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Introduction: Pembrolizumab monotherapy is widely used in advanced Non-Small-Cell Lung Cancer (aNSCLC). The COVID-19 pandemic has resulted in attempts to reduce hospital attendances.

Aim: determine whether there was a clinically relevant toxicity difference between the 3-weekly (3-WP) and 6-weekly (6-WP) regimens.

Method: We collected retrospective data using Welsh Clinical Portal (WCP) and Chemocare on 112 consecutive aNSCLC patients starting pembrolizumab monotherapy between 01/06/2017 and 29/09/2020 (Hywel Dda Health Board, Wales). Toxicities were estimated from the start of monotherapy using WCP patient records and CTCAE v5.

Results: Median age was 69 years (range 43 – 84), 60/112 (54%) were male. 98/112 (88%) were performance status 0-1. 81/112 (72%) had adenocarcinoma and 31/112 (28%) squamous cell carcinoma. 90/112 (80%) received pembrolizumab 1st line; 65/90 (72%) monotherapy, 25/90 (28%) maintenance following chemo-IO. 83/112 (74%) patients started 3-WP; 57/83 (69%) remained on 3-WP, 26/83 (31%) switched to 6-WP (twenty-four reported no significant side effects, one G2 nausea, one not documented). Three were changed back to 3-WP (one G2 arthralgia, one G3 rash, one patient request). 29/112 (26%) patients started 6-WP; 24/29 (83%) remained on 6-WP, 5/29 (17%) switched to 3-WP (three G2 toxicities – arthralgia, diarrhoea, adrenal insufficiency, two patient requests. One changed back to 6-WP at their request). CTCAE grade 2 and 3 toxicities were reported in 44% and 7%, 45% and 6% of patients on 6-WP and 3-WP respectively. No grade 4 toxicities were reported. The most common toxicities were anaemia (10%) and hypothyroidism (8%) across both regimens. One 6-WP patient stopped due to G3 pneumonitis. Six 3-WP patients stopped due to toxicities (G2 pneumonitis, arthralgia, hepatotoxicity and G3 pneumonitis (2) and hepatotoxicity). Conclusion

Results: suggest 6-weekly pembrolizumab is well-tolerated with no increase in side effects compared to the 3-weekly regimen. This is a retrospective study, and findings should be confirmed prospectively.

Disclosure: No significant relationships.

30 Patient and physician opinion of virtual care in the oncology department of an Irish tertiary care centre in the era of Covid-19

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In an effort to limit physical contact during the COVID-19 pandemic, there has been rapid implementation of virtual cancer care clinics using messaging, audio, and video communication. This model has advantages, particularly in convenience for patients who do not have to travel to a distant centre for specialist care, but has the potential to limit communication and also omits physical examination. The aim of this survey study was to assess whether patients attending the oncology unit at a tertiary care academic cancer centre were satisfied with the virtual clinic model and explore challenges in the delivery of virtual care. We also surveyed medical oncology trainees and consultant oncologists in the centre on the use of virtual care. 80% reported satisfaction with the experience. 85% received timely notice of their appointment, but 50% of patients did not receive a telephone call at the scheduled time. 80% of patients thought they had enough time with the doctor. 20% of patients did not fully understand the outcome of the consultation and 20% thought virtual care made obtaining medication prescriptions more difficult. Some patients who were travelling from outside Dublin found virtual clinics more convenient. 50% of patients want to continue virtual consultations post Covid-19; the main criticism was that patients want to receive the call at the appointed time. Irish patients attending a tertiary academic cancer centre were mostly satisfied with the telephone consultations they had with their oncology team. Satisfaction rates were lower among the doctors

than patients, reflecting doctors' difficulties in clinical assessment and teaching opportunities using virtual care. This survey highlights the need for more advanced technical platforms (including video calling and real time messaging) to provide excellent virtual care, as well as the development of new strategies for medical education through virtual clinics.

