1728P Evaluation of medical practices in oncology in a context of COVID-19 pandemic in France: Point of view of physicians, PRATICOVID study

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Background: The cancer population seems to be more susceptible to COVID-19 infection and have worse outcomes. Front of this pandemic, we had to adapt our patient care to protect our patients without compromising their prognosis related to their cancer. The national PRATICOVID study aims to describe the modification of the medical and surgical patient care for this population, according to the recommendations in this context of pandemic, within our hospitals which are strongly mobilized.

Methods: We analyzed data from 9 different institutions, 3 Military Hospitals, 4 Academics Hospital, 2 Private Hospital, from oncologists, surgeons, radiotherapists. The primary endpoint was to assess the prevalence of adapted patient care during pandemic. The secondary endpoints were to describe the point of view of clinicians and patients during and after the pandemic.

Results: We analyzed 435 medical care between 9th of March and 30th of April. The median age was 69 years (range, 24-99), 54% was male. 167 patients (38.4%) were newly diagnosed and only 4% were included in a clinical trial. Because of COVID-19 pandemic, 47.6% of the outpatients had modified patient care. The main primary tumor site was breast cancer (22.7%) at a metastatic stage. 24.6% have postponed surgery, or not receive perioperative chemotherapy, 18.4% received hypofractionated schedule and 57% had an adaptive systemic protocol (stopped, oral protocol, spacing between cures). 70% of physicians are used telemedicine. During this period, 67% of the physicians were relaxed to taking care of their patients. 57% of the patients have seen to be relaxed or low worried about the pandemic. However, 71% are worried after the lockdown, because of future patient care, stage at diagnosis, access to clinical trial, our abilities to receive in the same time all the patients.

Conclusions: PRATICOVID study is the first to assess modification of patients cares during an epidemic in cancer outpatients. Faces with this unprecedented crisis, physicians were able to adapt their practice in order to protect their patients against the virus and while ensuring the course of patient care. But physicians are worried after de lockdown because of the care pathway's issues.

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1729P Influence of recent administration and type of oncological treatment (T) in survival of oncological patients (p) with COVID-19: Experience of Vall d'Hebron University Hospital

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Background: SARS-CoV-2 outbreak has impacted on the management of oncological p, leading to treatment delays in a considerable number of cases. The aim of this study was to evaluate if oncological T affected negatively COVID-19 outcome.

Methods: We retrospectively analyzed clinical data from p with solid tumors under active systemic T (received in the last 6 months) that were diagnosed with SARS-CoV-2 infection (defined as positive PCR) between March and 11th May 2020 in our center. Study endpoint was death due to COVID-19. We divided the patients in two groups; those who had received treatment in the last 4 weeks and those who had not.

Descriptive and univariate analysis were performed to detect the effect of T type and other variables on COVID-19 related mortality.

Results: A total of 70 p were included with a median follow-up of 28 days (10-47) and active oncological T had been administered in the past 4 weeks to 44 p. Median age was 66 (IQR 56-74), 23 p (52.27%) were female and 41 (93.2%) had a baseline ECOG≤1. The most frequent primary site was lung tumor (12 p [27.3%]), followed by breast (11 p [25%]) and gastrointestinal (5 p [11.4%]). Thirty-one p (70.5%) had metastatic disease and 13 (29.5%) were included in clinical trials. Twenty-four p (54.5%) received chemotherapy (CT), 14 (31.8%) targeted therapies, 9 (20.4%) immunotherapy (IT), 5 (11.4%) radiotherapy and 6 (13.6%) hormonotherapy. A total of 13 p (29.5%) received different combinations of oncological T. Death due to COVID-19 occurred in 5/22 (22.7%) p receiving CT and 6/21 (28.5%) p in the non-CT (p>0.05). Only 1/9 (11.1%) p treated with IT died compared to 11/35 (31.4%) p in the rest of the cohort (p>0.05). Age>71, comorbidities such as chronic obstructive pulmonary disease and ECOG status≥2 were associated to a higher mortality. The distribution of these variables between the anticancer T groups was not different.

Conclusions: Our results suggest that CT and other anticancer T might not worsen COVID-19 related mortality; nevertheless, the number of patients was small. and decision making has to be individualized. Our findings may warrant further investigation in larger studies.

