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.

Elsevier hereby grants permission to make all its COVID-19-related research that is available on the COVID-19 resource centre - including this research content - immediately available in PubMed Central and other publicly funded repositories, such as the WHO COVID database with rights for unrestricted research re-use and analyses in any form or by any means with acknowledgement of the original source. These permissions are granted for free by Elsevier for as long as the COVID-19 resource centre remains active.
Results: A total of 337 pts with solid tumors treated with anti-PD1/PDL1 antibody regardless the line of treatment was identified. Cancer diagnosis included 156 (46.3%) lung, 74 (22%) melanoma, 36 (10.7%) kidney, 23 (7%) colorectal, 12 (3.4%) head and neck, 36 (10.6%) miscellaneous. Only 3 pts (0.9%), with advanced disease and in first line therapy were hospitalized for COVID-19 (Table). The onset symptom was fever in 2 pts, and subjective dyspnea in 1 pt. Subsequently, they develop respiratory distress and underwent to non-invasive assisted ventilation, receiving hydroxychloroquine, steroids, low molecular weight heparin. Tocilizumab was administered in 1 pt due to progressive increase of serum IL-6 values. Nobody was admitted in Intensive Care Unit. Since the last update, May 15th 2020, 1 pt died; the others have recovered with negative nasopharyngeal swab.

Conclusions: Although not conclusive, in our series, cancer pts infected by COVID-19 receiving immunotherapy do not appear to be exposed to greater risk of recovery.

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Table: 1748P Demographics

| Total n (%) | N = 27 | Died n (%) | N = 5 |
|------------|-------|------------|-------|
| Age        |       |            |       |
| Median (years) | 71    | 73         |       |
| Sex        |       |            |       |
| Male       | 16 (59) | 4 (80)     |       |
| Female     | 11 (41) | 1 (20)     |       |
| Ethnicity  |       |            |       |
| White      | 23 (85) | 4 (80)     |       |
| Other      | 4 (15)  | 1 (20)     |       |
| Smoking    |       |            |       |
| Never      | 6 (22)  | 0          |       |
| Ex/current | 21 (78) | 5 (100)    |       |
| ECOG       |       |            |       |
| 0-2        | 27 (100)| 5 (100)    |       |
| Comorbidities |      |            |       |
| COPD       | 9 (33)  | 2 (40)     |       |
| Cardiac    | 4 (15)  | 2 (40)     |       |
| Diabetes   | 3 (11)  | 0          |       |
| Medication |       |            |       |
| Steroids   | 4 (15)  | 1 (20)     |       |
| Cancer type|       |            |       |
| NSCLC      | 22 (81) | 3 (60)     |       |
| SCLC       | 1 (4)   | 0          |       |
| Mesothelioma| 2 (7)  | 1 (20)     |       |
| Thymoma/Thymic | 2 (7) | 1 (20) |       |
| Current stage|     |            |       |
| 1-2        | 3 (11)  | 1 (20)     |       |
| 3-4        | 24 (89) | 4 (80)     |       |
| Current treatment |    |            |       |
| None       | 8 (30)  | 2 (40)     |       |
| Immunotherapy| 2 (7) | 0          |       |
| Chemotherapy| 4 (15) | 2 (40)     |       |
| Chemoimmunotherapy | 7 (26) | 1 (20) |       |
| TRI        | 5 (18)  | 0          |       |
| Radiation  | 1 (4)   | 0          |       |

Conclusions: Despite UK patient shielding and risk-minimizing therapy modifications, the immediate morbidity from COVID-19 remains high in thoracic cancer pts. Rates of hospitalisation and treatment interruption were high. Although numbers were small, no deaths occurred in never smokers or pts on single modality therapy. Continued follow up is needed to better understand the direct and indirect impacts of COVID-19 on morbidity and subsequent mortality.

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Results: Forty three hospitalized pts were diagnosed with COVID-19; 30 pts (69.8%) done using logistic regression. Multivariant analysis (MA) has been performed using univariate and quantitative variables, respectively. COVID-19 mortality in UA. Similarly, high risk factors for developing severe events were associated with active treatment with ICI (RR 4.03, 95%CI 1.8-8.9, p=0.007) and lymphopenia (RR 4.0, 95%CI 1.1-14, p=0.007).

Conclusions: We confirmed the vulnerability of cancer patients to COVID-19. Although the sample size was small, treatment with ICI and lymphopenia seem to be risk factors for death and severe events. Screening cancer patients for infection is advisable, in particular before starting immunotherapy or in case of lymphopenia.

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1749P COVID-19 impact and predictive factors for mortality in cancer patients
E. Sanz García1, P. Peinado1, I. Moreno1, M. Dorta1, B. Alvarez1, R. Alvarez Gallego1, R. Madurga1, J. Rodríguez Pascual1, L. Ugidos1, C. Muñoz1, E. García-Rico1, A. Cubillo1
1Medical Oncology Department, Hospital Madrid Norte Sanchinarro - Centro Integral Oncologico Clara Campel, Madrid, Spain; 2Radiation Oncology Department, Hospital Madrid Norte Sanchinarro - Centro Integral Oncologico Clara Campel, Madrid, Madrid, Spain.

Background: SARS-CoV-2 is a novel coronavirus that has been responsible for the largest pandemic in the last century: COVID-19. This disease has widely affected Spain, with a high lethality in ancient patients (pts) and with comorbidities. Oncological pts were not an exception.

