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for home administration. Monthly at home laboratory testing and virtual consultations with medical oncologists every 1-3 months were arranged.

Results: A total of 52 patients were enrolled during the period of March 2020 – March 2021. All men were White and had ECOG 0/1. The mean age was 71 [±6.3] years. Sixteen (31%) patients had stage IIIB PC and 36 (69%) patients had stage IV disease. Stage IIIB patients were receiving adjuvant ADT with SQ Goserelin Acetate 10.8mg every 8 weeks and bicalutamide 50mg daily for two weeks after definitive local treatment. Thirty-one (86%) patients had hormone sensitive metastatic PC and were receiving SQ Goserelin Acetate 10.8mg (28) every 8 weeks or SQ Leuprolide Acetate 22.5mg every 8 weeks (3) with 2 weeks of Bicalutamide 50mg daily. Five (14%) patients had castration resistant (CR) PC and were receiving SQ Goserelin Acetate 10.8mg every 8 weeks with Enzalutamide 160mg daily. Thirty-three (63%) patients had Gleason's score of 8/9. All patients were compliant with home injections, laboratory tests and virtual physician visits. Thirty-nine (75%) patients administered injections by themselves. Forty-two (80%) patients had PSA reduction >50%. Ten (20%) patients had disease progression and required clinic visits for investigations. Median time to progression was 12 months. Only 1 (2%) patient acquired COVID-19 infection, was hospitalized and died of respiratory failure.

Conclusions: At home ADT with appropriate patient/caregiver education and close follow up may be safe for patients with PC during the COVID-19 pandemic.

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1633P Why do cancer clinical trials (CT) discontinue prematurely in the era of COVID-19?

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Background: The COVID-19 pandemic (C19P) is causing several detrimental effects on cancer care globally. CT are crucial to obtain high quality literature evidence and "poor accrual" is the most common reason for their early discontinuation (ED). At our best knowledge, no data are available on ED of cancer CT after the beginning of C19P.

Methods: ClinicalTrials.gov was queried for terminated (T), withdrawn (W) and suspended (S) CT for the following terms: "cancer", "neoplasm", and "tumor". The search was made for all the CT available from the inception to 26th February 2021, without any restrictions. The following characteristics were extracted: reason for ED, study type (interventional [In] vs observational), sponsored (yes vs not). ED rate was compared between CT discontinued for C19P or not (χ^2); $p < 0.05$ was set as statistically significant. A multiple linear regression analysis was also conducted to identify independent factors of ED.

Results: 9990 CT were identified, but 765 CT were excluded as not related to cancer. Thus, 9225 CT were included (66% was T, 23% was W and 4% was S). Among CT classified as T, W and S, the frequency of In CT was 92%, 88% and 85% respectively, while the frequency of sponsored CT was 46%, 35% and 26% respectively. The most common reasons for ED were: "poor accrual" (29%), "lack of funding" (6%) and "sponsor decision" (5%). No reason for ED was available for 15% of CT. One hundred (1%) CT were discontinued due to C19P (27% was T, 7% was W and 66% was S). Comparing CT discontinued due to C19P with those discontinued due to other reasons, a lower rate of In-CT (73% vs 91%, $p < 0.05$) and sponsored CT (14% vs 42%, $p < 0.05$) was found in the C19P group. At the multiple linear regression analysis, C19P was strongly positively correlated with ED (coefficient 0.59952, $p < 0.0001$) whereas sponsored CT resulted as negatively correlated with ED (coefficient -0.02746, $p < 0.0001$).

Conclusions: "Poor accrual" continues to be the main reason for ED of cancer CT, but C19P represents a new additional cause of ED. Sponsored trials showed less risk for ED. Further research is needed to maximize the expected benefit of cancer CT, reducing the anticipated risks.

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1634P Communication specifics with cancer patients during the COVID-19 pandemic in Croatia: Can a virtual visit meet the needs of cancer patients?

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Background: In this study, we focused on communicating with cancer patients on active treatment during the first lockdown due to the COVID-19 pandemic and the patient's main sources of pandemic information.

Methods: In the first wave of the pandemic, during the first lockdown, we conducted an observational study in 8 of the 13 oncology centers in Croatia. The study is based on an anonymous self-report questionnaire designed for this study. It included 422 oncology patients, older than 18 years, who were in active oncology treatment at the time. To study the correlation between the patient's perspective on communicating with medical staff during a pandemic, the preferred type of communication, and the main sources of pandemic information relative to clinical and sociodemographic data, we used univariate descriptive and bivariate analyses.

