Stage I non-seminoma testicular cancer: Adjuvant management and outcomes

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Background: Treatment options for stage I (CS1) non-seminoma testicular cancer (NSGCT) following surgery include active surveillance (AS) or adjuvant bleomycin, etoposide and cisplatin (BEP). Presence of lymphovascular invasion (LVI) and embryonal carcinoma (EC) have been associated with an increased risk of relapse.1-4

Methods: Data on CS1 testicular cancer patients presenting to two sites in Western Sydney between 1990 and 2019 were analysed. Tumour characteristics including tumour markers, size of primary, LVI, rete testis involvement (RTI) and histology were correlated with relapse.

Results: A total of 168 cases of CS1 NSGCT were identified. None of the 20 patients who received 2 cycles of adjuvant BEP relapsed, compared to 47 of 148 (32%) on AS. All relapsed patients received BEP and 19 (40%) had post-chemotherapy surgery. 14 out of 19 resection samples showed residual teratoma, and the remaining showed necrotic tumour. The 2 deaths from relapse, one from other causes (RFS at 5 years was 71% and OS 97%). In AS patients, LVI and RTI were predictors of relapse with HR of 8.50 (95% CI 4.12, 17.54, p<0.0001) and 3.12 (95% CI 1.46, 6.70, p=0.01). 29 of 44 pts (66%) with LVI relapsed compared to 10 of 85 (12%) without LVI. EC was not associated with relapse. (HR 1.80, CI 0.71, 4.57, p=0.2).

Conclusions: In our series, relapse rate of 32% in AS group is in keeping with published data from a large population-cohort study.1 LVI was associated with an almost 9-fold increase in risk of recurrence, also consistent with previous findings. Of those, 40% required post-chemotherapy surgery. Although long term outcomes remain good, treatments for relapse are associated with increased morbidity. Therefore, we recommend CS1 NSGCT patients with LVI be considered for a single cycle of BEP rather than AS to reduce risk of relapse and prevent relapse related treatment morbidity.1-4


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Stage I seminoma testicular cancer: Predictors of relapse and outcomes for adjuvant carboplatin vs active surveillance

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Background: Stage I (CS1) testicular cancer management has changed dramatically in the last few decades. Seminoma patients now rarely receive adjuvant radiotherapy. Most have adjuvant carboplatin or active surveillance (AS). Tumour size >4cm and rete testis involvement (RTI) have been described as predictive features for relapse but not consistently demonstrated in studies.1

Methods: Data on CS1 testicular cancer patients presenting to two sites in Western Sydney between 1990 and 2019 were collected. Tumour characteristics including tumour markers, size of primary, LVI and RTI were correlated with relapse.

Results: Total of 322 cases of CS1 seminoma were identified. 222 received adjuvant radiotherapy and were excluded from this analysis. 2 of 33 (6%) who received carboplatin relapsed compared to 11 of 67 (16%) on AS. All relapsed patients were successfully treated with bleomycin, etoposide and cisplatin (BEP) without recourse. Two of the AS group died of other causes. RFS at 5 years was 82% and OS 99%.

In the AS group, the only parameter statistically associated with relapse was LVI with a hazard ratio (HR) of 3.89 (95% CI 1.01, 14.70, p=0.05). beta HCG elevation (HR 3.89 (95% CI 0.92, 16.50, p=0.07), RTI (HR 0.54 (95% CI 0.11, 2.62, p=0.05) and tumour size >4cm (HR 0.83 (0.21, 3.22, p=0.8) were not statistically associated with relapse.

Conclusions: Patients with CS1 seminoma have good long term outcomes regardless of first-line management choice. In our series, LVI was associated with relapse of seminoma patients on AS and not tumour size >4cm or RTI. These results further support recent findings on the lack of power and consistency of these tumour characteristics in predicting relapse.2-3


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214P Study of treatment outcome in adults with TFE related RCC


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Background: Translocation renal cell carcinoma (TRCC) represents 1% to 5% of all cases of renal cell carcinoma (RCC), with the highest frequency among children and young adults. Management of these tumors is ill defined. This is a retrospective analysis of treatment outcome in adult patient 18 years or above treated at our hospital between January 2013 to November 2019.

Methods: Clinical and pathological data of 26 patients from a single institution diagnosed with TRCC between January 2013 and November 2019 were retrospectively reviewed. We analyzed our data of patients treated with Surgery only or who progressed after surgery and treated with systemic therapy or who upfront due to unresectable or metastatic disease treated with systemic therapy with respect to Event free survival and overall survival.

Results: Between Jan 2013 to Nov 2018, 26 adult patients were treated at our centre. Out of 26 patients 25 had radical surgery after evaluation and 1 had metastatic disease who was started on systemic therapy. Out 25 patient who were treated with radical surgery, 16 patients progressed and they were started on systemic therapy. Median EFS and median OS among overall population was 22 month and 30 month respectively. Among 16 patient who were treated with systemic therapy, median EFS to first line therapy was 8 month and to second line therapy was 2.5 month. Median OS was 17 month.

Conclusions: TRCC is rarely seen but carries significant risk of disease progression with potential response to targeted therapy of short duration.

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