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### 1703P UK Coronavirus Cancer Monitoring Project (UKCCMP): A national reporting network for real time data of the COVID-19 pandemic

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**Background:** The COVID-19 pandemic required a rapid response and need for real-world data in cancer patients. The nationwide, real-time coordinated UKCCMP reporting network provided an immediate solution.

**Methods:** The ability to set up an interdisciplinary multi-organisational team quickly, covering expert knowledge from clinical, legal, statistical, and computer science was essential. The technical infra-structure allows clinician-led anonymised data entry and rapid dissemination of results with a clinical (RedCap) database as core. However the development of a national cancer reporting network was crucial for the viability of the project. From its inception in March 2020 the reporting network was established via 4 iterative phases.

**Results:** Within the first 4 weeks, >50 centres were involved with coverage throughout the UK. Expansion has continued with >70 centres within 6 weeks reporting over 1200 COVID positive cancer patients. This was achieved through a 4-phase approach: phase 1 - Outline: This involved project protocol development where key data and timelines were confirmed by a small project team followed by whole-team sign-off. phase 2 - Engagement: This involved identification and engagement of existing groups to establish an initial network. Professional body endorsement led to increased recognition and utilisation of their membership networks. Finally regional leads were identified. phase 3 - Invitation: The third phase involved the distribution of a formal invite letter via identified networks. Project specific email and standard mailing lists were created to enhance network identity and communication. phase 4 - Consolidation: Early development of an interactive project website and focus on communication via social media with varied content consolidated interest and led to further extension.

**Conclusions:** Real-time reporting of real world data can be achieved with clearly defined project phases, standardised documentation and an iterative recruitment process. The COVID-19 pandemic necessitated a rapid response, proving that similar reporting networks can be set up quickly and robustly to react to the evidence-based needs of the oncology community in the drive for implementation of change.

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### 1704P COVID-19 mortality in patients receiving anti-cancer therapy in a UK national cancer centre

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**Background:** The COVID-19 (C19) pandemic has prompted alterations to systemic anti-cancer therapy (SACT) due to concerns of immunosuppression and healthcare exposure. However, the effects of SACT on mortality in patients who acquire C19 are not well understood. As a national cancer centre within a major C19 hotspot, we seek to address these risks at scale.

**Methods:** Patients with a history of solid cancers and laboratory confirmed C19 (1 Mar to 31 May 2020) were included. Haematological malignancies were excluded. The primary outcome was time from C19 diagnosis to death. The last follow-up date was 22 Jun 2020.

**Results:** We identified 94 cancer patients; 62 males (median age 73, BMI 24.9), and 32 females (median age 68.5, BMI 25.7). Genitourinary (n = 24) cancers were the most common, followed by gastrointestinal (n = 23), thoracic (n = 15), and gynaecological (n = 9) cancers. 25 patients received SACT: chemotherapy (n = 15), endocrine therapy (n = 8), immunotherapy (n = 4), and targeted anti-cancer therapy

(n = 2). 16 patients received SACT with palliative intent. Patients on SACT had a greater incidence of metastatic disease (48.0% vs 10.6%, p < 0.001) and were younger (median age 62.5 vs 73.0, p = 0.01). They were also more likely to have renal impairment (p = 0.02), lymphopaenia (p = 0.01) and anaemia (p = 0.04) compared to those not on SACT. The univariate analysis showed age and co-morbidities were associated with mortality (Table). Adjusting for age, ethnicity, co-morbidities and the presence of metastatic cancer, SACT was an independent risk factor for C19 mortality (HR 2.46, 1.09 – 5.5, p = 0.03). Age, South Asian ethnicity, hypertension and cerebrovascular disease were also independent risk factors for C19 mortality.

**Table: 1704P Univariate analysis of key variables associated with COVID-19 mortality**

Variable	Alive (53)	Dead (41)	p-value
Systemic anti-cancer therapy *	13 / 24.5%	12 / 28.3%	0.81
Age (years) †	66 (17)	78 (11)	<0.01
C-reactive protein (mg/L) †	60.4 (87)	183.7 (215.3)	<0.01
Hypertension*	16 / 30%	21 / 51%	0.04
Cardiovascular disease *	8 / 15%	10 / 24%	0.25
Lymphocytes (10 <sup>9</sup> /L) †	0.85 (0.68)	0.66 (0.57)	0.07
Creatinine (µmol/L) †	79 (30)	83.5 (64.7)	0.44
Haemoglobin (g/L) †	121 (18)	116 (29)	0.29
Leukocytes (10 <sup>9</sup> /L) †	7.15 (4.03)	9.35 (7.46)	0.23
Neutrophils (10 <sup>9</sup> /L) †	5.53 (3.88)	7.52 (5.91)	0.14

