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First results of the COCO study: COVID-19 outcomes in patients with cancer

E. Segui1, M. García de Herreros1, E. Aucin1, O. Mirallas1, D. Casadellà1, M. Rodríguez1, N. Epallard1, M. Tagliamento1, S. Pilotto1, R. López-Castro2, X. Mielgo3, C. Urbano4, D. Pesante5, N. Saoudi4, M.V. Bluthgen1, L. Masfarre6, J.N. Minatta7, C.A. Cruz7, L. Mezquita7, A. Prat1

1Medical Oncology, Hospital Clínic de Barcelona, Barcelona, Spain; 2Medical Oncology, Hospital Europeen George Pompidou, AP-HP, Paris France; 3Medical Oncology, Vall d’Hebron University Hospital and Institute of Oncology VHIO, Barcelona, Spain; 4Medical Oncology, Hospital del Mar, Barcelona, Spain; 5Medical Oncology, Parc Taulí Hospital Universitari, Sabadell, Spain; 6Medical Oncology, University of Genova and IRCCS Ospedale Marassi, Genova, Italy; 7Medical Oncology, University of Verona and Verona University Hospital Trust, Verona, Italy; 8Medical Oncology, Hospital Clínico Universitario de Valladolid, Valladolid, Spain; 9Medical Oncology, Hospital Universitario Fundación Alcorcón, Alcorcón, Spain; 10Medical Oncology, Hospital General Universitario de Alicante, Alicante, Spain; 11Medical Oncology, Hospital Alemán Buenos Aires, Argentina; 12Medical Oncology, Hospital Italiano de Buenos Aires, Buenos Aires, Argentina

Background: COVID-19 pandemic has drastically changed the management of patients with cancer; however, limited data exists regarding which pre-conditions affect the course of COVID-19 infection. Here, we sought to assess the clinical features and outcomes of COVID-19 infection in a large cohort of patients with cancer.

Methods: We conducted a multicenter retrospective cohort study of patients with cancer diagnosed with SARS-CoV-2 infection by RT-PCR/Aq detection (n=274) or CT scan (n=13) between 7 March and 30 April across 12 international centers. Clinical, pathological and biological data were collected. Primary endpoints were 30-day mortality rate and the rate of severe acute respiratory failure (SARF), defined by oxygen requirements >15 L/min. Descriptive statistics were used.

Results: 287 patients were enrolled with a median follow-up of 23 days [95%CI 22-26]. 148 (54.4%) were female, 52% were male, 49% had hypertension and 23% had cardiovascular disease. As per cancer characteristics, 68% had active disease, 52% advanced stage and 79% had a baseline ECOG PS ≤1. Most frequent cancer types were: 26% thoracic, 21% gastrointestinal, 19% breast and 15% genitourinary. Most patients (61%) were under systemic therapy, including chemotherapy (51%), endocrine therapy (23%) and immunotherapy (19%). At COVID-19 diagnosis, 44% of patients had moderate/severe symptoms such as fever (70%), cough (54%) and dyspnea (48%). The majority of patients (90%) required in-patient management and the median duration of hospitalization was 10 days (IQR 6-14). 8% of patients received intermediate or intensive care unit admission. Patients received treatment with: hydroxychloroquine (81%), azithromycin (61%), antiviral therapy (38%) and immunomodulatory drugs (14%). Finally, the overall mortality rate was 27% and the rate of SARF was 26%. In patients admitted to intermediate/intensive care units, the mortality and SARF rates were 45% and 73%, respectively. Mortality rate according to ECOG PS before COVID-19 was 20% in PS≤1 and 51% in PS>2 (p<0.0001).

Conclusions: Patients with cancer are a susceptible population with a high likelihood of severe complications and high mortality from COVID-19 infection. Final results and treatment outcomes will be presented at the ESMO Congress.

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SARS-CoV-2 infection and lung cancer management in Europe

A. Agbarya1, A. Addeo2, A. Charpidou3, A. Araújo4, K. Cuppens5, O.T. Brustugun6, M. Rajer7, M. Jakopovic8, M.V. Marinca9, A. Pluzanski10

1Oncoaly, Bnai Zion Medical Center, Haifa, Israel; 2Medical Oncology, Geneva University Hospital, Geneva, Switzerland; 33rd Dept of Internal Medicine, National and Kapodistrian University of Athens, Greece; 4Department of Medical Oncology, Centro Hospitalar Universitário do Porto, Do Porto, Portugal; 5Dept. of Pulmonology and Thoracic Oncology, Jessa Hospital, Hasselt, Hasselt, Belgium; 6Vestre Viken Hals- pital Trust, Drammen Hospital, Drammen, Norway; 7Oncology, Institute of Oncology, Ljubljana, Slovenia; 8Clinical Center for Pulmonary Diseases Jordanovac, University Hospital Centre Zagreb, Zagreb, Croatia; 9Medical Oncology (IRO Isiz), Grigore T. Popa University of Medicine and Pharmacy, Iasi, Romania; 10Oncoaly, The Maria Skłodowska Curie Cancer Management Centre and Institute of Oncology (MMC-C), Warsaw, Poland

Background: Patients (pts) with lung cancer (LC) are at high risk for hospitalization and mortality from COVID-19. Patients and physicians don’t feel safe to continue LC diagnosis and treatments. Modifications of LC management varied between countries. ESMO guidelines in the COVID-19 era were published promptly, during the COVID-19 epidemic in Europe aiming to guide all stakeholders in lung cancer.

Methods: A virtual meeting among LC experts from Belgium, Switzerland, Portugal, Slovakia, Croatia, Poland, Romania, Greece and Israel was held on April 27 to discuss the impact of the COVID-19 pandemic on the lung cancer care in each country. A questionnaire was based on this virtual meeting and was filled by 15 experts. Results of the questionnaire were collected and analyzed.

Results: All countries are in the community level SARS-CoV2 transmission. In 3 countries health care services exceeded their capacities. Four countries have implemented the ESMO guidelines without any modification (Switzerland, Norway, Israel and Croatia). High Level of recommendations in the outpatient and inpatient services were implemented in all countries with minor modifications. Intermediate level recommendations were implemented in 9 of 10 countries. Low priority level was implemented in 7 of 10 countries. Main modifications were: surgery for stage I NSCLC and LC: all non-curative surgical interventions postponed, differences in imaging priorities. In 5 of 10 countries local oncology societies issued recommendations mainly consistent with ESMO but medical oncologists also follow recommendations issued by the health ministry.

Conclusions: ESMO guidelines prioritizing LC management are implemented in all participating countries. High and intermediate level recommendations are implemented with minor modification regardless the phase of the pandemic. The differences among countries are not related to the phase of pandemic but mostly to the health system capacity and socioeconomic factors in each country.

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