Disclosure: No significant relationships.

31 Emergency presentation of lung cancer: did it increase during the COVID-19?

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Background: Lung cancer has the lowest 5 year survival when compared to colon, prostate and breast. 34% of all lung cancer patients in the UK are currently diagnosed at an emergency presentation [1]. There is an increased concern that patients have delayed their presentation due to the COVID pandemic. We aim to review the emergency presentation of lung cancer during the COVID pandemic (01/03/20 to 01/03/21) and compared to the previous year (01/03/19 to 01/03/20).

Methods: Retrospective review of all emergency presentation lung cancer diagnosis for the year 2019/2020 and 2020/2021 were obtained from the COSD data submission. Data including patients' demographics, histology diagnosis, cancer treatments and outcomes were collected. In addition, the COVID-19 Status of those been referred between 2020/2021 was also obtained.

Results: (See Table 1) 95 (19%) and 121 (23%) patients presented as an emergency for the year 2019/20 and 2020/21. 88% (84) of the patients who presented in 2019 had died within 12 months. 86% and 83% were advanced stage at presentation for the year 2019/20 and 2020/21. In view of this, most patients (2019 - 72%, 2020 - 73%) were for supportive care only. Only 3 of the 121 were COVID positive at the time of presentation.

Conclusion: There was no significant difference in the emergency presentation during the COVID-19 when compared to the previous

Table 1 (abstract 31).
Emergency presentation results

	2019/2020	2020/2021
Number of patients	95 (total number of diagnosis 545)	121 (total number of diagnosis 579)
Male:Female	52:43	60:61
Alive/Died	11/84	92/29
Smoker		
Current	27 (28%)	26 (21%)
Ex-smoker	35 (37%)	60 (50%)
Histological diagnosis		
NSCLC (non-small cell lung cancer)	36 (38%)	45 (37%)
SCLC (small cell)	14 (15%)	11 (9%)
Mesothelioma	3 (3%)	6 (5%)
No pathological diagnosis	42 (44%)	59 (49%)
Stage		
1	9	14
2	4	7
3	10 (10%)	21 (17%)
4	72 (76%)	79 (65%)
Treatment		
Best supportive care/palliative	68 (72%)	88 (73%)
Surgery	2	6
Oncology including SABR	25 (26%)	27 (22%)

year. In number of emergency presentation, there was no significant difference in treatment strategies offered. Our data confirms previous reviews of emergency presentations, that this group of patients have a poor survival, due to performance status and advanced presentation. Further review of the years data is required to see if there is a trend of increasing numbers at emergency presentation of lung cancer.

Reference:

[1] Public Health England (September 2015). Routes to Diagnosis 2006–2013; preliminary results. A National Cancer Intelligence Network short report.

Disclosure: No significant relationships.

32 The impact of SARS-COV-2 pandemic on pleural services, diagnosis of malignant effusions and junior doctors' procedural training

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Introduction: The SARS-COV-2 pandemic has introduced unprecedented demand on NHS services and has required significant internal adaptation to ensure patient safety, operational efficiency and continuation of training. With respiratory teams taking on particularly high workloads it could be anticipated that elements such as pleural oncology services were disproportionately impacted. An essential part of the service is intercostal drain (ICD) insertion. Our evaluation aimed to assess the impact of the COVID-19 pandemic on ICD insertion in our pleural service.

Methods: Date of ICD insertion, operator grade and complications were obtained for the past 3 years through access of the trust internal database. Data was analysed since the first cases of COVID-19 and prior to that, and during the two national lockdowns with their respective periods in the preceding years. Chi2 test by Social Science Statistics was used.

