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.

are warranted to assess the reliability of PFU compared to standard FU visit to implement telemedicine in daily clinical practice.

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1731P Molecular diagnostics for cancer patients and high-risk individuals during the SARS-CoV-2 pandemic at the Institute for Oncology and Radiology of Serbia

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Background: The SARS-CoV-2 pandemic introduced a dangerous distraction effect in all aspects of oncological patients' care. The aim of this research was to explore the effect of the pandemic on the efficacy of the largest molecular diagnostics centre for cancer patients and high-risk individuals in Serbia (IORS).

Methods: *EGFR, KRAS, BRAF, BRCA1/2* mutation testing of advanced lung adenocarcinoma, metastatic colorectal, metastatic melanoma and ovarian cancer patients were performed by qPCR and NGS. NGS was also used for panel testing of hereditary breast cancer and cancers associated with Lynch syndrome. IORS's analytical output during the two-month long state of emergency was compared to the two-month period prior to the outbreak.

Results: A 57% reduction (188 vs. 81) in the total number of patients that were referred to IORS for targeted molecular testing was detected (*EGFR* - prior to initiation of TKI therapy 55 vs 26 patients, at progression 21 vs 4; *KRAS* 73 vs 34, *BRAF* 39 vs. 17). Due to the prolonged transport of the necessary consumables and the fact that two essential laboratory personnel were absent from the Institute (sensitive category and obligatory quarantine), somatic testing for *BRCA1/2* mutations was not performed at all during the state of emergency. All new high-risk individuals with the referral for genetic counselling had to be postponed, so the lockdown was used to test the patients who were waiting for results. The number of NGS analyses for high-risk individuals increased by 50 % during the outbreak (36 vs. 72) and post-test genetic counselling was successfully performed by phone and/or web calls.

Conclusions: The SARS-CoV-2 pandemic had a profound negative effect on the overall diagnostic output of the centralized molecular diagnostics for cancer patients and high-risk individuals in Serbia. This effect will be further evaluated through the analysis of both the survival and quality of life of the cancer patients that were unable to receive targeted therapies in a timely efficient manner. The only positive effect of the pandemic was that the waiting lists for genetic testing of high-risk individuals were shortened.

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1732P Prognostic indicators for COVID-19 related deaths in patients with cancer

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Background: The COVID-19 pandemic has impacted significantly on health systems across the globe. It has been reported to have higher incidence and to be associated with worse outcomes in patients with cancer. Beaumont Hospital is a large Dublin-based teaching hospital which was at the centre of the Irish outbreak of COVID-19.

Methods: During the period 11th March to 15th May 2020, patients diagnosed with COVID-19 infection who were attending Beaumont Hospital for systemic anti-cancer therapy were included. Data were collected by chart review. Statistical analyses were performed using SPSS. Cancer-related prognosis was estimated using the Palliative Prognostic Score (PAP) with a score $\geq$11 associated with a 30-day survival of $<$30%.

Results: In total, 717 patients attended oncology services for cancer directed treatment during the study period. 27 of these patients were diagnosed with COVID-19 based on RT-PCR. A further 4 patients were diagnosed clinically due to characteristic symptoms and radiology. The median age was 60 (38-84). 12 (39%) were female. The most common cancer type was lung n=9 (29%). 21 (67%) had metastatic disease; 4 (13%) locally advanced disease and 6 (19%) were being treated with curative intent. Of the 31 patients diagnosed with COVID-19, 25 (80%) were hospitalised and none were admitted to intensive care. In total, 12/31 (41%) died, of which 5 (41%) had lung cancer, 10 (83%) had an PS of $\geq$3 and 3 (25%) had received systemic anti-cancer treatment in the last 30 days of life. The median age was 66 (38-84). 4 (33%) were female. All had incurable, locally advanced or metastatic disease. The mean time from diagnosis to death was 9.5 days. Those with an ECOG performance status (PS) $\geq$3 were more likely to die than those with PS $\leq$2 ($p<0.001$).Compared to those who recovered, patients who died from COVID-19 had higher mean number of organs affected by cancer (3.7 vs. 1.8, p=0.015) and higher mean PAP score (9.6 vs. 1.5, $p<0.001$).

Conclusions: Patients with cancer who contracted COVID-19 and died had more sites of metastatic disease, a poorer performance status, and a higher Palliative Prognostic Score. The presence of multi-organ involvement appears to predict for poorer outcomes in COVID-19 positive cancer patients.

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1733P Real-world data: Cancer and SARS-CoV-2 infection

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Background: Madrid has been the epicenter of the SARS-CoV2 pandemic in Spain. We analyzed the experience at our hospital with SARS-CoV2 infection and cancer patients (p).

Methods: We analyzed our experience from March 1 to April 30 at the Puerta de Hierro University Hospital in Madrid. Diagnosis of SARS-CoV2 infection was made by RT-PCR, suspected cases not confirmed were excluded.

Results: Overall in-hospital mortality cancer p with COVID-19 was 15.2% (95%CI, 6.3; 5.2), similar to 12.7% (95%CI,11.1;4.4) with p=0.615 of the global COVID-19 hospitalised population and greater than that of patients admitted without SARS-

Table: 1733P

VARIABLE	OTHER CANCER N=34 (%)	LUNG CANCER N=12 (%)	
Male	52.9	50	
Age mean	63.9	63.5	
Active Smoking	0	16.7	
Ex-smokers	35.3	50	
COMORBIDITIES			
Coronary heart disease	8.8	16.7	
Hypertension	35.3	41.7	
COPD	8.8	16.7	
Dyslipidemia	23.5	25	
STAGE			
IV	52.9	50	
SYMPTOMS			**p**
Neutropenia	6.1	0	1.0
Cough	67.6	41.7	.17
Temperature	37.1	37.3	.36
Dyspnoea	47	91.7	**.007**
Diarrhea	8.8	8.3	1.0
Lymphopenia	68.7	36.4	.08
PROGNOSTIC CRITERIA			
IL6			.41
D-DIMER	0.9 (0.6; 2.2)	0.9 (0.5; 2.7)	.57
PCR		**107.7**	.44
LDH	266 (207; 326)	290 (238; 352)	.19
FERRITIN	562 (358; 933)	1111 (392; 2672)	.15
CHARLSON INDEX*	8 (6; 9)	8 (6; 9)	.80
CURB65 SCALE **			.31
BRESCIA SCALE			.17