transplant; Group 2 consisted of patients with ESRD who underwent RN, with or without subsequent transplant. Dominant tumor size and histopathologic characteristics, recurrence and survival outcomes were compared between groups. Chi-square and Mann-Whitney U tests were used to compare categorical and continuous baseline and histopathologic characteristics, respectively. Univariate analysis and log rank test were used to compare RCC recurrence rates between groups after RN.

RESULTS: We identified 28 RN in 24 patients in group 1 and 70 RN in 61 patients in group 2. Median time from transplant to SRM radiologic diagnosis in group 1 was 87 months. Median time from radiologic SRM diagnosis to RN was 3 and 4 months for group 1 and 2, respectively. Baseline demographic, clinical and histopathologic features of both groups are depicted in Table 1. Demographic characteristics were similar between groups. There were no statistically significant differences between pathologic dominant mass size, histologic subtype breakdown, grade or stage between the groups. Median follow-up after RN was 40 and 43 months for groups 1 and 2, respectively. Univariate analysis did not reveal a statistically significant difference in recurrence-free survival between the groups (P = 0.9). Two and 8 patients died in groups 1 and 2, respectively. One patient died of RCC and was from group 1.

CONCLUSIONS: Patients undergoing RN before or after transplant with malignant SRM have similar clinicopathologic characteristics and recurrence-free survival outcomes. Our results suggest that patients with ESRD and SRM need not delay transplant and AS may be a good first line option for many.

Table 1: Baseline clinicopathologic features and outcomes of Group 1 and Group 2 patients

Characteristics	Group		p-value
	Nephrectomy After Transplant (1)	Nephrectomy Before Transplant (2)	
N	28	70	
Age at nephrectomy; mean (IQR)	58 (52-68)	57 (48-65)	0.5
Sex			0.3
Female; n (%)	10 (36)	30 (43)	
Male; n (%)	18 (64)	40 (57)	
Smoking Hx; n (%)	12 (43)	42 (60)	0.2
Path Histology Breakdown; n (%)			0.2
Clear Cell	11 (39)	24 (34)	
Papillary Type 1	9 (32)	10 (14)	
Papillary Type 2	2 (7)	5 (7)	
Papillary Type Unspecified	0 (0)	7 (10)	
Chromophobe	2 (7)	2 (3)	
Unclassified	0 (0)	2 (3)	
Acquired Cystic Disease-Associated Renal Cell Carcinoma	4 (14)	19 (27)	
Metastasis	0 (0)	1 (2)	
Path max dimension of dominant mass (cm); mean (IQR)	2.3 (1.5-3.0)	2.7 (1.5-2.8)	0.6
Path stage breakdown; n (%)			0.6
T1a	26 (93)	56 (80)	
T1b	2 (7)	8 (12)	
T2a	0 (0)	0 (0)	
T2b	0 (0)	1 (2)	
T3a	0 (0)	4 (6)	
Path Fuhrman Grade; n (%)			0.5
Low (1-2)	16 (57)	37 (53)	
High (3-4)	9 (32)	18 (26)	
Not Reported	3 (11)	15 (21)	
Median Follow Up After RN; months	40	43	0.7
Radiographic Recurrence; n (%)	1 (4)	3 (4)	0.9

Source of Funding: None

MP19-12

PRIMARY SMALL CELL CARCINOMA OF THE KIDNEY: DISEASE CHARACTERISTICS AND OUTCOMES

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INTRODUCTION AND OBJECTIVES: Primary small cell carcinoma (PSCC) of the kidney represents a rare disease entity. There is little data about the characteristics, optimal therapies, and survival associated with this malignancy. We examined the largest cohort of patients to date with PSCC of the kidney in order to better characterize the disease.

METHODS: We utilized the National Cancer Database (NCDB) to identify patients with histology-confirmed primary small cell carcinoma of the kidney with no history of other malignancies between 2004 and 2015. Three patients with unknown treatment regimens and the one patient who received radiotherapy alone were excluded from analysis. Adjusted Cox proportional hazards regression was utilized to assess overall patient survival. Kaplan-Meier analysis was used to estimate median survival time

RESULTS: We identified 121 patients with PSCC of the kidney who met inclusion criteria. The patients with treatment had a median overall survival time of 10.28 months. 23.1% of patients had no treatment, with a median survival of 1.64 months. We found no gender predominance in disease prevalence (Table 1). Female gender, however, was associated with increased mortality when compared to males (p = 0.043, OR 2.02). Patients treated at academic facilities had significantly improved survival (p = 0.015, OR 0.39), while those managed at integrated cancer centers (p = 0.046, OR 2.80) fared worse compared to those treated at comprehensive community cancer programs. Metastasis upon presentation, found in 47.1% of patients, was associated with an increased risk of mortality (p = 0.043, OR 2.23), as was lymph node involvement (cN1: p = 0.05, OR 2.46). Surgery alone was performed in 26.4% of patients with a median survival of 9.00 months (Figure 1) compared to 13.50 months in the 18.2% of patients who received surgery with adjuvant chemotherapy (p = 0.37).