Results: Rates of ICD insertion from March 2020–2021 were comparable to 2019–20 and 2018–19 (87 vs 89 and 83 respectively). However, operator grade changed from predominantly pleural fellows (7 vs 38 and 28) towards consultants (11 vs 3 and 4) and advanced nurse practitioners (30 vs 18 and 19), Chi2 $p < 0.001$ for both. Numbers completed by training doctors were comparable overall (35 vs 30 and 31). This trend was reflected during the lockdown periods versus the same periods in previous years. One case of delayed diagnosis of malignancy was identified (patient opted to delay thoracoscopy and later diagnosed with lymphoma).

Conclusions: Our data shows a significant adaptation in personnel leading our service due to COVID-19 with juniors being pulled to the "COVID rota". However, ongoing support for pleural training despite COVID pressures exists. Overall, the pandemic has not lead to a delay in diagnosis of malignancy. Since the first lockdown e-learning modules have been created, individual ICD training

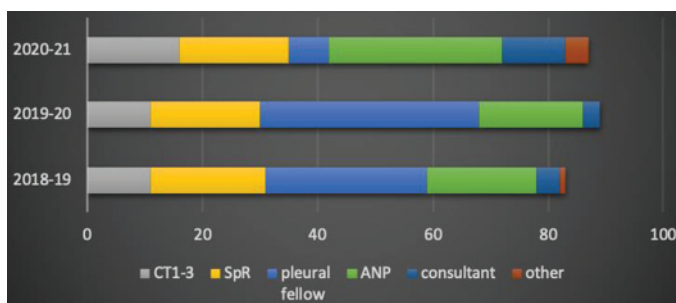


Fig. 1 (abstract 32). ICD insertion by operator grade in COVID-19 and before.

sessions undertaken and trainees scheduled directly into procedural clinics in order to further support this.

Disclosure: No significant relationships.

33 Does the use of primary care spirometry results in patients referred with suspected lung cancer have potential to avoid delays in the lung cancer referral pathway as a result of the SARS-COV-2 pandemic?

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Background: The SARS-COV-2 pandemic has had significant impact on the UK National Optimal Lung Cancer Pathway (NOLCP) leading to potential delays in diagnosis of patients with lung cancer. The NOLCP recommends Pulmonary Function Tests (PFTs) in certain patients suitable for curative intent management. PFTs can help guide prognostication, assessment of Performance Status and potential for pre-habilitation. Unfortunately, infection control measures during the pandemic have caused delays in access to PFTs. Patients referred with suspected lung cancer are often current or ex-smokers and many have co-existing COPD. The Quality and Outcomes Framework for primary care recommends that diagnosis of COPD should be confirmed by spirometry [1]. Therefore many of those referred will already have had baseline spirometry performed.

Aim: To assess whether access to primary care spirometry results at point of referral has potential to reduce delays to the NOLCP caused by the SARS-COV-2 pandemic.

Methods: This retrospective study examined patients referred via the 2 week wait lung cancer pathway over a 6 month period during the pandemic. Electronic Primary care records were reviewed to confirm diagnosis of COPD and whether spirometry had been performed. Indications for PFTs and time from request to test were recorded.

Results: 36 of 198 patients referred were diagnosed with lung cancer. 15/36 underwent PFTs. Median time to PFTs was 16 days. 3/15 had pre-existing Spirometry.

Table 1 (abstract 33)

Gender	
Male	117
Female	81
Median age	70 (34–99)
Smoking status	
Current/ex	146
Never	52
GP spirometry	
Yes	65
No	133
COPD diagnosis	
Yes	49 (with spirometry, 34; without spirometry, 15)
No	149

Conclusion: These data show that very few patients underwent spirometry in primary care prior to referral. Whilst this didn't impact the NOLCP for the majority of patients in this small study, baseline primary care spirometry has potential to guide management and prognostication in future. Further work is needed to ascertain whether inclusion of spirometry on the referral proforma would enable better focus of resources and improve the flow of the NOLCP.

Reference:

[1] NHS England. 2019/20 GMS contract QOF. gms-contract-qof-guidance-april-2019.pdf (england.nhs.uk)

Disclosure: No significant relationships.