were independent with some or minimal discomfort. 14 patients required assistance for some of their basic daily needs. 9 patients (2.2%) had sepsis. 131 patients (32.4%) required additional oral analgesia following TRUSB$_x$ on days 0, 1 and 2. Mean age of these patients was 63.6 years. This group had mean VAS during the procedure of 4 and when patients reached home was 3.5. Mean maximum VAS on day 1 and 2 was 2.1 and 1.3 respectively.
Conclusion: A third of patients require self-medicated analgesia post-procedure. Age alone cannot be used as a criterion to identify patients who will subsequently require analgesia post-procedure, but a higher VAS during the procedure may be indicative.

1304: CHAIRING AND LEADERSHIP IN MULTIDISCIPLINARY CANCER TEAMS: DEVELOPMENT AND EVALUATION OF AN ASSESSMENT TOOL

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Introduction: High quality leadership and chairing skills are vital for good performance in cancer multidisciplinary teams(MDTs), but no tools exist for assessment. Our objective was to construct a robust tool for assessment of MDT-chairing performance.
Methods: An observational tool was developed to assess the chairing and leadership skills of MDT chair. The tool includes 11 elements of effective MDT chairing. After it was content-validated by 10 senior MDT members, the MDT chair person was assessed by two surgeons(blinded to each other) in seven live-observed Urology MDT meetings (286 cases) and ten video recorded MDTs(131 cases) of different specialities. All chairing elements were analysed via descriptive statistics. Intraclass correlation coefficients(ICCs) were used to assess inter-rater agreement and assessors' learning curves.
Results: The inter-rater agreement was adequate-high(ICC= 0.63-0.91) for all of the chairing elements. Agreement was higher in live MDT ratings(mean 0.79,SD 0.092) compared to video ratings(mean 0.72,SD 0.069).
Conclusion: an observational assessment tool can be reliably used for assessing the chair person in cancer MDTs (both in live and video-recorded). Such robust assessment tools provide part of a toolkit for MDT leadership evaluation and enhancement. The ability to feed back their performance to MDT leads can enable promotion of good practice.

1308: HYPERTHERMIC MITOMYCIN C IN THE TREATMENT OF HIGH RISK NON MUSCLE INVASIVE BLADDER CANCER – IS IT EFFECTIVE AND SAFE? A REGIONAL CENTRE'S EXPERIENCE

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Aims: High risk non muscle invasive bladder cancer (HRNMIBC) is commonly treated with intravesical BCG, but fails in approximately 50% of patients after 5 years. Hyperthermic Mitomycin C (HTMMC) is now being considered for patients who failed BCG and avoid cystectomy. Our prospective study was to investigate efficacy and tolerance of HTMMC and factors that influence success.
Methods: Patients with HRNMIBC who failed BCG or are immunocompromised were treated with HTMMC from June 2006 to June 2012. Induction HTMMC was given at 42+/-2$_o$C through a Synergo device, with induction and regular maintenance courses. Every three months, cystoscopy and cytology was taken.
Results: Of 95 eligible patients, 75 completed at least one review. 77% of patients had a complete response with HTMMC. High grade cancer and CIS did not influence HTMMC initial response. No Clavien score over 2 was reported. Median follow up was 33 (3-78) months. At 5 years, disease specific survival was 96.8%, overall survival was 82.3% and failure-free survival was 47.6%. 14 proceeded to cystectomy on HTMMC failure, with 11 performed locally. Of the 11, all had organ-confined disease.
Conclusion: HTMMC is well tolerated and suitable treatment for patients who are unfit or do not wish cystectomy.