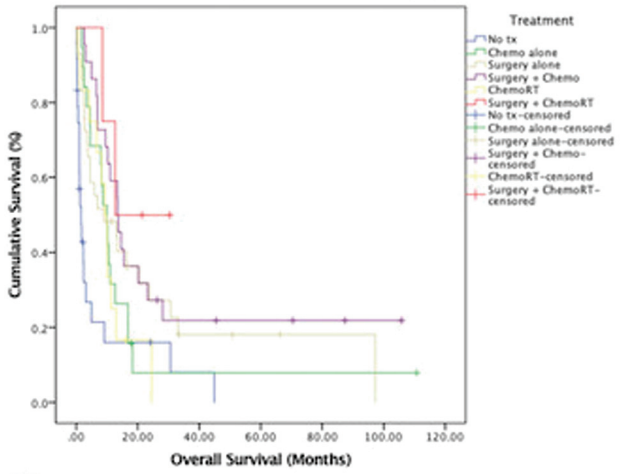
CONCLUSIONS: PSCC of the kidney is a rare and very aggressive malignancy with a median survival less than one year. In the largest cohort of such patients to date, we found that multimodal treatment approaches improve survival. Surgery alone is associated with a lower median survival time, despite being the most frequently employed treatment modality. Future studies should focus on correlating clinical tumor staging with specific treatment modalities to best optimize management for individual patients.

Table 1: Demographics

	Frequency (%)	Odds Ratio (95% Confidence Interval)
Gender (n=121)		
Male	53.7	1.00 (Reference)
Female	46.3	**2.02 (1.02-3.99)***
Age (n=121)		
18-39	4.1	0.90 (0.14-5.69)
40-49	7.4	0.58 (0.10-3.46)
50-59	11.6	1.00 (Reference)
60-69	25.6	**3.50 (1.08-11.35) ***
70-79	27.3	1.07 (0.27-4.16)
>80	24.0	2.62 (0.68-10.04)
Race (n=121)		
Caucasian	86.8	1.00 (Reference)
African American	6.6	1.00 (0.27-3.70)
Hispanic	4.1	2.75 (0.63-12.03)
American Pacific Islander	1.7	0.44 (0.02-8.29)
Other	0.8	5.66 (0.14-234.76)
Treatment Facility (n=106)		
Community Cancer Program (CCP)	10.4	0.44 (0.12-1.56)
Comprehensive Community Cancer Program (CCCP)	45.3	1.00 (Reference)
Academic Program	34.9	**0.39 (0.19-0.83) ***
Integrated Cancer Center	9.4	**2.80 (1.02-7.71) ***
Metastasis at Diagnosis (n=121)		
Yes	47.1	**2.23 (1.03-4.83) ***
No	49.6	1.00 (Reference)
Unknown	3.3	2.33 (0.39-14.00)
Lymph Node Involvement (n=121)		
cN0	25.6	1.00 (Reference)
cN1	27.3	**2.46 (1.00-6.04) ***
cN2	4.1	0.60 (0.08-4.48)
cNX	42.0	1.42 (0.53-3.81)
Tumor Size (n=103)		
Mean	8.5cm	
Median	7.1cm	

* Result is significant at p<0.05

Figure 1: Kaplan Meier Survival Curves by Treatment Modality



p= 0.01
No tx (n=28, median survival=1.64), Chemo alone (n=22, median survival=10.00), Surgery alone (n=32, median survival=9.00), Surgery + chemo (n=22, median survival=13.50), Chemo + RT (n=13, median survival=9.36), Surgery + chemo + RT (n=4, median survival=12.65)

Source of Funding: None

MP19-13

COMPARING UROLOGIST RECOMMENDATIONS FOR SMALL RENAL MASS BIOPSY WITH PATIENT OPINIONS BEFORE AND AFTER COUNSELING

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INTRODUCTION AND OBJECTIVES: Shared decision making is important for patients who are considering treatment of small renal masses (SRM). The purpose of this study was to compare patient's opinions with surgeon perspectives regarding the use of pre-treatment SRM biopsy.

