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patients preferred a face-to-face consultation, 39% said that they would like to use a face-to-face consultation, while 36% preferred a remote consultation. 30% preferred a hybrid approach. 25% said they would not participate in any consultation. Only 16% preferred a purely remote approach. The majority of patients (72%) would like to have a consultation with a medical or clinical oncologist and 58% worked in public hospitals. Only 213 (23%) were able to join the survey. The majority of patients (65%) had a good knowledge of COVID-19 prevention and transmission. 66% of patients reported listening to the news about COVID-19 at least once a day, and 71% reported following guidelines from the World Health Organization. However, 25% of patients reported feeling anxious about the disease, and 15% felt they were at risk of contracting the virus. The majority of patients (72%) felt that their overall health had improved since the beginning of the pandemic, while 28% felt that their overall health had worsened. The majority of patients (70%) reported feeling happy or satisfied with their current situation, while 30% felt stressed or anxious. Additionally, 75% reported feeling safe in their home environment, while 25% felt unsafe. Finally, 70% of patients reported feeling supported by their healthcare providers, while 30% felt unsupported.

Conclusions: The results of this study highlight the importance of patient preferences and the need for a personalized approach to healthcare during the COVID-19 pandemic. Patient preferences should be considered when designing healthcare services, and healthcare providers should be aware of the emotional and psychological impact of the pandemic on their patients. The results also indicate the need for ongoing support and education for patients, as well as the importance of mental health and well-being in the context of the pandemic.

Disclosure: All authors have declared no conflicts of interest.

https://doi.org/10.1016/j.annonc.2020.08.1752

The appropriateness of invasive ventilation in COVID-19 positive cancer patients: The hardest decision for oncologists

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Background: Over the last two months we have frequently been contacted to estimate the prognosis of cancer patients (pts) affected by COVID-19 infection. Until now, there have been no clear markers to guide decision making regarding the appropriateness of invasive ventilation (IV) in COVID-19 cancer pts. Therefore, we developed a practical tool which encompassed the UICC TNM staging system, the ECOG PS, and the WHO performance status. We also included the SOFA score and the d-dimer values, previously described as the need for O2 supplementation (PS 1/50). All patients included in the analysis were referred to our hospital from March 1st to April 15th 2020.

Methods: A cross-sectional study was conducted using a validated questionnaire disseminated to oncologists by SurveyMonkey©. The tool had 42 questions that encompassed sociodemographic characteristics, medical history, treatment history, current disease status, and the presence of comorbidities. The tool also included a prognostic score in order to identify patients who may benefit from IV and those who may not benefit. The prognostic score was calculated using the following formula: PS = (1.157 × age) + (0.7) + (0.55 × BMI) + (0.52 × ECOG PS) + (0.75 × d-dimer values) + (0.5 × SOFA score).

Results: Among 381 cancer pts diagnosed with SARS-CoV-2, 21 pts were excluded from the analysis due to insufficient data. The remaining 360 pts were included in the analysis. The majority of pts were male (61%) with a median age of 75.5 years old. Most frequent underlying cancers were solid tumors (92%) including GI (19%), lung (17%), GYN (14%) and head and neck (14%). Most OP (36%) were ECOG Performance status 2 versus 24% in younger patients (YP). The diagnosis of SARS-CoV-2 infection was made by RT-PCR or thoracic CT scan in all pts and the diagnosis was confirmed by negative test in all pts.

Conclusions: The results of this study indicate the importance of considering the patient's overall medical condition, treatment status, and comorbidities when deciding whether to provide IV. The tool developed in this study provides a practical approach to determine the appropriateness of IV in COVID-19 cancer pts. The tool can be used to help oncologists make informed decisions and improve patient outcomes. However, further validation studies are needed to confirm the effectiveness of the tool in a larger population.
Results: We identified three different groups. We recommend that pts with a low risk score should be offered IV if necessary, while high-risk pts are best managed with best supportive care. Pts in the intermediate-risk group deserve a case-by-case discussion to derive a decision (Table).

### Table: 1689P The Milano Policlinico ONCOCID-ICI score

| Variables Score Categories of risk for pts | Score | Categories of risk for pts |
|-------------------------------------------|-------|----------------------------|
| Linked to pts F M = 1 | Score < 4: Low Risk | IGV admission and IV. |
| Age < 70 = 0 | Score 4 - 6: Intermediate Risk | Case-by-case |
| < 30 = 3 | Score > 7: High Risk Palliative care. |
| Comorbidities NO = 0 YES = 1 YES | 1 | ≥ 2 |

#### Oncological

- Treatment intent Curative = 0 Palliative = 1
- Life expectancy ≤ 6 mo = 0 > 6 mo = 1
- Pts on treatment NO = 0 YES = 1

#### Clinical + lab values

- SOFA score 2-7 = 0 ≥ 8 = 1
- D-dimer < 1 μg/mL = 0 ≥ 1 μg/mL = 1

Legend: BMI: body-mass index; F: female; HO2: fraction of inspired oxygen; IV: invasive ventilation; M: male; mo: months; PaO2: partial pressure of oxygen; Pts: patients.

Conclusions: A considerable proportion of oncology pts may experience clinical deterioration due to the worsening course of the infection. These cases require a comprehensive evaluation before considering ICU admission and IV. The division between groups is arbitrary and the score needs further validation. Therefore, we plan to assess the clinical history of all cancer pts admitted to Milano Hospital Maggiore Policlinico’s ICU and retrospectively apply the score to this cohort. [1] Ferreira FL et al. JAMA 2001; 286:1754-8.

