moderate-severe acute urinary symptoms; baseline condition heavily modulated the risk in 6 out of 7 endpoints.

Abstract P020

The effect of the bladder take down on vesicourethral anastomosis and urinary incontinence in patients with localized prostate cancer

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Introduction & Objectives: Postoperative urinary incontinence after robot assisted radical prostatectomy (RALP) is one of the most bothersome complications, that affects to patient’s daily life. Time to recovery from postoperative urinary incontinence is important in patients satisfaction. We evaluate the effect of degree of bladder takedown on urethrovaginal anastomosis and continence.

Material & Methods: We prospectively analyzed 60 patients who underwent robot assisted laparoscopic prostatectomy for prostate cancer at our institute from March 2013 to August 2014. Patients were randomly assigned into two groups, Group I, 30 patients underwent deperitonization of lateral of bladder above the level of vas until exposing the both vas, the group II was done below it and cutting the vas. We compared the anastomosis time and postop continence. Defining continence as patients being pad free, continence at 1, 3, and 6 month were checked.

Results: There were no significant differences in age, body mass index, membranous urethral length, prostate volume, results of neurovascular bundle saving and between urethrovaginal anastomosis leaking between both groups. Anastomosis time were mean 25.5 min (16–35min) in group I and 23.4 min (17.5–33min) in group II (P=0.654). Cumulative number of patients, who recovered from incontinence at postoperative 1, 3, and 6 months in group I, were 9 (30%), 14 (46.6%) and 22 (73.3%), respectively. In group II, cumulative number of patients were 10 (33.3%), 16 (53.3%) and 21 (70%), respectively. There was no difference in time to recovery of urinary incontinence between two groups.

Conclusions: more wide deperitonization of bladder lateral attachment would not meaningful affect the result of urethra-vesical anastomosis and continence in RLRP.

Abstract P021

Rectal diameter on staging scan can predict risk of requiring rescan at radiotherapy planning for radical radiotherapy to the prostate: Test and confirmatory datasets

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Introduction & Objectives: Patients with large anterior posterior rectal diameter (RD) at the time of CT planning scan (RT planning scan) for prostate radiotherapy may exhibit more variability in rectal size and prostate position during treatment, potentially changing dose received by the rectum and prostate. At this centre patients with a RD of >4 cm at mid prostate at RTP undergo rescan after dietary advice/laxative intervention. We have previously reported a dataset examining the relationship between RD on staging imaging and RTP. Here we report results from a confirmatory study.