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SHORT ORALS

SO-1 The impact of COVID-19 on daily practice patterns in the third-line setting for patients with metastatic colorectal cancer: Results of a real-world survey

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Background: The emergence of the COVID-19 virus in 2020 led to unprecedented challenges in the way oncologic care is organized and performed. The scope of COVID-19 pandemic on daily practice patterns in patients with metastatic colorectal cancer (mCRC) remains to be defined. We report the results of a survey conducted in the European Union and in 14 countries in Latin America.

Methods: An expert panel of gastrointestinal oncologists developed the survey, which was undertaken between October 2020—January 2021. Questions were designed to evaluate the practice patterns during this time and assess the future impact of COVID-19 on treatment decisions. The survey was conducted online using FocusVision Decipher. Oncologists from 14 countries, the majority of which were in Europe, participated.

Results: As of 31 January 2021, there were 228 respondents. The majority were medical oncologists (89%), aged between 35—55 years (62%), practiced in a university hospital (49%), and saw between 10—29 patients with mCRC/month (53%). Overall, few restrictions affecting cancer patient management, such as staff being redeployed, were reported by the majority of oncologists (84%). That said, there were a number of changes to practice patterns: the most frequent were a reduction in the number of hospital visits (83%), increased use of virtual consultations/telemedicine (82%), increased frequency of prescribing oral versus intravenous (IV) treatments (73%), and an increase in follow-up/monitoring procedures done closer to home (73%). The third-line treatment goals remained similar to the pre-COVID era; preserving quality of life remained the singular most common primary goal (36%), while 42% of respondents cited efficacy-focused goals, such as prolonging overall survival and improving progression-free survival as their main aim. Overall, 93% of oncologists opined that treatment decisions over the next 12 months would be influenced by the pandemic. While 86% predicted a return to normal for the initial visits for new patients, 84% believed for ongoing patients, 83% foresaw that there will be a continued increase in the use of virtual consultations/telemedicine, 80% envisioned reduced frequency of hospital visits, and 74% foresee the increased frequency of prescribing oral versus IV treatments to be maintained, as well as follow-up being undertaken closer to home. In total, 40% of oncologists believe that the changes to existing protocols, incurred as a result of the pandemic, will be in effect for at least a year.

Conclusions: The main third-line treatment goals for patients with mCRC remained the same during the COVID-19 pandemic. However, there were changes to the daily practice patterns. There was an increased use of oral versus IV therapies, and more follow-up and monitoring procedures were undertaken closer to home. Patients visited hospitals less frequently, with a shift toward virtual consultations/telemedicine, practices that are thought to continue for the foreseeable future. The latter observation suggests there is a need to further develop and invest in all aspects of digital health.

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SO-2 Pancreatic cancer in HIV versus non-HIV population: Analysis of demographics, outcomes and healthcare utilization from a national sample

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Background: Pancreatic cancer (PC) is a highly fatal cancer with a dismal 5-year overall survival. With the advent of combined antiretroviral therapy, the lifespan of HIV patients has substantially improved and the incidence of non-AIDS-defining cancer is rising. PC remains rare in HIV and there is very little data about outcomes of PC in HIV versus non-HIV patients. We attempted to evaluate characteristics and outcomes, including healthcare utilization (HCU), in patients with HIV-PC compared to non-HIV-PC using a national sample.

Methods: United States Health Care Cost and Utilization Project's National Inpatient Sample (HCUP-NIS) (>7 million discharges/year) was queried to identify HIV- and non-HIV-PC admissions between 2016-2018. We studied socio-demographic differences, medical comorbidities, mortality, length of stay (LOS), total hospital charges (THC). Secondary outcomes included sepsis, septic shock, neutropenia, anemia and malnutrition. Statistics were performed using the t-test, univariate and multinomial logistic regression.

Results: A total of 775 HIV-PC admissions and 317,415 non-HIV-PC admissions were identified. HIV-PC comprised 0.24% of all PC admissions. HIV-PC patients were significantly younger (mean age 59.9 vs 68.1, p<0.001) compared to non-HIV-PC. Proportion of patients over 65 years old was only 29.7% in HIV-PC group compared to 63.3% in non-HIV-PC group. HIV-PC patients were more likely to be men (71% vs 52%, p<0.0001), Black (52% vs 14%, p<0.0001), and less likely Caucasian (34% vs 71%, p<0.0001) compared to non-HIV-PC. HIV-PC were more likely to be treated at an urban teaching hospital (84.5% vs 76%, p=0.047) compared to non-HIV-PC but there were no differences in treating hospital bed size or zip-codes divided by income levels where patients hailed from. HIV-PC patients were less likely to be on private insurance and more likely to be on governmental sponsored insurance (p<0.001). The groups had similar rates of medical comorbidities including diabetes, CAD, COPD, heart failure, obesity and smoking. The HIV-PC group had significantly higher rates of chronic kidney disease (19% vs 12%, p=0.012) and dialysis (4.5% vs 0.86%, p<0.001) while non-HIV-PC showed higher rates of dyslipidemia (36% vs 25%, p=0.01) and hypertension (68% vs 39%, p=0.045). HIV-PC patients were also more likely to be malnourished (42% vs 34%, p=0.04) compared to non-HIV group. Rates of anemia, neutropenia, thrombocytopenia and sepsis were similar between groups.

The mean LOS was higher in HIV-PC group (7.5 vs 6.1 days, p=0.001) while most medical comorbidities were not significant when adjusted for patient demographics, hospital demographics and medical comorbidities. Adjusted mortality was lower in HIV-PC while most medical comorbidities, secondary outcomes and adjusted healthcare utilization was not significantly different between HIV and non-HIV groups with PC. HIV-positive status does not add significantly to the medical burden in patients with pancreatic cancer.

Conclusions: Pancreatic cancer occurred at a significantly younger age in HIV-PC patients compared to non-HIV-PC patients. Racial disparity followed the same trend as general HIV-infection. Adjusted mortality was lower in HIV-PC while most medical comorbidities, secondary outcomes and adjusted healthcare utilization was not significantly different between HIV and non-HIV groups with PC. HIV-positive status does not add significantly to the medical burden in patients with pancreatic cancer.

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