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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Results: Of the 11,945 incident cancers, 4.8% were diagnosed with CVD, 7.1% with T2D and 1.3% were diagnosed with both CVD and T2D. When we excluded screenable cancer sites from our sample, we observed that individuals with T2D more likely to be diagnosed with metastatic cancer at diagnosis compared to individuals with neither T2D nor CVD (OR 1.26, 95% CI 1.04–1.55).

Conclusions: These findings suggest an increased risk of advanced tumour stage at diagnosis, particularly for non-screenable cancers, among individuals with pre-existing T2D. The results underline the importance of encouraging participation of the eligible population in screening programmes by healthcare professionals and pay special attention to individuals with pre-existing cardiometabolic diseases.

Table 1: Association of pre-existing cardiometabolic comorbidities and cancer stage at diagnosis

| Comorbidities | No CM | screened cancers | Breast cancer (N = 2823) | No CM | Non-screened cancers (N = 7400) |
|---------------|-------|------------------|--------------------------|-------|-------------------------------|
| CVD           | 45    | 793              | 806                      | 793   | 565                           |
| T2D & CVD     | 34    | 243              | 65                       | 243   |                              |
| Colorectal cancer (N = 1722) | 1     | 1824             | 806                      | 1824  | 806                           |

No conflict of interest.

Follow up

30 (PB-033) Poster Oncophone20 study: Patients’ perception of telemedicine in the COVID-19 pandemic during follow-up visits for gynecological and breast cancers

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Objective: To analyze oncological patients’ perception of telemedicine during COVID-19 pandemic

Methods: A total of 345 women, of whom 267 experienced breast cancer and 78 experienced a gynecological cancer, were enrolled. Specific questionnaires about their experiences and feelings about telemedicine in the COVID-19 era were collected.

Results: In the breast group, “enhanced care” showed moderate positive perception (mean 4.40) among less-educated women that was slightly lower among better-educated women (mean 4.14) with a significant difference (P = 0.034); “satisfaction” had an opposite pattern: a mean of 3.99 for a lower level of education and 4.16 for a higher level of education, with a strong significant difference (P < 0.001); “privacy and discomfort” approached neutrality for less-educated women, while for higher-educated women the lower mean of 2.93 indicted a more positive perception (P = 0.007). In the pelvic group, younger women had a better perception towards telemedicine for “telemedicine as a substitution” (mean 3.68) compared to older women (mean 3.05). The privacy and discomfort subscale was in favor of better-educated women (mean 2.57) compared to less-educated women (mean 3.28, P = 0.042).

Conclusion: Telemedicine was generally well accepted, not only among younger and higher-educated women but also by women needing intensive care, in both cancer groups.

No conflict of interest.

31 (PB-031) Poster Routine and interval detection of locoregional breast cancer recurrences and risk of subsequent distant metastasis: a population-based study

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Background: The benefits of routine visits, i.e. planned surveillance visits, remain debatable for breast cancer survivors. Therefore, the current study aimed to compare the severity of the locoregional recurrence (LRR) and regional recurrences (RR) and the subsequent risk of a distant metastasis (DM) between LRRs detected at routine and intervals.

Methods: Women diagnosed with early breast cancer (T1-3NanyMO) between 2003 and 2008 in one of the 15 participating hospitals, and who developed a LRR as first event after primary treatment, were selected from the Netherlands Cancer Registry (n = 222, cohort A). Chi-squared tests were used to compare the severity of routine- and interval-detected local recurrences (LR) and regional recurrences (RR). Data on the development of subsequent recurrences after a first LRR was available for a subset of patients (n = 127, cohort B). Cohort B was used to calculate cause-specific hazard ratios (HR) and 95% confidence intervals (CI), estimating the association between way of LRR detection and risk of a subsequent DM. Cause-specific HRs take the development of competing events (i.e. death, second primary cancer, or second LRR) into account. Patients were censored at the development of a competing event or at the date of last observation. The analysis was adjusted for size, grade, number of positive lymph nodes and type of surgery of the primary tumor, and grade and number of positive lymph nodes of the LRR.

Results: A total of 109 patients had a routine-detected LRR (49.1%) and 113 patients had an interval-detected LRR (50.9%). Interval-detected LRs were more often smaller than routine-detected LRs, although not significant (P = 0.06). Tumor grade did not differ between interval-detected LRs and routine-detected LRs (P = 0.84). Tumor grade and number of positive lymph nodes did not differ between interval-detected RRs and routine-detected RRs (P = 0.32, P = 0.67, respectively). In cohort B, median time between diagnosis of the primary tumor and diagnosis of the LRR was 3.8 years (IQR: 2.1–6.3) for routine-LRR patients and 3.3 years (IQR: 2.3–6.0) for interval-LRR patients. Median time from diagnosis of the LRR to a DM, competing event, or last observation was 2.8 years (IQR: 1.2–5.4) for routine-LRR patients and 2.9 years (IQR: 0.9–5.8) for interval-LRR patients. After adjustment, way of detection of the LRR was not associated with the risk of developing a subsequent DM (HR: 1.22; 95% CI: 0.49–3.08).

Conclusions: We found no association between way of detection of the LRR and severity of the LRR or the risk of a subsequent DM. It could therefore be suggested to reduce the number of follow-up visits. However, reduction in the number of surveillance visits should always be done in shared decision with the patient and should be accompanied by self-examination instructions.

No conflict of interest.