Results: As of July 15, 2020, 1012 patients from 20 countries have been entered; median age was 68 with 56% male, 80% current/former smokers, most common comorbidities of HTN (49%) & COPD (26%); 82% NSCLC, 68% patients with stage IV disease at COVID diagnosis, 65% on treatment (38% chemotherapy, 26% immune checkpoint inhibitor (ICI), 16% targeted tyrosine kinase inhibitor (TKI)). Of these, 72% were hospitalized; 56% of patients developed complications, most frequently pneumonia (40%) and 47% who did not have prior oxygen therapy required it. 32% of patients continued their oncologic treatment. Patients presenting with pneumonitis (OR 2.7-3.5), consolidation (OR 2 CI 1.5-2.8), bilateral lung abnormalities (OR 2.8 CI 2.3-3.9) and pleural effusion (OR 2.7 CI 1.8-4) were at increased risk of mortality. In multivariate analysis age >65 (OR 1.51 CI 1.11-2.1), active smoking (OR 2 CI 1.3-3.3), higher stage of cancer (OR 1 1.3-2.7), EGOG PS >2 (OR 3.7 CI 2.5-7.6), steroids use for COVID diagnosis (OR 1.8 CI 1.2-2.7), were associated with increased risk of death, while chemotherapy and TKI therapy use were not and interestingly patients on immunotherapy appeared to be at decreased risk for mortality (OR 0.6 CI 0.5-0.97).

Conclusions: Facing this ongoing global pandemic, TERAVOLT is the largest thoracic malignancy COVID-19 mortality in this multicenter prospective study of a large patient group. Physicians need to evaluate the risk of mortality from COVID-19 based on age, smoking status, stage of cancer, performance status, need for steroids and specific therapy in order to determine the appropriate risk for cancer therapy and tailor patient care taking into account patients’ wishes and status of pandemic in the country.

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Expected medium and long term impact of the COVID-19 outbreak in oncology


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Background: The ongoing SARS-CoV-2 pandemic and ensuing coronavirus disease (COVID-19) is challenging cancer care and services worldwide.

Methods: A 95 items survey was distributed worldwide by 20 oncologists from 10 of the most affected countries in order to evaluate the impact on organization of oncological care.

Results: 109 representatives from oncology centers in 18 countries (62.4% academic hospitals) filled out the survey (June 17 – July 14, 2020). A swab or gargoyle test is systematically performed before day care unit or overnight stay admissions in 27.5% and 58.7% of the centers, respectively. A local registry (64.2%) and systematic tracing (77.1%) of patients was organized in most centers. Treatment of patients was mostly affected by the pandemic (cancellation/delay) were surgery (44.1%) and chemotherapy (25.7%). Earlier cessation of palliative treatment was observed in 32.1% of centers, and 64.2 % of participants agree that under-treatment is a major concern. During the pandemic peak, teleconsultations were performed for follow-up (94.5%), for oral therapy (92.7%), but also for patients receiving immunotherapy (57.8%) or chemotherapy (55%). Approximately 82% of participants estimate that they will continue to use telemedicine. Most participants reported more frequent use of virtual tumor boards (82%) and oncological team meetings (92%), but 45.5% thought that virtual meetings are an acceptable alternative to live international meetings. Although 60.9% report reduced clinical activity during the pandemic peak, only 28.4% had an increased scientific activity. Only 18% of participants estimate that their well-being will recover to previous levels by the end of the year; 63% would like to continue the work they do, mostly from home. 28.4% of participants would enroll in telemedicine.”

Conclusions: COVID-19 has a major impact on organization of patient care, well-being of oncologists, PANCADELs, clinical trial care and clinical trials activities in oncology.

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Anti-SARS-CoV-2 antibody response in patients with cancer and oncology healthcare workers: A multicenter, prospective study

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Background: Poor outcomes for patients with cancer and severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2)-related disease (COVID-19) have been reported so far. Although anti-SARS-CoV-2 IgG response is usually detectable within three weeks from RT-PCR-confirmed SARS-CoV-2 infection, patients with cancer or oncology healthcare workers may present delayed IgG responses.

Methods: This work was partially supported by the Italian Ministry of Health with “Piano Nazionale Sars-CoV-2. The aim of the study was to evaluate anti-SARS-CoV-2 seroconversion rates by qualitative assay in patients with cancer and HCWS with confirmed or clinically suspected COVID-19.

Results: At first interim analysis, 166 subjects were enrolled in the study. Cancer patients and HCWS were 61 (36.7%) and 105 (63.3%), respectively. IgG responses were detected in 96.7% of cancer and 93.3% of HCWS. In patients with RT-PCR-confirmed SARS-CoV-2 infection, 62 (83.8%) were IgG- positive. Neither differences in terms of IgG positivity (87.9% vs 80.5%; P=0.039) nor in median time from COVID-19 diagnosis to IgG detection (23.0 vs 28.0 days; P=0.21) were found between patients with cancer and HCWS.

Conclusions: Our data show that SARS-CoV-2-specific IgG antibody response is not different between cancer patients and healthy subjects. Qualitative rapid test for antibody detection represents an useful support to RNA RT-PCR testing for the diagnosis of COVID-19 in high-risk populations, including patients with cancer.

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