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.

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SARS-COV-2 AND CANCER

1670O Prospective data of first 1,797 hospitalised patients with cancer and COVID-19 derived from the COVID-19 Clinical Information Network and international Severe Acute Respiratory and emerging Infections Consortium, WHO Coronavirus Clinical Characterisation Consortium

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Background: The SARS-CoV-2 pandemic in the UK triggered a national characterisation protocol and information on co-morbidities including malignant neoplasm is recorded. A lack of prospective data regarding cancer patients with COVID-19 hampers the development of an evidence based approach in this population. The Clinical Characterisation Protocol-CANCER-UK is a UK multi-disciplinary project aimed at characterising the presentation and course of COVID-19 in cancer patients with the aim of informing practice.

Methods: The international Severe Acute Respiratory and emerging Infections Consortium (ISARIC)-4C COVID-19 Clinical Information Network (CO-CIN) collects data on hospital inpatients with proven/high likelihood of COVID-19. Data was collected in 166 UK sites using a questionnaire adopted by the WHO. Data on patients with malignant neoplasm was extracted from the main dataset. We chose a priori to restrict any analysis of outcome to patients who were admitted more than 14 days before data extraction (13th May 2020).

Results: As of 13th May 2020 1797 of 16160 participants had malignant neoplasm (8.6% of all cases). Age<50 62 (3.5%), 50-60 378 (21%), 70-79 558 (31%), 80+ 1002 (42%). Male 1147 (64%); Female 645 (36%). Commonest comorbidities chromic pulmonary disease (22%), chronic kidney disease (21%), uncomplicated diabetes (19%) and dementia (14%). Outcomes 35% discharged alive, 30% care ongoing & 35% died. Admiited to ICU: 150 cases (25% discharged alive,31% care ongoing & 45% died). Receiving invasive ventiation: 67 cases (18% discharged alive, 25% care ongoing:25% & 57% died). HR mortality for malignancy (adjusted for age, sex, other comorbidity): 1.13 (1.02-1.24, p=0.017). Data on presentation will be presented.

Conclusions: Europe's largest prospective COVID-19 dataset demonstrates that cancer is independently associated with mortality in patients admitted with COVID-19. Data collection is on-going and updated data will be presented including a comparison of cancer vs. non-cancer cohort with regard to presentation, comorbidity and otucomes.

Clinical trial identification: ISRCTN66726260.

Legal entity responsible for the study: and international Severe Acute Respiratory and emerging Infections Consortium (ISARIC) WHO Coronavirus Clinical Characterisation Consortium (ISARIC4C).

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1671MO Provision of palliative care for patients with cancer and SARS-CoV-2 infection

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Background: Patients with cancer (pts) are particularly vulnerable to SARS-CoV-2 infection (C19). In this study we aimed to characterise the supportive care needs of hospitalised pts with C19, evaluate indications for specialist palliative care (SPC) referral and describe end of life (EOL) care for in-hospital decedents.

Methods: From the OnCOVID database (n=892) we analysed a subset of 191 pts hospitalised between 9/3 and 27/4/2020 in 9 centers from the UK (n=110, 57.5%), Spain (n=79, 41.5%) and Germany (n=2, 1%). Eligible pts were those with complete SPC referral data including EOL symptomatic burden.

Results: Of 191 eligible pts, 101 were male (52.9%) with mean age (±SD) of 68±12 years. Most prevalent tumour sites were genito-urinary (n=41, 21.5%) and breast cancer (n=33, 17.3%), with non-metastatic disease (n=118, 63.7%). At C19 diagnosis, 96 pts (50.3%) were on active cancer therapy, 95 (49.7%) had >1 co-morbidity, most commonly hypertension (n=95, 49.7%) and diabetes (n=41, 21.5%). Median Australia-modified Karnofsky Performance Status (AKPS) score was 70 (IQR 30). In total, 114 pts received SPC input, mostly from hospital-based teams (n=98, 85.9%), for 9 (±11) days before death or discharge for symptom control (n=101, 52.9%), psychological support (n=79, 41.4%) or advance care planning (n=78, 40.8%). In total 161 pts (84.3%) had evidence of a documented treatment escalation plan, with 84 (43.9%) having a valid DNACPR order. At database censoring, 72 pts had died (37.6%), 67 were prescribed anticipatory medications including opioids (n=51, 70.8%) and benzodiazepines (n=44, 61.1%). Amongst 64 in-hospital decedents, only 14 died in oncology wards (21.8%). Breathlessness (n=56, 87.5%), agitation (n=31, 48.4%) and confusion (n=23, 35.9%) were most common EOL symptoms. EOL symptomatic burden was not correlated with age, co-morbidities or AKPS at C19 diagnosis (p>0.05).

Conclusions: In the early phase of the C19 pandemic, the high in-hospital mortality from C19 in pts occurred mostly outside dedicated oncology inpatient areas. Complex palliative care needs and high EOL symptomatic burden of C19+ pts should inform SPC service planning in this population to optimise supportive and EOL care.

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