\* shown as n / %; † shown as median (IQR)

**Conclusions:** C19 infection poses a substantial risk to cancer patients and our data suggests that SACT is an independent risk factor for mortality in C19 infection. These findings call for a nuanced approach to C19 risk, focusing on established risk factors such as age and co-morbidities to guide treatment decisions.

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### 1705P SARS-CoV-2 infection among cancer patients receiving antitumor treatment in Italy: A nationwide observational study (CIPOMO ONCO COVID-19)

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**Background:** Cancer patients are more susceptible to infections and potentially at higher risk to develop COVID-19. Tumor type and antitumor treatment may also affect both the susceptibility to and the severity of SARS COV-2.

**Methods:** To analyze the distribution of patients who developed COVID-19 during active antineoplastic therapy and the related clinical course by tumor type, stage and class of oncologic treatment (chemo, immune, biologic, other) a multicenter, retrospective, observational study was proposed to the Hospital Medical Oncologic Units of the National Health Service in Italy (168 centers of the Collegio Italiano dei Primari Oncologi Medici Ospedalieri -CIPOMO). Data were collected on demographics, tumor characteristics, treatment setting, type of ongoing anti-cancer therapy and COVID-19 clinical course (phenotype, hospitalization, therapy, duration and outcome). Eligibility required a positive COVID-19 molecular test before May 4th, 2020 and at least 1 course of antitumor therapy delivered after January 15th.

**Results:** At the present analysis data are available for 116 of 168 centers (7 declined, 28 pending, 17 data awaited). 64 of 116 centers (55%) had COVID-19 positive cases (cases/center: median 3, range 1-40). At these 64 centers, 283 positive cases (males

158, 55.9% - females 125, 44.1%; median age 67 years, range 28-89) were observed among a total population of 40894 patients receiving active treatment between January 15 and May 4 2020. 65 of 283 (23%) had cardiovascular comorbidities and 7 (2%) pre-existent pulmonary disease. 239/283 patients (84.4%) were receiving treatment for metastatic disease and 44 (15.6%) in the adjuvant setting. Breast, lung, colon and prostate cancer were the main tumor types accounting for 61 % of cases.

**Conclusions:** The occurrence of COVID-19 among cancer patients receiving active antitumor treatment appears to reflect tumor epidemiology. Full analysis of the distribution of COVID-19 occurrence and clinical course by tumor type, stage and oncologic treatment will be presented.

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### 1706P Implementing oncology virtual clinics (VC) in response to COVID-19 pandemic: A transformation driven by a crisis

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**Background:** In response to COVID-19 pandemic, we launched VC to minimize hospital visits, decrease exposures to infection and ensure continuity of care to all cancer patients. Our project aimed to assess the value of VC in management of oncology patients and the level of patient and staff satisfaction with it.

**Methods:** On March 18, 2020, we introduced VC to all specialties at the Oncology Department, King Abdulaziz Medical City, Riyadh, Saudi Arabia. Medical records were reviewed by the oncologists to identify patients who can be evaluated through VC, those who need to come personally, and those whose appointment can be deferred. Scheduled patients in VC were contacted through locally developed application (EiADATY) or by phone call. Performing laboratory testing near home and shipping medications were done when feasible. We reviewed the data of VC from March 18 to April 30, 2020 including satisfaction results of patients and staff using Likert scale from 1 to 5 with 1 being very dissatisfied and 5 being very satisfied).

**Results:** A total of 29 clinic sessions/week were established for different oncology services. Out of 1319 scheduled patients, 1152 (87%) answered the call (90% via phone, 5% via application and 5% used both). Of the 149 patients surveyed, their overall satisfaction (Score >= 3 out of 5) with punctuality was (92%), physician interaction (90%), duration of visit (90%), medication requesting (91%), medication shipping (79%) and satisfaction with whole experience (92%). Out of 89 involved physicians, 74 (83%) completed the survey with overall satisfaction with booking process (91%), communication tools (77%), and general satisfaction (93%). 93% of physicians believed that patients were satisfied with the experience and 81 % expected to continue VC beyond the pandemic. Survey of 44 support staff (nurses, coordinators, and pharmacists) revealed similar results.