Legal entity responsible for the study: The authors.

Funding: Financed by Italian fiscal contribution “5x1000” 2016 devolved to Fondazione IRCCS Ca’ Granda Ospedale Maggiore Policlinico.

Disclosure: All authors have declared no conflicts of interest.

https://doi.org/10.1016/j.annonc.2020.08.1753

1690P Development of a model to predict hospital admission and severe outcome in cancer patients with COVID-19

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Background: Patients (pts) with cancer are at increased risk of severe COVID-19 infection and death. Due to the heterogeneity of manifestations of COVID-19, accurate assessment of patients presenting to hospital is crucial. Early identification of pts who are likely to deteriorate allows timely discussions regarding escalation of care. It is equally important to identify pts who could be safely managed at home. To aid clinical decision making, we developed a model to determine which pts should be admitted vs. discharged at presentation to hospital.

Methods: Consecutive pts with solid or haematological malignancies presenting with symptoms who tested positive for SARS-CoV-2 at 10 UK hospitals from March-May 2020 were identified following institutional board approval. Clinical and laboratory data were extracted from pt records. Clinical outcome measures were discharge within 24 hours, requirement for oxygen at any stage during admission and death. The associations between clinical features and outcomes were examined using ANOVA or Chi-squared tests. A logistic model was developed using clinical features with p < 0.05 to predict patients who need hospital admission.

Results: 52 pts were included (27 male, 25 female; median age 63). 80.5% pts had solid cancers, 19.5% haematological. Association analysis indicated that smoking status, prior cancer therapy and comorbidities had no significant association with outcomes. A number of other factors presented in the table had significant associations. A multivariate logistic regression model was generated to predict need for admission to hospital. Of note, age and male sex lost significance in the multivariate model (p > 0.8). Using haematological cancer, NEWS2 score, dyspnoea, CRP and albumin, the model predicted requirement for admission with an area under the curve of 0.88.

### Table: 1690P Patient characteristics and association with outcomes

| Association with admission | Association with oxygen | Association with death |
|---------------------------|-------------------------|------------------------|
| p value                  | p value                  | p value                |
| Age                       | 0.054                   | 0.0346                 | 0.057               |
| Male sex                  | 1                       | 0.52                   | 0.051               |
| World Health Organisation | 0.012                   | 1.30E-06               | 1.30E-06            |
| COVID-19 severity score   | 0.142                   | 0.8655                 | 0.036               |
| Underlying haematological | 0.1                     | 0.0003                 | 0.1                 |
| cancer                    |                         | 0.0131                 | 0.191               |
| Dyspnoea                  | 0.022                   | 0.00024                | 0.069               |
| C-Reactive Protein (CRP)  | 0.492                   | 0.0099                 | 0.04                |
| Albumin                   | 0.205                   | 0.0097                 | 0.041               |
| Lactate dehydrogenase (LDH)| 0.0067                 | 0.0000121              | 0.051               |

Conclusions: We have developed a model to predict which pts require hospital admission. Further refinement and validation in larger cohorts of pts will be presented.

Legal entity responsible for the study: The Christie NHS Foundation Trust.

Funding: Has not received any funding.

Disclosure: R. Lee: Honoraria (self); Bristol Myers Squibb; Honoraria (self): Astra Zeneca; Research grant (funding): Bristol Myers Squibb. M.P. Rowe: Travel/Compensation/Expenses: Astellas Pharma. L. Horsley: Travel/Compensation/Expenses: Lilly C. Wilson: Honoraria (self); Advisory/Consultancy, Speaker Bureau/Expert testimony: Pfizer; Angen; Novartis. T. Cooksley: Speaker Bureau/Expert testimony: Bristol Myers Squibb; A. Armstrong: Shareholder/Stockholder/ Stock options, husband had shares now sold: Astra Zeneca. All other authors have declared no conflicts of interest.

https://doi.org/10.1016/j.annonc.2020.08.1754

1691P Evaluation of practice variation for cancer patients care in a French cancer center during the COVID-19 outbreak

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Background: The COVID-19 pandemic rapidly spread in Europe and France. Cancer patients were identified at higher risk of infection and evolution to severe forms, especially those undergoing active treatment. Academic and experts’ recommendations proposed to protect cancer units and prioritize cancer treatment. In the same time, French authorities implemented a national lockdown from march 16, 2020. Most anti-cancer institutions have modified their organization, trying to combine cancer units COVID-free sanitization, continuity in priority care and precautionary principle. The impact of COVID-19 outbreak on global cancer care has not been formally evaluated.

Methods: Data of oncological practice at the Antoine Lacassagne Center (mild-COVID-19 incidence rate area) were recorded (per week) for 3 periods, based on the timing of french lockdown: before (Jan-1 to Mar-15), during (Mar-16 to May-10) and after the end of lockdown (May-11 to Jul-12). We collected the number of chemotherapy and radiotherapy sessions, surgery procedures (selenology and gynecology), blood products transfusions, on-site / telemedicine visits and inclusions in clinical trials.

Results: Preliminary results compare period 1 (Jan-1 to Mar-15) to interim period 2 (Mar-16 to Apr-19, available data at the time of submission). Variation of practice is detailed in the table. Activities were negatively impacted by the lockdown, mostly