1317: THE USE OF STAGING AND MULTIPARAMETRIC MRI IN PROSTATE CANCER – A NATIONAL SURVEY

Sophia Cashman, Evangelos Gkougkousis, Paula Allchorne, Bruce Turner, James S.A. Green. *Barts Health NHS Trust, London, UK.*
Introduction: Current guidelines on the use of multiparametric MRI in prostate cancer are limited. Its role in diagnosing and staging prostate cancer remains a subject of debate. We designed a questionnaire to assess the current uptake of both staging MRI prior to treatment decision, and the use of multiparametric MRI prior to initial prostate biopsy in target patients.
Methods: Questionnaires were handed out to healthcare professionals involved with uro-oncology MDTs. Individuals at each of the urology specialist multi-disciplinary team (SMDT) centres in England were also contacted by email, with a link to the questionnaire.
Results: In total, 79 responses from 57 centres were received. Of these, 46 centres reported having a protocol which defines which patients have a staging MRI prior to treatment decision. Nine centres report using multiparametric MRI prior to initial biopsy in target patient, which includes centres using this as part of a research trial or service improvement assessment.
Discussion: Our data suggests that the use of multiparametric MRI as an imaging modality is limited. This is in keeping with the current limited data on its value as a diagnostic tool. Further evidence is needed to assess its role within the diagnostic pathway for prostate cancer.

1345: RADIATION EXPOSURE IN UROLOGICAL SURGERY: AN AUDIT OF CLINICAL PRACTICE

Jennifer Martin, Paul Downey, Binu Thomas. *Causeway Hospital, Coleraine, Northern Ireland, UK.*
Aim: Intraoperative radiology has led to an evolving awareness of the potential risks of radiation exposure. The increased use of radiation within urology necessitates further study and this audit evaluated its use in comparison to guidelines produced by the IAEA (International Atomic Energy Agency).
Methods: From January to September 2012, 176 patients were identified from a retrospective review of theatre records, to have undergone one of five types of urology surgery involving radiation exposure. Procedure type, screening time and radiation dose area product were recorded, from which the effective radiation dose was calculated. Performance was reviewed and compared against IAEA guidelines.
Results: All five procedures were found to have used lower levels of radiation in comparison to the IAEA guidelines. Variations in radiation doses between individual urologists were identified, with a particularly wide effective radiation dose range of 0.8mSv to 1.9mSv found in the commonest procedure, ureteroscopy and laser lithotripsy.
Conclusions: Intra-operative radiation use at Causeway Hospital appears to be well below the levels recommended by the IAEA. Measures to continue to effectively treat urological disease whilst minimising patient radiation exposure should be introduced.

1367: CAN TRANSPERINEAL SECTOR BIOPSY PREDICT FINAL PATHOLOGY MORE ACCURATELY THAN TRUS BIOPSY OR MRI?

David Eldred-Evans, Paul Sturch, Janette Kinsella, Prokar Dasgupta, Rick Popert, Declan Cahill, Ben Challacombe. *Guys and St. Thomas' Hospital, London, UK.*
Objectives: To compare the accuracy of TRUS biopsy, Transperineal sector biopsy and multiparametric MRI (mp-MRI) at predicting final pathology at radical prostatectomy.
Methods: A retrospective diagnostic accuracy study of patients who all had a mp-MRI, a TRUS biopsy and a transperineal sector biopsy followed by a robot assisted radical prostatectomy (RARP) at a single institution between January 2010 and December 2012. The final pathology at radical prostatectomy was compared across MRI, TRUS and TPSP.
Results: 104 consecutive patients were identified with a mean age 62 years (range 40-74) and a median PSA 7.9μg/L (range 0.8-40). The Gleason score at radical prostatectomy was accurate in 71% transperineal sector biopsies but only 27% TRUS biopsies. The Gleason score was upgraded in 77% TRUS biopsies compared to 16% transperineal sector biopsies.
There were 23 patients who had extracapsular extension (ECE) at radical prostatectomy but only 25% were predicted by mp-MRI. The MRI did not identify 12 patients staged at T3a and 4 patients staged at T3b.
Conclusions: Transperineal sector biopsy was the best predictor of final pathology. Neither TRUS biopsy nor MRI stage predicted final pathology reliably, particularly with regard to extracapsular extension, and this has implications for the use of preoperative nomograms.