**Conclusions:** The transition to VC was well accepted by both patients and clinicians. Optimizing the video communication tool and the process of performing pre-visit laboratory and radiology tests closer to patients home and shipping medications are essential for the enhancement of the VC function.

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### 1707P CureCancer digital tool in the routine clinical oncology practice facilitates PROs, communicating with HCPs, treatment adherence and "distancing interventions" during COVID-19 and reduces costs: A feasibility and satisfaction study

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**Background:** CureCancer is a patient-centered/patient-driven digital tool integrated in the routine oncology practice. Patients self-create their medical profile, record their symptoms and communicate them to health care professionals (HCPs). We aimed to assess the tool's feasibility and patients' satisfaction.

**Methods:** 14 Centers participated, starting from 02.2020. COVID-19 epidemic period was included. Patients signed consent to upload their data, report their symptoms

and complete 2 questionnaires. Results following the completion of the 1<sup>st</sup> questionnaire are reported.

**Results:** 78 patients were enrolled and 68 (87%) uploaded their data to date; 60 of 68 (88%), 30 males and 30 females, median age 53 years, completed the 1<sup>st</sup> questionnaire. Thirty-seven (61.6%) were University graduates. Cancer types included breast cancer (21.6%), Head/Neck cancer, pancreatic cancer and other cancers. Ten patients reported "other", 4 reported multiple cancers, 28 had metastatic disease and 45 active treatment. Registration and use of the platform was reported as "very to very much" easy by 52 (86.6%) and 50 (83.3%) patients, respectively. File uploading was "very to very much" easy for 33 (55%) patients; 49 (81.6%) preferred the digital way and 50 (83.3%) will introduce it to others. Patients highlighted that CureCancer improved communication with HCPs, increased their sense of safety, facilitated treatment adherence and interventions at distance, particularly when outside the Cancer Center and during the COVID-19 pandemic, reduced the number of visits, time and out-of-pocket expenses. Benefits liked best were easy data access, improved communication and sense of safety.

**Conclusions:** CureCancer use was feasible, increased communication with HCPs, patients' sense of safety, treatment adherence and medical interventions at distancing, reduced visits and saved time and money. Continuing integration of CureCancer to embed PROs in routine cancer care is expected to improve treatment outcomes within or outside the Cancer Center and in pandemics and to reduce costs.

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### 1708P Online survey on SARS-CoV-2 infections in cancer patients during a nationwide lockdown in France

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**Background:** The COVID 19 pandemic outbreak caused 143427 cases and more than 28000 deaths in France. To contain this highly contagious and potentially deadly disease, the French government decided an unprecedented nationwide lockdown. We investigated in a large cohort of cancer patients from Hauts-de-France, the third French region most stricken by COVID-19, the frequency of symptoms, how cancer navigated the health care system during these very difficult circumstances, and their feelings.

**Methods:** We made a flash survey among 6900 patients treated at our cancer center within March 2019 and March 2020. Respondents were asked by email to fill in a short web-based survey sent on April 30 and closed on May 14.

**Results:** We received reports from 2224 cancer patients. Mean age was 63 years, 72% were women, only 9% were smokers, 26% had hypertension, 9% diabetes, and 5% asthma. The most represented cancers were breast (45%), gynecologic cancers (12%), digestive (8%), and head and neck cancer (6%). Most patients were in follow up, 13% were receiving chemotherapy. The majority did not develop symptoms associated with COVID during the COVID wave; one third experienced symptoms. The main symptoms reported were headache (38%), myalgia and arthralgia (31%), cough (25%), digestive signs (20%), intense fatigue (19%), or fever (13%). Among patients with symptoms, 58% did not seek medical advice during the COVID wave and 95% of them were not tested. For those receiving chemotherapy, 80% had their treatment as planned. Among patients with a planned surgery, 30% of them were delayed. 32% of the patients reported anxiety, 35% felt insecure and 16% reported an increased consumption of antistress medication, tobacco or alcohol. We also discuss the pattern of symptoms and feelings according to the cancer type and the treatment received.

**Conclusions:** This study showed that most of our cancer patients were probably not infected during the COVID wave, which highlights the need to maintain barrier measures to protect them and perform validated tests. An appropriate supportive care is also necessary to manage patients' distress due to COVID 19 in many of them.

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