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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respiratory tract malignancies (10%). Most patients were on active systemic therapy or radiotherapy (84%), largely for advanced or metastatic disease (55%). In the overall population, early death rate was 15%, which was numerically higher than the Brazilian general population with COVID-19 diagnosis in 2020 (2.5%). We were able to match 442 cancer patients with COVID-19 to 1,187 controls with cancer from pre-pandemic times. The 30-day mortality rate was 12.4% in COVID-19 cases as compared to 5.4% in pre-pandemic controls with cancer (Odds Ratio 2.49, 95%CI 1.67 - 3.70; P value < 0.01, Power 97.5%). COVID-19 cancer patients had significantly higher death events than historical controls (Hazard Ratio 2.18, 95%CI 1.52 - 3.12; P value < 0.01, Power 99.7%), particularly from 20 to 30 days after diagnosis of the infection.

Conclusions: Cancer patients with COVID-19 have an excess mortality 30 days after the infection when compared to matched cancer population from pre-pandemic times and the general population with COVID-19, reinforcing the need for priority vaccination in public health strategies.

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Clinical outcomes of patients with cancer who tested positive for COVID-19 hospitalised in a UK district general hospital

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Background: Individuals diagnosed with cancer have been particularly affected by the COVID-19 pandemic. Most of the relevant information so far has come from tertiary cancer centres and less is known of the outcomes of patients in District General Hospitals (DGH). In this audit, we aimed to investigate the clinical outcomes of patients with cancer who tested positive for COVID-19 and were admitted in a DGH.

Methods: Electronic records of patients admitted at Tameside General Hospital (TGH) (>500 beds) between March 2020—March 2021 were reviewed retrospectively. Clinical outcomes of those who tested positive for COVID-19 and factors relating to death were analysed. Cox regression and Kaplan-Meier survival analyses were performed (SPSS v26.0).

Results: Within the 12-month study period, there were 2417 inpatients who tested positive for COVID-19 at TGH. Of 235 individual patients with cancer admitted during this period, 14% (n=33) tested positive. Median age was 75 (68;81) years; majority female (67%). The most prevalent primary site of cancer were lung (21%) and breast (12%). Most were ECOG PS 1 (39%) or PS 2 (36%), and had high Charlson Comorbidity Index (median 5 (3;6), range 0-10). 24% of patients were on curative treatment, 39% palliative treatment, 18% best supportive care and 18% not on treatment. Types of treatment included chemotherapy (37%), hormonal treatment (26%), radiotherapy (21%) and immunotherapy (5%). On average, patients were admitted at least once (range 0-4) prior to positive test for COVID-19. At last follow-up, there were n=664/2417 (27%) and n=22/33 (67%) deaths in the non-cancer and cancer patient subgroups, respectively. The median time from diagnosis of COVID-19 to death/censor date was 44 (4-85) days. In univariable Cox regression analysis, only ECOG PS was significantly correlated with death, HR 1.523 (95% CI 1.064-2.181, p=0.022).

Conclusions: The outcomes of our cohort of patients with cancer who tested positive for COVID-19 and hospitalised were poor. The high comorbidity burden and poor ECOG PS could potentially account for this rather than the recent oncological treatment. Acute oncology input to general medical teams treating cancer patients with COVID-19 is pivotal for best possible outcomes for patients.

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Impact of COVID-19 infection on breast cancer patients: Experience in Latin-American country ACHOC-19B study

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Background: There are not specific information about outcomes of COVID-19 infection in patients with breast cancer. We aimed to describe the outcomes in this population in our national cohort of patients with cancer and infection for COVID-19.

Methods: ACHOC-19B registry is a multicenter observational study composed of a cross-sectional and a prospective cohort component. Eligibility criteria were the diagnosis of breast cancer and COVID-19 infection confirmed with RT-PCR. Follow-up of 30 days was completed. Clinical data were extracted of the multicentric register of cancer and covid-19 in Colombia (ACHOC-19B), collected from Apr 1 until Oct 31, 2020. The primary outcome was 30-day mortality from all causes and secondary
outcome was asymptomatic disease. Associations between demographic or clinical characteristics and outcomes were measured with odds ratios (ORs) with 95% CIs using multivariable logistic regression.