Methods: We evaluated the association between COVID-19 mortality and clinical/laboratory/radiological parameters in cancer pts from March to April 2020 at our institution. Past medical history and COVID-19-related parameters (symptoms, laboratory results, treatments) were retrospectively collected. Univariate analysis (UA) has been done using Fisher exact and U-Mann-Whitney test for qualitative and quantitative variables, respectively. Multivariant analysis (MA) has been done using logistic regression.

Results: Forty three hospitalized pts were diagnosed with COVID-19; 30 pts (69.8%) were symptomatic on admission and 13 pts (30.2%) were hospital-acquired cases. Median age was 68 ± 7.8 years. Most part of the pts had gastrointestinal (GI) (13, 30.2%), thoracic (Tx) (12, 27.9%) and breast (6, 14%) cancer. A higher prevalence of Tx tumours compared to our new pts prevalence is observed (9%). Fever was the most common symptom (27, 62%) and bilateral pneumonia was observed in 24 pts (55.8%). SARS-CoV-2 PCR was positive in 34 pts (79.1%). Hydroxychloroquine was administered in 35 pts (81.4%), steroids and antiretrovirals in 19 pts (44.1%) and tocilizumab in 12 pts (27.9%). Mortality rate due to COVID-19 was 30.2% (13 pts).

Conclusions: COVID-19 showed a relative higher incidence in pts with Tx and GI tumours. Some clinical and laboratory parameters were found to be predictive factors of mortality as previously reported in non-cancer pts. Further investigations with larger number of pts are needed. Legal entity responsible for the study: HM Hospitals.

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1750P Clinical course and outcome of COVID-19 in cancer patients: Early results from the "onCOVID-19" study
V. Di Noia1, M. Squadrini2, R. Barile2, A. D’Aveni2, L. Gigli2, F. Brena2, S. Dalto2, D. Di Cintio2, M.G. Sauta1, G.L. Ceresoli1, P. Salvin1, G.D. Beretta1, M. Squadroni, R. Barile, A. D’Aveni, L. Gigli, F. Brena, S. Dalto, D. Di Cintio, M.G. Sauta, G.L. Ceresoli, P. Salvin, G.D. Beretta1, M. Squadroni, R. Barile, A. D’Aveni, L. Gigli, F. Brena, S. Dalto, D. Di Cintio, M.G. Sauta, G.L. Ceresoli, P. Salvin, G.D. Beretta1
1Medical Oncology, Humanitas Gavazzeni, Bergamo, Italy.

Background: Cancer patients are considered at higher risk of SARS-CoV-2 infection and more serious COVID-19 illness compared to the general population. We present the early results of the "onCOVID-19" study exploring the clinical course and outcomes of SARS-CoV-2 infection in patients affected by cancer.

Methods: In this observational study, we collected clinical data from patients referred to our institution with histologically confirmed diagnosis of solid cancer and COVID-19 from Feb 1 to May 2020. COVID-19 diagnosis was laboratory or radiologically confirmed or clinically suspected for suggestive symptoms, including fever (>37.5°C) and/or respiratory tract symptoms. Univariate and multivariate analyses were performed to explore the risk factors associated with severe events defined as hospitalisation, admission to an intensive care unit, mechanical ventilation or death.

Results: Of the 64 patients included, 35 had available clinical data on medical and on-cotherapy variables. Cancer history was required for the analysis. Median age was 63 (47-86) years. Male were 22 (63%) and current or former smokers were 25 (76%). Lung was the most frequent site of primary tumor (15, 43%) or metastases (13, 37%). Out 26 (74%) patients on active anti-tumor treatment, 6 (23%) received immune checkpoint inhibitors (ICI). Most common symptoms were fever (40%), shortness of breath (34%) and cough (23%); lymphopenia (<1000/mm3) was found in 5/15 (33%) tested patients. The diagnosis of COVID-19 was only clinically suspected in 2 (6%) cases and confirmed by RT-PCR or imaging (ground glass opacity and/or patchy consolidation) in 11 (31%) and 6 (18%) patients, respectively. An antimicrobial treatment was administered in 19 patients. Eleven (31%) patients had severe events, death occurred in 7 (20%) cases. Higher risk for developing severe events was associated with active treatment with ICI (RR 4.03, 95%CI 1.8-8.9, p=0.007) and lymphopenia (RR 4.0, 95%CI 1.1-14, p=0.007).

Conclusions: We confirmed the vulnerability of cancer patients to COVID-19. Although the sample size was small, treatment with ICI and lymphopenia seem to be risk factors for death and severe events. Screening cancer patients for infection is advisable, in particular before starting immunotherapy or in case of lymphopenia.

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Table: 1751P

| Unscheduled hospital admissions | aLOS |
|--------------------------------|-----|
| Total                          |     |
| phase I                        |     |
| ED                             | 67  |
| Outpatient                     | 52  |
| AOS                            | 6   |
| CoV                            | 0   |
| Other                          | 2   |
| phase II                       |     |
| ED                             | 37  |
| Outpatient                     | 20  |
| AOS                            | 1   |
| CoV                            | 10  |
| Other                          | 4   |

Conclusions: A reduction in aLOS and ED admissions was paralleled by increasing use of alternative pathways. Processes which facilitate urgent assessment of oncology patients in specialized units avoid ED attendance and accelerate discharge planning in the care of cancer patients in the face of a pandemic and beyond.

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