

**MP19-09****INTERACTIVE HOME MONITORING AFTER RADICAL CYSTECTOMY**

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INTRODUCTION AND OBJECTIVE: Interactive home monitoring (IHM) is a comprehensive transition program designed to dynamically monitor and deliver post-surgical needs at home. This program not only assesses vitals and sends them directly into the electronic medical record but also combats barriers to healthcare and functions as an advocate for clinical follow-up. Use of IHM in radical cystectomy, a surgery with high risk of complications and re-admissions, has not been evaluated. This study assesses outcomes of radical cystectomy patients enrolled in IHM and compares results to a control group.

METHODS: Retrospective data was evaluated on all patients receiving radical cystectomy from September 2020 to June 2022. Primary outcomes are 90- and 30-day re-admissions and mortality. We defined cohorts based on IHM status and comparison tested was performed using chi-squared, Fisher's exact, and student's t-test. Multivariate linear regression was performed on combined cohorts to identify variables associated with outcomes.

RESULTS: A total of 80 patients were evaluated during the study period. Table 1 contains patient demographics. There were no differences in baseline characteristics between the IHM and control groups in age, gender, BMI, smoking status, surgical technique, diversion type, or adjuvant therapy. Charleston comorbidity index ($p=0.006$) and enhanced recovery after surgery protocol (ERAS) ($p=0.011$) differed between cohorts. When dichotomized by T2 or less vs greater than T2, the IHM group had higher cancer stage ($p=0.004$). The IHM group had 35% of patients with a 90 day re-admission and 30% with a 30 day re-admission. The control group had 47.5% of patients with a 90 day re-admission and 40% with a 30 day re-admission. Combination of cohorts showed ERAS to be a predictor of 90- (OR = 0.10; $p<0.001$) and 30-day (OR=0.14; $p<0.001$) readmission on multivariate analysis. The IHM group had 0 (0%) deceased patients and the control group had 2 (5%) deceased patients 90 days following surgery.

CONCLUSIONS: Although the IHM group had significantly more comorbidities and greater disease burden, the IHM group had a lower 35% 90-day readmissions relative to the control group's 47.5% readmissions. This novel method of post-discharge continuity of care is appealing in the potential to discharge highly comorbid patients to their homes and decrease re-admission and mortality rates.

Patient Characteristics	Interactive Home Monitoring (n=40)	Control Group (n=40)	p-value
Age at Surgery, years	69.82 (63.97- 75.08)	70.94 (63.09- 74.59)	0.57
Gender			0.41
Male	33 (82.5%)	30 (75%)	
Female	7 (17.5%)	10 (25%)	
CCI	6 (5-7)	5 (4-6)	0.006
BMI	25.86 (23.18- 30.73)	28.47 (24.17- 31.72)	0.44
Smoking Status			1
Never	16 (40%)	16 (40%)	
Ever	24 (60%)	24 (60%)	
pT Stage (highest of TURBT and RC)			0.004
T0	1 (2.5%)	1 (2.5%)	
Ta	0 (0%)	1 (2.5%)	
Tis	4 (10%)	3 (7.5%)	
T1	2 (5%)	9 (22.5%)	
T2	14 (35%)	19 (47.5%)	
T3	13 (32.5%)	6 (15%)	
T4	6 (15%)	1 (2.5%)	
Surgical Technique			0.64
Robot-assisted laparoscopic RC	15 (37.5%)	13 (32.5%)	
Open	25 (62.5%)	27 (67.5%)	
Diversion			0.14
Ileal Conduit	38 (95%)	34 (85%)	
Neobladder	2 (5%)	6 (15%)	
ERAS Protocol	31 (77.5%)	20 (50%)	0.01
Adjuvant Therapy?	6 (15%)	3 (7.5%)	0.24
Re-Admitted after 90 days?	14 (35%)	19 (47.5%)	0.26
Re-admitted after 30 days?	12 (30%)	16 (40%)	0.35
Deceased after 90 days?	0 (0%)	2 (5%)	N/A
Deceased after 30 days?	0 (0%)	0 (0%)	N/A

Data presented as n (%) or median (IQR), as appropriate.

BMI, body mass index; ERAS, enhanced recovery after surgery; CCI, Charleston Comorbidity Index; RC, radical cystectomy; TURBT, transurethral resection of bladder tumor

Source of Funding: None**MP19-10****FEASIBILITY AND COMPLICATIONS OF OUTPATIENT ROBOTIC RADICAL PROSTATECTOMY WITH LYMPH NODE DISSECTION**

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INTRODUCTION AND OBJECTIVE: Prostate cancer is one of most common cancers in men. Outpatient robotic radical prostatectomy (RRP) is currently a topic of interest because of its ability to minimize costs while minimizing complications. However, few studies have analyzed the differences in outpatient RRP in patients undergoing concurrent lymph node dissections (LND) versus those without. As such, we compare the complication rates of inpatient versus outpatient RRP both with and without LND.

METHODS: Using the National Surgical Quality Improvement Program Database (NSQIP), we identified total RRP with and without LND by current procedural terminology code, and reported patient comorbidities, intra-operative or post-operative complications, and 30-day complication events from 2010-2020. We further divided this data into inpatient and outpatient surgeries.

RESULTS: Between 2010-2020, a total of 79381 RRP were performed, 98.2% inpatient and 1.7% outpatient, of which 50% and 54% had LND respectively. Comparing patients undergoing outpatient RRP with LND versus those without LND, patients with LND had an average age of 63 ± 7 years while patients without LND averaged 62 ± 7 years. Mean operative time was 180.5 ± 63.2 minutes and 187.6 ± 72.9 minutes respectively. Patients undergoing outpatient RRP with LND were less likely to have an active smoking history (7.5% vs. 10.7%), or a history of hypertension (45.1% vs. 50.6%) but had higher rates of sepsis (0.8% vs. 0%) and superficial incisional infection (1.4% vs. 0.2%) when compared those without LND. All other complications and 30-day events such as unplanned readmission, reoperation rates, and mortality were similar in both groups.

CONCLUSIONS: Patients undergoing outpatient RRP with LND had similar overall age and operative times as outpatient RRP without LND. Patients that had outpatient RRP with LND were less likely to have an active smoking history and hypertension but had higher rates of sepsis and superficial incisional infections.