Results: 132 patients were included (18.5% of global ACHOC-19 cohort). 18.2% died and 25.8% was asymptomatic. In relation to the patients who died vs did not die, 68 vs 66% were > 50 years, 20 vs 10.2% with obesity, 32 vs 51.4% without comorbidities: 24 vs 12% with Diabetes, 56 vs 29% arterial Hypertension, 17.75 vs 3.88% ECOG > 2, 50 vs 12.5% progressive cancer, 20 vs 5.6% bacterial coinfection, 65 vs 25.2% received antibiotic and 68 vs 19% steroids for Covid-19 infection. 11.3% had severe infection and received ventilatory support and 66% died. About the asymptomatic patients 74% were > 50 years, 2.9% had obesity, 56% without comorbidities, 56% with ECOG 0 and 17.6% had metastatic disease. In the logistic regression analysis, age > 50 years (OR 2.79, 95% 0.54-13.81), >2 comorbidities (OR 3.48 95% 0.26-45.71), progressive disease (OR 3.52 95% 0.47-26.57), steroids (OR 6.62 95% 1.5-26.6) and antibiotic treatment for Covid19 (OR 6.88 95% 1.60-29.76) behaved as risk factors for mortality, but only steroids and antibiotic was sta-
tistically significant.

Conclusions: In our study, breast cancer patients have high mortality by Covid-19 infection. Age, comorbidities, ECOG > 2, progressive disease, and use of antibiotic and steroids are factors for worse prognosis.

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1581P Impact of the COVID-19 pandemic on patients with head and neck cancer assisted in a public cancer center in Brazil

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Background: Since the beginning of the COVID-19 pandemic, over 400,000 Brazilians have died and its impact on other diseases is yet to be revealed. Due to contingency strategies, there was a significant reduction in screening programs and this would potentially affect cancer treatment outcomes. There is no updated national data regarding the real impact on delaying diagnosis and cancer treatment in Brazil. Objective: To analyze whether the COVID-19 pandemic impacted delaying cancer treatment, yielding more advanced cases as analyzing patients’ clinical features before oncological treatment.

Methods: This is a retrospective cross-sectional study with patients assisted in a public cancer center in southeastern Brazil between 2019 and 2020 with a comparison of patients’ clinical features in both years. We analyzed all 207 patients with head and neck treated in 2019 and 2020 (85 and 122 patients, respectively) and stratified them by clinical stage (CS), tumor size, lymph node status (LNS), the occurrence of metastatic disease (MD), body mass index (BMI), need of enteral nutrition, age, performance status (PS) and the indication of exclusive palliative care. We performed comparisons between these groups using Student t-test and chi-square test with a significance level of 5%.

Results: Our results reported a statistically significant difference on tumor size (p = 0.024); in 2019, 50.6% of the tumors were classified as T4 in comparison with 66.4% in 2020. Data showed no statistically significant difference among groups regarding age (median of 56y in 2019 and 58.5y in 2020; p = 0.056), BMI (47% had a BMI below 20 on each group, p = 0.595), need of enteral nutritional (54.1% in 2019 and 59.8% in 2020, p = 0.254), CS (75.3% had stage IV disease in 2019 and 81.1% in 2020 — p = 0.486), LNS (42% were N2 in 2019 and 38.5% in 2020, p = 0.243), MD (9.4% in 2019 and 13.9% in 2020, p = 0.326), PS (59% had PS 1 in 2019 and 45% in 2020, p = 0.061) and indication of exclusive palliative care (4.7% in 2019 and 10.7% in 2020, p = 0.125).

Conclusions: The real impact of the COVID-19 pandemic in cancer treatment is yet to be discovered but so far, our results from 2020 patients indicated a tendency of advanced primary tumor size at the time of cancer diagnosis.

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1583P COVID-19 related risk in patients enrolled in early-phase clinical trials

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Background: Early phase clinical trials often represent a therapeutical opportunity for cancer patients (pts). However, high logistic commitment is demanded for participation. Here we explore the COVID-19 related risk during the pandemic for pts enrolled in clinical trials compared to pts receiving standard treatments.

