Most patients had acceptable gastrointestinal and urological toxicity of the treatment (Grade 0-II >83% pts.).
Conclusions: Curative radiotherapy of bladder cancer to the dose 64−74 Gy is an effective treatment. For a large proportion of patients, it leads to long-term DFS with an acceptable toxicity. An important advantage is to preserve the bladder. This treatment is wrongly neglected and for elderly patients may mean the only curative treatment option.

7128 POSTER

Superficial Bladder Cancer, the Problem of T1 G3 Tumours − an Egyptian Experience

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Background: Most genitourinary oncologists would agree that T1 G3 superficial bladder cancers are a watershed for therapeutic interventions, but the ideal treatment remains controversial. Our study aimed at reviewing a random sample of the cases with superficial bladder cancer that presented to the national cancer institute − Cairo university (a leading Egyptian centre) within the last five years in a retrospective way. Our aim was to try to establish a standard treatment for this controversial group.
Materials and Methods: One hundred patients with superficial bladder cancer were included in the study. They were randomly selected out of 800 patients with different pathologies included in the definition of "superficial bladder cancer" from the pathology department at our institute from 2005 to 2009. The data for the selected patients was collected in a data sheet designed for the study. The condition at last follow-up was obtained from frank statements in the patients' records as well as by analysis of the preceding disease history.
The returned data was tabulated in a master table, and statistical analysis was done whenever appropriate to illustrate correlation or significance.
Results: Out of 22 cases primarily diagnosed as T1 G3 tumours on first cystoscopy, 19 showed recurrence within the first 6 months, 100% recurred as T1 G3 with multicentricity.
The T1 G3 group never changed the grade or the stage on subsequent recurrences, whereas other grades and stages progressed to T1 or G3 throughout their course.
13 progressed to invasive type within a time interval ranging between 2 months and 3 years. 11 were explored for possibly radical cystectomy following diagnosis of invasion, only 6 of them were operable. The rest were locally advanced or metastatic. The urinary diversion following cystectomy in the 6 operated cases included 4 ileal conduits, one rectal bladder and one uretero-cutaneous. In all cases, it was not possible to try for a continent orthotopic bladder in those patients.
The median time to first recurrence (tumour-free period) was 6 months in G3 tumours, while 12 months in other grades. The invasion-free survival at 12 months was 84% with T1 tumours, while 92–100% in other T stages (Ta and Tis). This meant that at 12 months follow-up, the highest percentage of invasive tumours were originally T1 G3 type.
Conclusions: The recurrence of T1 G3 tumours always occurred within the first 12 months of the follow-up period. They progressed to invasive cancer within the following 12 months. Whenever they progressed, they presented with advanced stage of the disease and sometimes metastasized. Subsequent mortality followed within 12−24 months interval. T1 G3 tumours showed a high rate of progression and sometimes they invaded very rapidly, leading to unacceptable mortality from what is originally described as "superficial" tumours; thus justifying the adoption of a new policy for early radical cystectomy in T1 G3 tumours.

7129 POSTER

Adjuvant Chemotherapy for High-risk Patients With Urothelial Carcinoma

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Background: In Europe in 2008, there were an estimated 139,500 new cases of urothelial cancer (UC) and 51,300 related deaths. Surgical treatment is the gold standard treatment for muscle-invasive disease. However, disease recurrence is observed in 30% to 56% of patients undergoing surgery (S), most often the result of occult metastatic disease. Nowadays there is a lack of data in the current literature to provide strong recommendations of adjuvant chemotherapy (AC) for patients with high-risk UC.
Material and Methods: We retrospectively analysis 59 pts with diagnosis of UC of the bladder(B) or upper urinary tract (UUT) treated with S diagnosed between November 2004 and June 2010. Pts were divided in two groups: S only (29 pts-49%) and S+AC (30 pts-51%). Adjuvant chemotherapy schedule (ACS) were cisplatin-based 56% and carboplatin-based 43%. The tumour stage and grade were recorded according to the 2002 TNM and WHO system, respectively. PFS, OS and predictors of outcomes were analyzed using Kaplan–Meier method and Cox regression analysis.
Results: Median age was 69 years, pT3−4: 91%, pN+: 46.9%, stage (St) III/IV: 48.3%/51.7%, primary site (B 61%, UTT 39%), surgical margen +: 6.8%, serum creatinine $\geqslant$1.6 mg/dl: 25%, median nodes resected: 11 (0−21). There were no differences in characteristics patients between both groups (gender, pT, pN, St), except ECOG PS 0 and 1(S 65% vs S+AC 13%, S 34% vs S+AC 86%; $p < 0.001$). At a median follow-up time of 20.6 mo, 43.1% have relapsed (S 51.7%, S+AC 33%; $p = 0.023$) and 40.6% have died (S 48%, S+AC 33%; $p = 0.04$). ACS were similar in terms of number of cycles delivered, PFS and OS (P = NS). On multivariable Cox regression analysis St was independent predictor factor of PFS (HR 0.28, 95% CI 0.08–0.98; $p = 0.047$) and OS (HR 0.31, 95% CI 0.11–0.87; $p = 0.026$) and not receiving AC was independent predictor factor of PFS (HR 4.27, 95% CI 1.78–10.27; $p = 0.001$) and OS (HR 3.27, 95% CI 1.57–8.98; $p = 0.003$). Main G3−4 toxicities were neutropenia 54%, febrile neutropenia 10.8%, thrombocytopenia 16.2% and anemia 18.9%. There was one toxic death (sepsis).
Conclusion: AC is associated with a significant improvement in relapsed and survival for pts high-risk patients with UC treated in an off-protocol clinical setting.

7130 POSTER

Does Chemotherapy for Testicular Cancer Warrant Prophylactic G-CSF?

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Introduction: Chemotherapy for metastatic germ-cell tumours (GCT) is highly curative. Myelotoxicity is a main side effect of standard regimens such as bleomycin, etoposide, cisplatin (BEP) or etoposide, cisplatin (EP). Usage of prophylactic G-CSF varies amongst centers and countries.
Hypothesis: BEP and EP can be safely administered without prophylactic use of G-CSF.
Methods: The BCCA registry was analyzed for all patients who were treated with either BEP or EP for metastatic GCT between 2001 and 2010. Data on neutropenic fever episodes, usage of G-CSF, frequency of dose delays and dose reductions were recorded.
Results: A total of 281 patients were identified. Results are currently available for 50/281 patients. 29% of patients were treated for FNE while receiving chemotherapy, all of whom completed recommended chemotherapy without subsequent G-CSF. 1 patient received a dose reduction in chemotherapy due to bone marrow toxicity. No other dose reductions or dose delays occurred. Nearly all of the patients who had FNE had good prognosis by IGCCCG staging with one intermediate and no poor prognosis. 9% were treated prophylactically with prophylactic G-CSF, none of whom experienced FNE.
Discussion: Although the incidence of FNE is relatively high, the associated morbidity was low, Neutropenic fever episodes were generally short, uncomplicated and did not result in dose delays or reductions. Administration of BEP and EP appears safe even without prophylactic use of GCS-F. Results on all 281 patients will be available.