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

**Oncological**
- Treatment
- Life expectancy
- Pts on treatment
- Clinical + lab values

| Variable | Score | Categories of risk for pts |
|----------|-------|---------------------------|
| SOFA score | 2-7: 0 > 8: 1 | 15 |
| Number of symptoms | 0.022 | 10 |
| C-Reactive Protein (CRP) | 0.09 | 9 |
| Albumin | 0.025 | 0.097 |
| Lactate dehydrogenase (LDH) | 0.0067 | 0.000121 |

Legend: BMI: body-mass index; F: female; FiO2: 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.

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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** |
| Age | 0.054 | 0.0346 | 0.057 |
| Male sex | 1.05 | 0.52 | 0.051 |
| World Health Organisation COVID-19 severity score | 0.012 | 1.30E-06 | 1.30E-06 |
| Underlying haematological cancer | 0.142 | 0.8655 | 0.036 |
| Dyspnoea | 0.1 | 0.0003 | 0.1 |
| Number of symptoms | 0.492 | 0.0131 | 0.191 |
| C-Reactive Protein (CRP) | 0.022 | 0.00024 | 0.069 |
| Albumin | 0.009 | 0.04 | 0.773 |
| Lactate dehydrogenase (LDH) | 0.205 | 0.0097 | 0.041 |
| National early warning score (NEWS2) | 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.

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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 sanctuarization, 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 (senology 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...
Background: During the SARS-CoV-2 pandemic, cancer patients (pts) who are infected may develop severe disease if their systemic treatment is not temporarily stopped. Nasopharyngeal swab was not extensively available to screen cancer pts for SARS-CoV-2 infection in northern Italy, the most area in the country most affected by the pandemic. From the beginning of the outbreak onwards, all pts admitted to the Medical Oncology Unit at Spedali Civili Hospital, Brescia, underwent a triage investigating the presence of symptoms and signs suggestive of SARS-CoV-2 infection. Triage results were used to decide which pts should continue anticancer treatments.

Methods: All consecutive cancer pts being admitted for systemic treatment from February 24th to April 21st 2020 were considered. Triage, performed by a trained nurse, consisted of questions regarding the presence of fever, cough, dyspnea, anosmia, dysgeusia, headache, nasal congestion, conjunctival congestion, sore throat, diarrhea, nausea and vomiting, measurement of body temperature and pulse oximetry. All enrolled pts were followed-up for overt SARS-CoV-2 development until May 18th.

Results: Overall, 1180 pts were included, 54% female and median age 65 years. Most represented primary malignancies were breast (32%), gastroenteric (18%) and lung (16.5%). Thirty-one (2.5%) presented with clinically evident SARS-CoV-2 disease and infection was proven by positive nasopharyngeal swab and/or radiological imaging. The triage identified 69 (6%) “grey zone” pts, with suspicious symptoms (i.e. fever 41%, cough 30%, dyspnea 19%). The nasopharyngeal swab was negative in 48% of them and was not performed in the remaining 52% of pts, as well as in all pts who were triage negative. Both SARS-CoV-2 positive and “grey zone” pts did not receive systemic treatment and were addressed to hospitalisation or home quarantine. All the 1080 pts (91.5%) who resulted negative at triage continued their anticancer therapy as scheduled, none of them presenting symptoms of SARS-CoV-2 infection during the follow-up.

Conclusions: Accurate triage allowed safe continuation of anticancer treatment in 91.5% of pts during the SARS-CoV-2 outbreak.

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