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	2018–2019	2020–2021
Number of operations/patients	427/426	447/443
Male/female	291/135	285/158
Mean age	69.7	69.5
Patient status:		
ECOG 0-1	374	415
ECOG 2-3	39	27
Unknown	13	1
Surgical access:		
Thoracotomy	129	108
VATS (conversion to thoracotomy)	298 (38)	339 (26)
Extent of surgery:		
Lobectomy	318	319
incl sleeve lobectomy	18	30
Pneumonectomy	21	24
incl sleeve pneumonectomy	1	3
Segmentectomy	48	71
Wedge resection	36	30
Probatory surgery	1	3
Postoperative in-hospital mortality (%)	8 (1.9%)	8 (1.8%)
Cancer stage:		
0 (Tis)	1	4
I	254	259
II	80	85
III	82	91
IV	10	8
Cancer morphology:		
Adenocarcinoma	208	234
Squamous cell cancer	132	137
Small cell cancer	10	11
Carcinoid tumor	31	30
Other	46	38

	Total (N = 378)
Sex	Male: 256 (67.7%) Female: 122 (32.3%)
Age	67.0 (21.0-87.0)
Smoking habit	Never smoker: 42 (11.1%) Former smoker: 189 (50.0%) Current smoker: 137 (36.2%) Unknown: 10 (2.7%)
Stage at diagnosis	I: 130 (34.4%) II: 37 (9.8%) III: 98 (25.9%) IV: 109 (28.8%) Unknown: 4 (1.1%)
Histology	Adenocarcinoma: 192 (50.8%) Squamous carcinoma: 92 (24.3%) Small cell carcinoma: 39 (10.3%) Adenosquamous: 2 (0.5%) Large cell carcinoma: 3 (0.8%) Neuroendocrine large cell carcinoma: 11 (2.9%) Sarcomatoid: 1 (0.3%) NOS: 12 (3.2%) Carcinoid: 16 (4.2%) Mesothelioma: 2 (0.5%) Others: 8 (1.6%)
Symptoms reported at diagnosis	Asymptomatic: 131 (34.7%) Anorexia: 23 (6.1%) Asthenia: 34 (9.0%) Dyspnoea: 66 (17.5%) Pain: 64 (16.9%) Haemoptysis: 27 (7.1%) Weight loss: 57 (15.1%) Cough: 65 (17.2%) Others: 60 (15.9%)
Diagnosis due to SARS-CoV-2 suspicion/disease	20 (5.3%)
Causes of diagnosis in asymptomatic patients	Follow-up of a non-oncological pathology: 56.6% Follow-up of another tumour: 17.5% Preoperative study: 7.0% Extension study of another tumour: 6.3% Rutinary revision: 6.3% Symptoms not related with thoracic cancer: 6.3%

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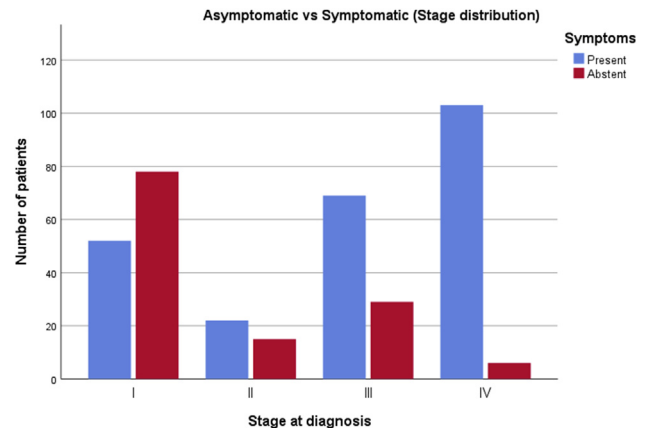
Clinical Impact of SARS-CoV2 Pandemic in the Diagnosis of Early-Stage Thoracic Tumours



Y. Garitaonandía Díaz, M. Blanco Clemente, M. Martínez-Cutillas, M. Gil Barturen, V. Calvo, A. Collazo-Lorduy, J.L. Campo Cañaverl, F. Franco, C. Traseira, R. Aguado, G. Visedo, M.M. Sanchez del Corral, D. Ruiz de Domingo, A. Gonzalez-Sanchez, M. Provencio H. U. Puerta de Hierro Majadahonda, Majadahonda/ES

**Introduction:** Cancer healthcare has been affected by Coronavirus disease 2019 (COVID-19) pandemic, interfering the normal function of oncology units and increasing diagnostic delay. Nevertheless, the rising incidence of respiratory infections led to an increase in medical consultations and chest imaging explorations. The aim of the study was to assess whether the increase in medical evaluations in the context of the pandemic led to an increase in the detection of early-stage thoracic tumours. **Methods:** We performed a retrospective single-institution study, collecting data from patients diagnosed with thoracic tumours between March, 1, 2020 and December, 31, 2021. We analysed their demographic and clinical data, symptoms at diagnosis and those who were diagnosed due to SARS-CoV-2 infection. **Results:** A total of 378 patients were analysed. Main results are shown in Table-1. Only 5.3% of newly diagnosed thoracic tumours were related to a suspected or confirmed SARS-CoV-2 infection. However, these patients were not diagnosed at earlier stages (p = 0.414). When we evaluated symptoms at diagnosis, we found that asymptomatic patients presented in earlier stages (p <0.000, Figure-1), being the majority incidental findings during the follow-up of oncological and non-oncological pathologies.

Regarding symptomatic patients, most presented as locally advanced or metastatic diseases and no changes have been observed in the pattern of presentation compared to studies prior to the pandemic. **Conclusions:** COVID-19 pandemic did not seem to increase thoracic tumours diagnosis in our study. Lung cancer diagnosed in patients due to SARS-CoV-2 infection was not detected in earlier stages. Clinical presentation was similar to previous reported outside COVID-19 pandemic. Nevertheless, we find that asymptomatic patients diagnosed incidentally presented more frequently in localized stages in comparison with symptomatic patients.



**Keywords:** COVID19, Lung Cancer, Diagnosis