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patients in the treatment group were significantly promote than that in the control group, and had statistical significance. Side effects: there were significant differences in constipation and excessive sedation between the two groups ($p < 0.005$), but there was no significant difference in other symptoms. **Conclusion:** Thalidomide is effective and safe in the treatment of patients with extensive-stage small cell lung cancer complicated with CACS. **Keywords:** extensive-stage SCLC, CACS, Thalidomide

MA10.10
Lung Cancer Admission Rates During the COVID-19 Pandemic to a Tertiary Cancer Centre in South East Scotland.



F. Torrance, K. Purshouse, P. Hall, M. Mackean, I. Phillips *Edinburgh Cancer Center, Western General Hospital, Edinburgh/GB*

Introduction: Lung cancer is associated with a lower socio-economic status, major co-morbidities and a poorer performance status. These factors, and the negative association often affiliated with lung cancer, can create barriers to healthcare engagement. Anecdotally patients admitted during the lockdown phase of the COVID-19 pandemic were more unwell and required more intervention than normal. We examined acute admissions during the pandemic to establish the impact of the COVID-19 pandemic on patients with lung cancer. **Methods:** We identified all patients admitted with suspected or previously diagnosed lung cancer admitted acutely to Edinburgh Cancer Centre between 29th of March and 29th June 2020. In Scotland, lockdown was eased from 29th of May, so we divided our analysis into early lockdown (29th March-April), late lockdown (May) and recovery (June). We gathered patient demographics (age, gender), duration of admission (days), admission route (referral from routine contact with oncology specialist for emergency care, self-presentation to oncology patient helpline, self-presentation to GP or A&E, and planned admission for specialist oncology treatment) and outcomes from the admission, including mortality and palliative care involvement. We compared this with admissions in April 2019. **Results:** During the three months evaluated, 77 patients were admitted, of whom 46 were male and 31 were female. The mean age of patients was 65.8 (range 42 to 87), with no significant difference between each month assessed. The number of admissions in the 3 assessment periods were 29 (early lockdown), 21 (late lockdown) and 27 (recovery), compared with 10 admissions in April 2019. Patients were admitted for a longer period of time in early lockdown (mean 7.4 days) and late lockdown (mean 7.0 days), but less in the recovery period (mean 2.7 days). There were 3 inpatient deaths in early lockdown, 2 in late lockdown and none during the recovery period, suggesting patients may have been presenting with more advanced acute illness during lockdown. Admission route shifted from being prompted by a routine remote consultation to patient-driven self-presentation as the pandemic progressed. During early and late lockdown, around half of patients were admitted after a scheduled remote consultation (48% (14/29) in early lockdown, 57% (12/21) in late lockdown). In contrast, 19% (5/27) patients were admitted via this route during the recovery period, with 41% (11/27) being admitted via patients self-presenting to the patient helpline and 37% (10/27) self-presenting to A+E/GP. **Conclusion:** Our data suggests that there were more patients with lung cancer admitted acutely with cancer, non-COVID-19-related illness during the COVID-19 pandemic. The early and late lockdown phase was particularly characterised by a reduction in self-presentation and longer resulting admissions, suggesting patients were admitted with more complex pathology and consequently longer admission from acute illness. Overall, our experience highlights the need to make acute cancer services accessible to patients as the COVID-19 pandemic continues, and

that patients with lung cancer may be a particularly vulnerable group. **Keywords:** COVID-19, Oncology, Admissions

MA10.11
End of Life Health Resource Utilization for Limited English Proficient Patients with Advanced NSCLC



B. Leung,¹ S. Wong,¹ K. Malli,² C. Ho¹ *¹Medical Oncology, BC Cancer - Vancouver Centre, Vancouver/BC/CA, ²Provincial Language Service, Provincial Health Services Authority, Burnaby/BC/CA*

Introduction: Immigrants with limited English proficiency (LEP) often encounter communication challenges with their health care team, have poor health literacy, and have difficulty navigating the health care system. In British Columbia, Canada, 28% of the population speak languages other than English in their homes. Due to communication barriers, NSCLC patients with LEP may receive less community palliative home care (CPHC) services and more aggressive end-of-life (EoL) care. The study goals were to observe the difference in health resource utilization at EoL between NSCLC patients who are English proficient (EP) and LEP. **Methods:** All patients with advanced NSCLC referred to BC Cancer – Vancouver Centre in 2016 and received medical care were included in the study. Patients seen with a medical interpreter were considered to be LEP. Demographics and clinical information were collected retrospectively. Statistical analysis included the t-test, X² test, Fisher's exact test and Mann Whitney U test to compare EP and LEP patients. **Results:** 186 advanced NSCLC patients were referred. Language of communication: English 66%, Cantonese 21%, Mandarin 6%, Korean 1%, Tagalog 1%, other 5%. Referral to CPHC services was 84% in both groups respectively. There was no difference of the rate of ER visits and hospitalization within 6 months and within 30 days of death between EP and LEP. LEP patients had a higher rate of dying in the tertiary palliative care unit (PCU) or acute care setting, but this was not statistically significant ($p=0.335$).

	English Proficient (Interpreters not needed) (n=122)	Limited English Proficient (Interpreters needed) (n=64)	p- value
Sex Female Male	54 (44%) 68 (56%)	36 (56%) 28 (44%)	0.126
Median Age at Diagnosis (years)	69 (IQR 61-76)	72 (IQR 62-81)	0.225
Community Palliative Home Care Yes No	102 (84%) 20 (16%)	54 (84%) 10 (16%)	1.000
Location of Death Acute Care/Emergency Department Home/ Long Term Care Community Hospice Care Facility Tertiary Palliative Care Unit	22 (18%) 35 (29%) 42 (34%) 23 (19%)	17 (23%) 10 (16%) 22 (34%) 15 (24%)	0.335
Average No. of ER visits within 6 months prior to death	0.89	0.70	0.374
Average No. of Hospitalization within 6 months prior to death	1.40	1.59	0.244
Average No. of ER visits within 30 days prior to death	0.10	0.13	0.640
Average No. of Hospitalization within 30 days prior to death	0.67	0.81	0.091