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The influence of the COVID-19 pandemic on haematuria diagnostic services: Are we adapting to a new era?

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Introduction & Objectives: England has had 3 national lockdowns to control the COVID-19 pandemic: Beginning on 23/3/20 for 7 weeks, 31/10/20 for 4 weeks, and since 31/12/20. Our hospital response strategy included outsourcing 2 week wait (2ww) cancer referrals to a 'clean' site to allow for continued assessment. However, patients appeared reluctant to present to primary care (GP) for fear of overwhelming the health service or contracting COVID-19. This prompted a national publicity drive to reduce delayed presentations and GP access shifted to a teletriage approach. We aimed to assess the effect of the COVID-19 pandemic on time to presentation, investigation and treatment for our 2ww cancer pathway haematuria clinics. Secondary aims included comparison of patient outcomes.

Materials & Methods: We defined 4 timeframes: Baseline (B): 01/04-15/05/19, Lockdown 1 (L1): 01/04 – 15/05/20, Recovery (R1): 01/07-15/08/20 and Lockdown 2 (L2): 01/11-7/12/20. Data analysts identified eligible patients. Baseline characteristics, referral criteria and outcomes were recorded. PRISM v9.0.1 was used for statistical analysis.

Results: Number of referrals fell from 41 (B) to 10 (L1), but recovered to 33 (R) and 38 (L2). Mean age was not significantly different between groups (one way ANOVA ($F(3,128)=0.45$, $p=0.75$). Median days of haematuria prior to GP referral during B, L1, R, and L2 were 16, 14, 4* and 6* respectively; (*significantly different compared to B, Kruskal-Wallis, $p<0.05$). Mean days from GP referral to flexible cystoscopy: 35, 23*, 27* and 19*; (one way ANOVA $F(3,122)=33.4$, $*p<0.05$). Mean days from flexible cystoscopy to biopsy/TURBT did not change: 37 (n=4), 38 (n=3), 28 (n=9), 22 (n=14), $p>0.20$. Posthoc analysis revealed significantly more cancers in R and L2 compared to B, ($p<0.05$, chi2, Fisher test) with L1 nearing significance despite small numbers ($p=0.08$), (table 1).

Conclusions: Number of referrals to 2ww haematuria clinic returned to baseline during recovery. Contrary to expectations, we are seeing a reduction in time to investigation with no delay to treatment; reflecting public health campaigns, adaptations to primary care triage and hospital pandemic response strategies. Interestingly, there is a significant rise in number of cancers being diagnosed, which may reflect patients' persistent reluctance to seek medical advice. Table 1:

Timeframe	Urological cancer diagnosed, n / total
Baseline, B	3 / 41 · LR NMIBC · IR NMIBC · RCC
Lockdown 1, L1	3 / 10 · 2 HR NMIBC · IR NMIBC
Recovery, R	9 / 33* · 4 IR NMIBC · 3 HR NMIBC · MIBC · 1 <u>CaP</u>
Lockdown 2, L2	13 / 38* · 3 LR NMIBC · 6 IR NMIBC · 1 HR NMIBC · RCC · 2 <u>CaP</u>
LR: Low Risk, IR: Intermediate Risk, HR: High Risk, NMIBC: non muscle invasive bladder cancer, MIBC: muscle invasive bladder cancer, RCC: Renal cell carcinoma, <u>CaP</u> : Prostate adenocarcinoma	