Results: In the first lockdown, our respondents communicated with the oncologist and oncology nurses mostly in-person (77.7% vs. 81%), and with the general practitioner mostly virtually, most often by phone (70.6%). Regardless of the pandemic, the majority of oncology patients (76.1%) prefer to communicate with an oncologist in-person, and most expressed satisfaction with communicating with medical staff during a pandemic. The choice of information sources and type of communication depends on the age, gender, income, education, and the seat of the disease of patients.

Conclusions: For most of our respondents, in-person visits were the basic way of communicating with oncologists and oncology nurses. On the other hand, a virtual visit was the basic way to communicate with the general practitioner. As patients stated that, regardless of the pandemic, they prefer to communicate with the oncologist in-person, we can conclude that the virtual visit does not meet the needs of cancer patients who are in active oncology treatment. In our study men showed a tendency to communicate in-person, while women, breast cancer patients, younger people, highly educated people, and people of higher income are more prone to virtual visits and are more inclined to use the Internet as a source of information about a pandemic.

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1635P Impact of the COVID-19 pandemic on cancer care in Tunisia: Oncologists' perception

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Background: The COVID-19 pandemic was confirmed to have reached Tunisia on March 2nd, 2020, and has therefore disrupted oncology practice ever since. We report the main difficulties encountered by oncologists across the country during the pandemic.

Methods: We conducted a national online survey on medical, surgical, and radiation oncologists to investigate their practice changes during the COVID-19 pandemic from March 2020 to January 2021.

Results: 136 oncologists responded to the survey (surgical oncologists 35.8%, medical oncologists 37.8%, and radiation oncologists 26.4%); 80% were working in public hospitals. Among oncologists working in the public sector, 59% were asked to join covid-19 units. Five percent stated that their cancer care units were requisitioned for the management of COVID-19 patients and therefore, their patients were referred to other hospitals to pursue their treatment. Moreover, when comparing the number of

new cancer cases diagnosed during and before covid-19, 63% of the surveyed oncologists reported a decrease in the number of new cases while 27% stated that the number was stable. During the lockdown, 45% of the participants noted that only 25 to 50% of their patients attended the follow-up visits and that 83% of them missed their CT imaging appointments. On the other hand, 62% of the surveyed oncologists stated that their patients experienced delayed curative surgeries, and 41% had chemotherapy delays. Decreased consultations at the emergency oncology departments were reported by 88% of the oncologists. Besides, 40% of oncologists reported that they adopted telemedicine to monitor patients during the lockdown, and, 48 % stated that they participated in videoconferences to learn about patients' management during the pandemic. Finally, 46% of the surveyed oncologists reported losing patients due to the COVID-19 infection, which was a trigger for anxiety symptoms in 35% of the participants.

Conclusions: Oncologists reported deleterious effects of COVID-19 on oncology practice and patients' management. Establishing standardized practice guidelines during the pandemic may help to decrease oncologists' distress and reassure them about the appropriateness of their treatment policies.

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1636P Health behavior of cancer patients during COVID-19 pandemic. Focus head neck cancer

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Background: During pandemic coping strategies become very important for each individual cancer patient. Are there any changes in health behavior of our patients due to pandemic?

Methods: We have analyzed questionnaire data of 575 patients, among them 171 head neck cancer patients. 246+84 questionnaires were filled in May 2020 (wave 1) and 158+87 questionnaires were filled in October 2020 (wave 2). We asked for alcohol consumption (5-point Likert scale), sportive activities, meditation, praying, and drug abuse (all 4-point Likert scale). We compared each item at both time points (t-test, 2 fold, inhomogenous variance). Sub-analysis were performed for head and neck cancer patients.

Results: Comparing between both time points, we see a stable alcohol consumption (1.700±1.463 vs. 1.66±1.428), a significant decrease in sportive activities (1.789±1.013 vs. 1.557±0.995, p=0.013), a trend to less meditation (0.571±0.951 vs. 0.408±0.873, p=0.056), a significant decrease in praying (0.938±1.225 vs. 0.650±1.126, p=0.009) and an unchanged drug abuse (0.366±0.891 vs. 0.392±0.942). Comparing head neck cancer patients with cancer patients of other tumor localizations, they show a significant stronger reduction of praying (p=0.002). During wave 2 head neck cancer patients reported about more alcohol consumption (1.473±1.491 versus 1.697±1.427) and drug abuse (0.333±0.875 versus 0.48±1.044).