METHODS: A 5 question survey was given to 100 consecutive patients with SRM before and after treatment discussion. The patient survey contains questions about anxiety level (visual analog scale) and whether patients believed biopsy would be helpful make decision about treatment. In addition to patient survey, a 10 question surgeon survey was linked to email sent to active members of the Society of Urologic Oncology. Respondents were grouped based on date of completion of training, type of practice, and geographic location.

RESULTS: A total of 100 consecutive patients completed a survey prior to discussion of SRM treatment. Pre-discussion anxiety was high with 46% of patients responding that SRM diagnosis was "among most stressful moments in life" When patients were asked "Would knowing whether or not there is cancer in your renal mass help you to make a decision about treatment?", 81% answered yes. When asked if they would consider biopsy, 84% answered yes. After renal mass counseling, only 46% of patients answered yes to "did you decide to have a biopsy?". A total of 42/100 patients subsequently received biopsy.

Of 717 surgeons who were emailed, 111 (15.5%) completed the online survey. Practice type included: Academic (76%), private (18%) and military/government (6%). The median year when training was completed was 2009 (IQR 2000-2015) and 62% of respondents evaluating $\geq$5 SRM/month. When asked how often biopsy is recommended for SRM, 60% recommend biopsy $<$25% of SRM patients, 20% recommend biopsy for half of SRM patients and 20% recommend biopsy greater for than 75% of SRM.

Training year and type of practice were not associated with how frequently biopsy was recommended ($p=0.27$, 0.17). Common responses for the advantage of using biopsy to evaluate SRM included: To identify benign tumors and avoid treatment (49%), to risk stratify renal cancer patients prior to treatment (21%), and to improve informed consent prior to treatment (14%). The most common response for why biopsy was not recommended is that it would not change management (86%).

CONCLUSIONS: Before counseling, most SRM patients favor biopsy. After treatment discussion, less than half of patients favored biopsy with 42% subsequently receiving biopsy. Practice patterns remain variable among surgeons, with 40% of respondents recommending biopsy for at least half of SRM evaluated.

Source of Funding: None

MP19-14

HIGH BURDEN OF IN-PERSON KIDNEY CANCER SURVEILLANCE IN A LOW RESOURCE POPULATION

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INTRODUCTION AND OBJECTIVES: Kidney cancer surveillance following nephrectomy is predominantly based on imaging and laboratory evaluation, rather than physical exam. Despite this, patients make substantial sacrifices to attend in-person follow-up visits. We sought to characterize the burden of kidney cancer surveillance in a low-resource population, with an aim to identify opportunities for telehealth implementation.

METHODS: We performed a retrospective review of patients who underwent partial or radical nephrectomy between November 2016 and May 2018 at an academic medical center with a large, rural referral base. We reviewed patient demographic characteristics including age, travel distance to hospital, Center for Medicare & Medicaid Services designation of home ZIP code as a Low-Income Area (LIA) or Health Professional Shortage Area (HPSA), and employment status. Follow-up visits were reviewed for intended and obtained imaging and laboratory studies, as well as new physical exam findings.

RESULTS: We identified 156 patients who attended 234 follow-up visits at mean 2.4 months (SD 2.9 months) following partial or radical nephrectomy. Patients' home ZIP codes were designated as LIA or HPSA in 93 (59.6%) cases. Fifty-three patients (34%) were employed at time of follow-up. One-way travel was mean 194 miles (SD 438 miles) for each visit. When intended, laboratory or imaging studies were not obtained ahead of follow-up visits in 34 of 196 cases (17%). New physical exam findings that altered management were identified in 27 visits (11%), though 17 of these occurrences (86%) were at the first post-op visit. Based on the absence of new physical exam findings or procedures performed, 201 (86%) visits were amenable to a telehealth encounter rather than in-person appointment.

CONCLUSIONS: Patients living in LIAs and HPSAs are asked to travel long distances to attend kidney cancer surveillance visits, often (86%) to review data that could have been obtained remotely. Necessary imaging or laboratory studies are frequently (17%) not obtained ahead of appointments, further diminishing their value. Kidney cancer surveillance may offer a promising opportunity for telehealth implementation within urology.

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MP19-15

PATIENT-REPORTED BARRIERS TO OBTAINING GENETIC COUNSELING IN EARLY-ONSET RENAL CELL CARCINOMA

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INTRODUCTION AND OBJECTIVES: The 2017 AUA Guidelines for localized renal cell cancer (RCC) recommend genetic