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for patients with stage III/IV NSCLC, including reducing barriers to effective care coordination and patient education, screening, diagnosis and biomarker testing, and adherence to evolving standards of care.

Table: Key Barriers to Delivering Quality NSCLC Care

Care Coordination	Screening	Diagnosis
Insufficient quantity of biopsy material	Lack of primary care provider referral	Cost
Coverage and reimbursement	Lack of community awareness	Poor handling of biopsy samples
Turn-around time	Cost	Scheduling challenges and/or limited access to biopsy procedures

CP01.03

COVID 19's Pandemic's Effect on a Community Lung Cancer Screening Program



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Background: COVID-19's pandemic spread in the US in early 2020 led to a drastic change in health care delivery. In April 2020 consensus statement on LC screening advised deferring enrollment in LC screening and modified the evaluation of nodules. This single institution has had an active LC screening program before COVID, which enrolled more than 300 patients per month before COVID and completed more than 11,000 screens over the last six years. Kentucky is the state with the highest LC mortality rate in the US and one of the highest smoking rates in the country. Government directed social distancing was put in place 3/14/2020. **Methods:** LC Screening Registry data 2015-2020 for St Elizabeth Healthcare (SEH) was accessed. The lung cancer screening volumes listed until May 2020 were recorded and graphically illustrated using polynomial trendlines and well as monthly point by point lines. John Hopkin's COVID Status Report on Kentucky's and SEH surrounding counties confirmed cases, fatality rate and number of tested patients. **Results:** By June 2020, Kentucky (pop 4.6m) had 13,630 confirmed COVID cases, 524 deaths and a 3.84% fatality rate with 317,161 tests performed. SEH's surrounding counties, (pop 370k) had 386 cases per 100k population and a 4.5 % county fatality rate with 71 deaths. The county with the highest rate in the county at the time was Cook county, IL, (pop 5,2m) with 1,711 cases per 100k population and 4,500 deaths due to COVID. 379 LC screens were performed at SEH in February 2020. 212 in March and 13 LC screens in April, 114 in May. The lung cancer rate in the screened population has been 1.81% over the course of six years. **Conclusion:** The consensus statement on LC screening during COVID advised a delay in LC screening, work up and treatment, even for high probability nodules and stage 1 lung cancers. A delay of LC screens in this community setting by 6 months would delay the diagnosis and treatment of 36 lung cancer cases. The course of the COVID pandemic is presently uncertain. Considering the fact that COVID will affect health care for the foreseeable future, it would be helpful to modify the recommendations based on the area's prevalence of COVID and prevalence of lung cancer.

CP01.04

Biomarker Testing Among Users of Online Lung Cancer Resources - Can Online Communities Make a Clinical Impact?



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Background: Comprehensive biomarker testing is vital to ensure detection of actionable mutations and appropriate treatment for lung cancer. However, research shows a lack of awareness among patients and few receiving biomarker testing. We aim to determine whether a link exists between involvement in online lung cancer resources, including community-based resources and online communities, in which patients can read and share experiences, and the receipt of biomarker testing. **Methods:** An online survey was conducted among lung cancer patients (n=867) to better understand patients' experiences. Survey questions included diagnosis, HCP interaction, treatment, resources, and quality of life measures. Responses were evaluated using descriptive statistics and comparisons tests. **Results:** Of 867 lung cancer patients, 29% received biomarker testing while 71% have not or were unsure. Patients using online community-based resources to learn about and manage lung cancer were more likely to have had biomarker testing than those not using these resources. These resources include social media (40% v 24%, p<.0005), online forums and message boards (41% v 26%, p<.0005), online support groups (45% v 23%, p<.0005), lung cancer blogs (38% v 25%, p<.0005), and lung cancer-specific websites (35% v 21%, p<.0005). **Conclusions:** Despite biomarker testing rates remaining low, a higher rate of patients leveraging online lung cancer resources, including community-based resources, received biomarker testing than those not using these resources, demonstrating the potential positive clinical influence and value of these resources. Broader awareness is needed about biomarker testing to ensure both patients who do and do not utilize online resources are aware and benefitting from biomarker testing.

CP01.05

Relapse Rate and Associated Healthcare Resource Utilization in Stage IIA-IIIB Adjuvant NSCLC Patients Treated in a US Oncology Community Network



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Background: Despite adjuvant systemic therapy in patients with completely resected non-small-cell lung cancer (NSCLC), many will subsequently relapse. This study evaluated real-world relapse rates and healthcare resource utilization in Stage IIA-IIIB NSCLC patients receiving adjuvant therapy after complete resection. **Methods:** This retrospective descriptive study included Stage IIA-IIIB NSCLC patients with complete resection (R0), receiving any adjuvant therapy within the US Oncology Network during 06/2008–04/2017, with follow-up through 04/2019. Data were captured using structured fields and chart review of iKnowMed electronic health records. Rate of relapse and time to relapse (TTR) were characterized descriptively. Relapse-free survival (RFS) and overall survival (OS) were estimated from the date of surgery using Kaplan-Meier method. Per patient per month (PPPM) emergency department (ED) visits and hospitalizations before and after relapse were compared. **Results:** The study identified 456 patients; median age was 66 years, 50% were male. A majority of patients (67%) had non-squamous histology, 67% were former/current smokers, and at the time of surgery 64% had Stage II and 25% Stage III (1.5% Stage IIIB) disease. In patients with relapse (45.2%), the median follow-up was 31.7 months, and the median time to relapse was 13.7 months (95% CI: 11.9 to 16.7 months). Median RFS for overall population was 42.9 months (95% CI 36.8 to 59.5 months). The median OS was 82.4 months in the overall population and was significantly shorter in the relapsed patients than those without relapse (41.6 months vs. median not reached, p<0.0001). Patients with relapse had significantly more ED visits (PPPM visits, mean[SD]: 0.10 [0.24] vs 0.03 [0.08], p<0.0001)