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1730P Electronic medical record (EMR)-assisted phone follow-up (PFU) for breast cancer survivors (CS) during COVID-19 pandemic: An Italian single institution experience

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Background: The COVID-19 outbreak became a public health emergency, leading to radical changes in care management. Telemedicine was adopted to minimize hospitals exposure for CS. In our region all patients (pts) data are available through an EMR: thus, the clinicians are able to access at any time CS medical history. From the start of COVID-19 pandemic we adopted EMR-assisted PFU instead of usual follow-up (FU) visit. This study aims to prospectively assess how breast CS perceived PFU.

Methods: We emailed to all breast CS managed by PFU a 15-items survey. Answers were measured with Likert scales. The correlation between CS characteristics and answers were analyzed with Pearson test.

Results: From February 2nd to May 20th, 107 out of 261 (41%) pts fulfilled the survey. The median age was 61, median FU was 43 months. 67.3% had high school diploma or higher degrees. 52% CS previously received chemotherapy whereas 80% adjuvant endocrine therapy. 78.5% could reach the hospital autonomously. 66.4% suffered from COVID-19 related anxiety for their health and 85% were waiting for FU visit to feel relief. 96.3% CS believed to have understood medical advice during PFU and were satisfied for the time and the opportunity to ask clarifications. 92% agreed with the decision to switch the usual FU visit in PFU. However, only 41.1% CS would like to have PFU in the future. We found a significant correlation between educational degree and comprehension during the visit (p=0.04) and with expectation for PFU feasibility (p=0.046). Age and educational level were significantly correlated with the ability to reach the hospital (p=0.046). CS treated with endocrine therapy were meaningfully correlated with the PFU satisfaction (p=0.048).

Conclusions: PFU was an important tool to avoid hospital contacts during COVID-19 pandemic and the majority of CS in the survey agreed and felt satisfied from this procedure. The number of CS willing to have PFU in non-emergency situations invites to investigate routine PFU at least for a subset of CS. Prospective randomized trials

are warranted to assess the reliability of PFU compared to standard FU visit to implement telemedicine in daily clinical practice.

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1731P   **Molecular diagnostics for cancer patients and high-risk individuals during the SARS-CoV-2 pandemic at the Institute for Oncology and Radiology of Serbia**

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Background: The SARS-CoV-2 pandemic introduced a dangerous distraction effect in all aspects of oncological patients' care. The aim of this research was to explore the effect of the pandemic on the efficacy of the largest molecular diagnostics centre for cancer patients and high-risk individuals in Serbia (IORS).

Methods: EGFR, KRAS, BRAF, BRCA1/2 mutation testing of advanced lung adenocarcinoma, metastatic colorectal, metastatic melanoma and ovarian cancer patients were performed by qPCR and NGS. NGS was also used for panel testing of hereditary breast cancer and cancers associated with Lynch syndrome. IORS's analytical output during the two-month long state of emergency was compared to the two-month period prior to the outbreak.

Results: A 57% reduction (188 vs. 81) in the total number of patients that were referred to IORS for targeted molecular testing was detected (EGFR - prior to initiation of TKI therapy 55 vs 26 patients, at progression 21 vs 4; KRAS 73 vs 34, BRAF 39 vs. 17). Due to the prolonged transport of the necessary consumables and the fact that two essential laboratory personnel were absent from the Institute (sensitive category and obligatory quarantine), somatic testing for BRCA1/2 mutations was not performed at all during the state of emergency. All new high-risk individuals with the referral for genetic counselling had to be postponed, so the lockdown was used to test the patients who were waiting for results. The number of NGS analyses for high-risk individuals increased by 50 % during the outbreak (36 vs. 72) and post-test genetic counselling was successfully performed by phone and/or web calls.

Conclusions: The SARS-CoV-2 pandemic had a profound negative effect on the overall diagnostic output of the centralized molecular diagnostics for cancer patients and high-risk individuals in Serbia. This effect will be further evaluated through the analysis of both the survival and quality of life of the cancer patients that were unable to receive targeted therapies in a timely efficient manner. The only positive effect of the pandemic was that the waiting lists for genetic testing of high-risk individuals were shortened.