Conclusions: During pandemic we see a reduction of individual coping strategies and changes in physical and mental health behavior. Societal activities are necessary to encourage coping strategies as sports or spiritual care.

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1637P Unintended consequences for an integrated oncology ecosystem from COVID adaptations

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Background: Cancer services had to adapt for social distancing to minimise risk of COVID spread between staff, persons with cancer attending and those supporting them. Prior to COVID patients attended a large combined outpatient clinic (OPC) once a week (12.30-7pm). This allowed optimal staffing of the day unit and inpatient service for the majority of the week. A separate outpatient facility at a removed

location, though still on the Hospital campus, was created for OPC assessments with the intent of dispersing the large clinic across 4 days during COVID outbreak. An analysis of the impact on staff availability throughout the service as a consequence of an increased frequency / reduced patient volume OPC is outlined below.

Methods: The numbers of non-consultant hospital doctors (NCHDs), their assigned location (day unit or OPC), allowances for full staff and also allowing for vacation time were gathered for 1) pre-COVID clinic and 2) modified COVID clinics. Activity levels within the day unit treatment facility was also assessed using the hospital information system. The number of NCHDs multiplied by the hours available to the day unit were calculated per week for both clinic structures to produce the "available NCHD hours".

Results: From Jan. 2nd to Dec. 31st 2020 there were 11089 day oncology treatment unit by 1304 patients, alongside 4045 OPC visits. To adjust for COVID social distancing the large OPC (7 hours) was dispersed across 4 mornings (18 hours). This change resulted in the reduction of available NCHDs to the day oncology unit from 247 available NCHD hours to 158 available NCHD hours once vacation and study leave are factored into the equation. This represents a 36% reduction in available staff yet no planned reduction in patient activity.

Conclusions: While dividing clinical activity in the OPC over several days allowed patients attend with a family member, allowing better insight and support, it reduced the numbers of doctors available for a significant part of the day, placing more strain on those doctors trying to manage a similar number of patients in a safe and patient-focussed manner. Changes within the outpatient clinic setup adjusting to COVID restrictions has inadvertently had knock-on effects on the "Oncology Ecosystem" and may impact on future service quality.

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1638P Experience with telemedicine during COVID-19 pandemic

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Background: Since the beginning of COVID19 pandemic, cancer patients were considered to be more susceptible to contract SARCOV2 due to their underlying disease, greater immunosuppression and comorbidities. This higher risk forced oncologist on March 2020 to switch to telehealth without previous knowledge on this field. The aim of this study is to review our experience with telemedicine during the COVID-19 pandemic.

Methods: Patients attended by a telephonic and/or an in-person visit in the Medical Oncology Service at Parc Tauli Hospital Universitari between March 13 to April 30 2020 were included. Characteristics of recruited patients were summarized using descriptive analysis. The study was approved by the Research Ethic Committee.

Results: 855 patients were attended. 24.4 % had an in-person visit, 63.2 % had a phone call visit and 12.4 % both types. Median age was 65,48 [26-94] years old. 48.7% were male. 65.4% ECOG 0. Cancer types were: 41.8 % Colorectal, 12.7% Gastrointestinal non-colorectal, 12% Lung, 21,3 % Breast and 12.2 % Others. Most patients (52.4%) had a follow-up visit. 26.4 % were receiving palliative treatment and the most frequent administered drug was chemotherapy (51.2%). Telephonic appointments were mainly follow-up visits (63.7%), used for older patients (median age 66 years) with colorectal and breast cancers (42.7 % and 24.3% respectively), ECOG 0 (65.4%) and stage I, II and III disease (73.9%). In contrast, in-person appointments were mostly treatment visits (84.1%), for younger patients (median age 63.4 years) with stage IV disease (60%), ECOG ≥ 1 (51.7%) and colorectal cancer (35.9%). The proportion of patients with non-colorectal and thoracic cancer was higher when compared to telephonic assistance (40.6 % vs 19.4% respectively). The differences between the two types of visit were statistically significant (p<0.0001).

Conclusions: Without a robust scientific basis or previous experience, it seems that during the first period of COVID-19 pandemic oncologist felt more comfortable with face-to-face appointments when visiting patients with stage IV disease and/or ECOG ≥ 1 that were receiving palliative treatment. These patients attended more to the hospital despite having a higher mortality for COVID19.

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