Since January 2020 Elsevier has created a COVID-19 resource centre with free information in English and Mandarin on the novel coronavirus COVID-19. The COVID-19 resource centre is hosted on Elsevier Connect, the company's public news and information website.

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

A.C. Olsson-Brown[1], D.J. Hughes[2], K. Purshouse[3], L. Lee[4], V.W. Cheng[5], A.J.X. Lee[6], E. Protheroe[7], A. Smith[8], H. Curley[9], R. Arnold[10], J-B. Cazier[11], J. D'Costa[4], C. Palles[12], N. Campton[9], C. Varnai[4], S. Sivakumar[13], R. Kerr[14], G. Middleton[15]

[1]Medical Oncology Department, Clatterbridge Cancer Center - NHS Foundation Trust, Wirral, UK; [2]UCL Cancer Institute,, University College London, London, UK; [3]Medical Oncology Department, Edinburgh Cancer Centre, Edinburgh, UK; [4]Oncology, University of Birmingham, Birmingham, UK; [5]Oncology, St James's University Hospital, Leeds, UK; [6]Department of Oncology, University College London Hospital, London, UK; [7]Biochemistry, University of Birmingham, Birmingham, UK; [8]IT, University of Birmingham, Birmingham, UK; [9]Cancer, University of Birmingham, Birmingham, UK; [10]Bioinformatics, University of Birmingham, Birmingham, UK; [11]Institute of Cancer and Genomic Sciences, University of Birmingham, UK; [12]Genetics, University of Birmingham, Birmingham, UK; [13]Oncology, University of Oxford, Oxford, UK; [14]Oncology, Churchill Hospital University of Oxford, Oxford, UK; [15]Oncology, The University of Birmingham Institute for Cancer Studies, Birmingham, UK

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.

Legal entity responsible for the study: The authors.

Funding: Has not received any funding.

Disclosure: A.C. Olsson-Brown: Honoraria (self): Roche; Honoraria (institution): Roche; Honoraria (self): Bristol Myers Squibb; Research grant/Funding (institution): Bristol Myers Squibb; Research grant/Funding (institution): USB Pharma; Research grant/Funding (institution): Eli Lily; Research grant/Funding (institution): Novartis. D.J. Hughes: Honoraria (self): Novartis; Research grant/Funding (self): NanoMab Technology LtD. S. Sivakumar: Research grant/Funding (self): Celgene. All other authors have declared no conflicts of interest.

https://doi.org/10.1016/j.annonc.2020.08.1767

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

A. Wu, C.C.T. Sng, S. Benafif, N. Chopra, M. Galazi, A.J.X. Lee, D. Ottaviani, G.B. Soosaipillai, Y.N.S. Wong, H.M. Shaw

Cancer Division, University College London Hospitals NHS Foundation Trust, London, UK

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 (10^9/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 (10^9/L) ¶	7.15 (4.03)	9.35 (7.46)	0.23
Neutrophils (10^9/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.

Legal entity responsible for the study: University College London Hospital.

Funding: Has not received any funding.

Disclosure: All authors have declared no conflicts of interest.

https://doi.org/10.1016/j.annonc.2020.08.1768

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

M.E. Negru[1], C. Tondini[2], A. Pastorino[1], M. Caccese[3], A. Cariello[4], A. Bertolini[5], G. Buzzatti[6], S. Cinieri[7], A. Comandone[8], F. Grossi[9], M. Franchini[10], O. Caffo[11], O. Garrone[12], A. Mambrini[13], F. Leone[14], C. Chini[15], F. Agustoni[16], F. Artioli[17], L. Blasi[18], C. Aschele[1]

[1]Medical Oncology, Ospedale Sant'Andrea, La Spezia, Italy; [2]Medical Oncology, Ospedali Riuniti di Bergamo, Bergamo, Italy; [3]Medical Oncology Department, IOV - Istituto Oncologico Veneto IRCCS, Padua, Italy; [4]Medical Oncology, Ospedale Santa Maria delle Croci, Ravenna, Italy; [5]Medical Oncology, AOVV Ospedale di Sondrio, Sondrio, Italy; [6]Medical Oncology, IRCCS Polinclinico San Martino, Genoa, Italy; [7]Medical Oncology Division & Breast Unit, Senatore Antonio Perrino Hospital, ASL Brindisi, Brindisi, Italy; [8]Ospedale San Giovanni Bosco, Oncologia Medica, Turin, Italy; [9]Medical Oncology unit, Fondazione IRCCS Ca' Granda Ospedale Maggiore Policlinico, Milan, Italy; [10]Medical Oncology, Ospedale Castelli - Azienda Sanitaria Verbano-Cusio-Ossola, Verbania, Italy; [11]Medical Oncology, Ospedale Santa Chiara, Trento, Italy; [12]Medical Oncology, Azienda Ospedaliera St. Croce e Carle, Cuneo, Italy; [13]Medical Oncology, Azienda USL Toscana Nord Ovest, Carrara, Italy; [14]Division of Medical Oncology, Nuovo Ospedale degli Infermi, Ponderano, Biella, Italy; [15]Medical Oncology, ASST Sette Laghi, Varese, Italy; [16]Medical Oncology -, Fondazione IRCCS Policlinico San Matteo, Pavia, Italy; [17]Medical Oncology, Ospedale Ramazzini, Carpi, Italy; [18]Medical Oncology, ARNAS Ospedali Civico Di Cristina Benfratelli, Palermo, Italy

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, retro-prospective, 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