Methods: We retrospectively assessed the incidence of COVID-19 in pts in treated in our Department from March 2020 to April 2021. Pts were divided into two groups; those enrolled in phase I/II clinical trials (A) and those being treated with standard therapies (B). Logistical (telemedicine and drug home-delivery), as well as clinical, characteristics of susceptibility to COVID-19 and number of events (SARS-CoV2 infections) were collected. The number of teleconsultations and COVID-19 events among the two groups were compared through Fisher’s exact test.

Results: 115 pts were evaluated: 36 pts (31%) in A and 79 pts (69%) in B. Pts in A were younger, with a median age of 55 years (range 39-77) compared to 62 years (range 31-83) in B. Performance status (PS, ECOG) was similarly distributed: 0 (A 78%, B 83%), 1-2 (A 22%, B 17%). The median of previous treatment was 1 in A (range 0-9) and 2 (range 0-14) in B. The majority of the pts had at least one comorbidity in both groups: (A: 72% and B: 83%). None of the pts had pulmonary comorbidity in A and 6% in B. Obesity was similarly distributed (A 11%, B 14%). The mean of monthly scheduled accesses was 1.5 in both groups. However, teleconsultation and delivery of oral cancer treatments at home were given, at least on one occasion, to only 6% of pts in A compared to 43% in B (p < 0.001). A total of 15 COVID-19 cases were observed (33%): B (22%) in A and 7% (8%) in B. No statistically significant difference was observed (p = 0.068).

Conclusions: Pts enrolled in early phase clinical trials had a significantly lower chance to perform teleconsultations compared to pts receiving standard therapy. Even if a trend was observed, they did not have a higher risk of contracting COVID-19.

1582P Thromboembolic disease in COVID-19 cancer patients: Impact on overall survival and prognostic factors

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Background: An increased risk of thromboembolic events (TE) is associated with COVID-19 infection. However, information available about thrombosis risk in COVID-19 cancer patients (Ca-P) is still scarce.

Methods: We retrospectively evaluated 219 Ca-P who were diagnosed of COVID-19 infection in our institution during the first pandemic wave. The study population was monitored for 12 months, and TE were recorded. A descriptive analysis of baseline and follow-up clinical characteristics was performed. Potential prognostic factors for developing TE and overall survival (OS) were analysed using logistic and cox proportional regression models.

Results: Overall TE rate was 13%. TE were reported during COVID-19 hospitalization (52%) and during follow-up (48%), the median time from COVID-19 diagnosis to TE was 12 weeks (w). Reported TE included pulmonary embolism (68%), deep vein thrombosis (16%), and other arterial thrombosis (16%). Pooled mortality rate among patients with TE was 52%, and 41% among patients without TE. Univariate analysis revealed haemoglobin < 10g/dl, D-dimer > 3000 ng/mL, CRP > 5 ng/mL, LDH > 190 U/L and ferritin > 296 ng/mL during follow-up as significant prognostic factors for TE. Cox regression analysis > 296 ng/mL remained significant after multivariable analysis. Neither being on any specific oncological treatment nor prior anticoagulant therapy influ-
enced TE risk. No differences in OS were found between patients who developed TE and those who did not. Though, diagnosis of TE during COVID-19 hospitalization conferred poorer survival (12 vs 52 w, p = 0.02). Also, being hospitalized for COVID-19 infection was a prognostic factor for worse survival (27 vs 52 w, p = 0.03). On multivariate analysis, only acute respiratory distress syndrome, metastatic disease, poor performance status, and history of TE before COVID-19 diagnosis remained significant predictors for poorer survival, and thrombophrophylaxis during COVID-19 hospitalization as a predictor for better survival outcomes.

Conclusions: TE in COVID-19 Ca-P can lead to fatal outcomes. Thrombotic risk may persist after acute infection; therefore, routine active surveillance should be consid-
ered. Larger studies are needed for developing a risk prediction tool for TE in COVID-19 Ca-P.

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