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1732P   **Prognostic indicators for COVID-19 related deaths in patients with cancer**

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Background: The COVID-19 pandemic has impacted significantly on health systems across the globe. It has been reported to have higher incidence and to be associated with worse outcomes in patients with cancer. Beaumont Hospital is a large Dublin-based teaching hospital which was at the centre of the Irish outbreak of COVID-19.

Methods: During the period 11th March to 15th May 2020, patients diagnosed with COVID-19 infection who were attending Beaumont Hospital for systemic anti-cancer therapy were included. Data were collected by chart review. Statistical analyses were performed using SPSS. Cancer-related prognosis was estimated using the Palliative Prognostic Score (PAP) with a score $\geq$11 associated with a 30-day survival of <30%.

Results: In total, 717 patients attended oncology services for cancer directed treatment during the study period. 27 of these patients were diagnosed with COVID-19 based on RT-PCR. A further 4 patients were diagnosed clinically due to characteristic symptoms and radiology. The median age was 60 (38-84). 12 (39%) were female. The

most common cancer type was lung n=9 (29%). 21 (67%) had metastatic disease; 4 (13%) locally advanced disease and 6 (19%) were being treated with curative intent. Of the 31 patients diagnosed with COVID-19, 25 (80%) were hospitalised and none were admitted to intensive care. In total, 12/31 (41%) died, of which 5 (41%) had lung cancer, 10 (83%) had an PS of $\geq$3 and 3 (25%) had received systemic anti-cancer treatment in the last 30 days of life. The median age was 66 (38-84). 4 (33%) were female. All had incurable, locally advanced or metastatic disease. The mean time from diagnosis to death was 9.5 days. Those with an ECOG performance status (PS) $\geq$3 were more likely to die than those with PS $\leq$2 (p<0.001).Compared to those who recovered, patients who died from COVID-19 had higher mean number of organs affected by cancer (3.7 vs. 1.8, p=0.015) and higher mean PAP score (9.6 vs. 1.5, p<0.001).

Conclusions: Patients with cancer who contracted COVID-19 and died had more sites of metastatic disease, a poorer performance status, and a higher Palliative Prognostic Score. The presence of multi-organ involvement appears to predict for poorer outcomes in COVID-19 positive cancer patients.

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1733P   **Real-world data: Cancer and SARS-CoV-2 infection**

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Background: Madrid has been the epicenter of the SARS-CoV2 pandemic in Spain. We analyzed the experience at our hospital with SARS-CoV2 infection and cancer patients (p).

Methods: We analyzed our experience from March 1 to April 30 at the Puerta de Hierro University Hospital in Madrid. Diagnosis of SARS-CoV2 infection was made by RT-PCR, suspected cases not confirmed were excluded.

Results: Overall in-hospital mortality cancer p with COVID-19 was 15.2% (95%CI, 6.3; 5.2), similar to 12.7% (95%CI,11.1;4.4) with p=0.615 of the global COVID-19 hospitalised population and greater than that of patients admitted without SARS-

Table: 1733P

VARIABLE	OTHER CANCER N=34 (%)	LUNG CANCER N=12 (%)	p
Male	52.9	50	
Age mean	63.9	63.5	
Active Smoking	0	16.7	
Ex-smokers	35.3	50	
COMORBIDITIES			
Coronary heart disease	8.8	16.7	
Hypertension	35.3	41.7	
COPD	8.8	16.7	
Dyslipidemia	23.5	25	
STAGE			
IV	52.9	50	
SYMPTOMS			p
Neutropenia	6.1	0	1.0
Cough	67.6	41.7	.17
Temperature	37.1	37.3	.36
Dyspnoea	47	91.7	**.007**
Diarrhea	8.8	8.3	1.0
Lymphopenia	68.7	36.4	.08
PROGNOSTIC CRITERIA			
IL6			.41
D-DIMER	0.9 (0.6; 2.2)	0.9 (0.5; 2.7)	.57
PCR		107.7	.44
LDH	266 (207; 326)	290 (238; 352)	.19
FERRITIN	562 (358; 933)	1111 (392; 2672)	.15
CHARLSON INDEX*	8 (6; 9)	8 (6; 9)	.80
CURB65 SCALE **			.31
BRESCIA SCALE			.17