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P-40 Clinico-pathological characteristics and outcomes of patients with early-onset colorectal cancer

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Background: The rising incidence of colorectal cancer (CRC) among young patients is alarming. We aim to characterize the clinico-pathological features and outcomes of patients with early-onset CRC (EOCRC).

Methods: We included all of the patients with pathologically confirmed diagnosis of CRC at Hospital Universitario La Paz from October 2016 to September 2020. EOCRC age cut-off was 50 years. All statistical analyses were carried out using SPSS v.25.

Results: A total of 1152 patients were diagnosed with CRC, fifty-nine (5.1%) of them were After a median follow-up of 24 months, 279 patients have died. Median overall survival (OS) was not reached in either group ($p = 0,06$). Three-year OS was 80% (95% CI: 73-87) and 67 (95%CI: 65-69) in the younger and older group, respectively. In patients with localized disease that underwent surgery or other antineoplastic treatment ($n = 856$), 159 events for disease-free survival (DFS) were observed. Median DFS was not reached in either group ($p = 0,144$). Three-year DFS was 86% (95%CI: 79-93) and 73% (95%CI: 71-75, respectively). In patients with metastatic disease ($n = 332$; synchronous or metachronic), median OS was not reach in the EOCRC group vs 18,1 (95%CI: 13,8-22,4), $p = 0,05$). In those patients with metastatic EOCRC with mutational status assessed ($n = 23$), no difference in OS according to RAS was observed ($p = 0,55$).

Conclusions: Patients with EOCRC are diagnosed at a more advanced stage and display distinct biological features (more prevalence of dMMR and WT tumors among others). Studies focusing on screening in this population and deeper molecular profiling are needed.

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P-41 What to expect from best supportive care as initial approach for newly-diagnosed colorectal cancer: A single institution experience

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Background: The treatment landscape of colorectal cancer (CRC) is constantly evolving. However, antineoplastic treatment is not possible for all patients. The aim of the study is to assess the outcomes of patients with CRC managed with best supportive care (BSC) as initial treatment strategy.

Methods: We included all of the patients with pathologically confirmed diagnosis of CRC at Hospital Universitario La Paz from October 2016 to September 2020. All statistical analyses were carried out using SPSS v.25.

Results: A total of 1152 patients were diagnosed with CRC. BSC was the initial treatment of choice in 114 (10%) patients. Seventy-four percent of patients that were treated with BSC were aged 75 years or older vs 39% in the antineoplastic treatment (AT) group; $p < 0,001$. Other baseline characteristics more frequently observed among the BSC group compared to the AT group were stage IV (48% vs 17%, respectively; $p < 0,001$) and ECOG PS ≥ 2 (60% vs 6%, respectively; $p < 0,001$) at diagnosis. After a median follow-up of 24 months, 279 patients have died. Median overall survival (OS) was 4,1 months (95% Confidence Interval [CI]: 1,6 to 6,6) vs not reached in the BSC and AT groups, respectively ($p < 0,001$). Twelve-months OS rate

was 30% (95%CI: 25 to 35) and 91% (95%CI: 90 to 92%) in the BSC and AT groups, respectively. In patients with localized disease, median OS was 13,0 months (95%CI: 4,9 to 21,0) vs not reached, respectively ($p < 0,001$). Twelve-months OS rate was 51% (95%CI: 44 to 58) and 95% (95%CI: 94 to 96%) in the BSC and AT groups, respectively. In patients with metastatic disease at diagnosis, median OS was 2,1 months (95%CI: 1,3 to 2,9) vs 24 months (95%CI: 19,5 to 28,6), respectively ($p < 0,001$). Twelve-months OS rate was 8% (95%CI: 4 to 12) and 74% (95%CI: 71 to 77%) in the BSC and AT groups, respectively. In the multivariate analysis, metastatic disease at diagnosis was the only independent prognostic factor associated with survival.

Conclusions: In our cohort, 10% of patients with diagnosis of CRC were initially managed with best supportive care. Older age, ECOG PS ≥ 2 , and stage IV disease at diagnosis were more frequently observed among the BSC group. OS in these patients is poor, and 70% of them will die within the first year of diagnosis. Early referral to the palliative care unit is therefore recommended.

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P-42 Iron surveillance and management in gastrointestinal oncology patients: A national survey of physician practice

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Background: In 2018, there were an estimated 4.8 million new cases of gastrointestinal (GI) cancers worldwide and 3.4 million related deaths. Iron deficiency (ID) is a frequent complication of GI malignancy that eventually manifests as iron deficiency anemia (IDA). Early recognition and treatment of ID/IDA in GI oncology patients is an important aspect of care. Traditional serum ferritin monitoring and oral iron supplementation hold limited diagnostic and therapeutic value in this population as it may be falsely elevated and confounded by poor absorption and blood loss, respectively. Therefore, we conducted a survey of Canadian physicians to assess disparities in IDA surveillance and management practices in GI cancer patients.

Methods: From February 2020 to September 2021, a 20-question electronic survey was sent to Canadian medical oncologists (MO), surgical oncologists (SO), and gastroenterologists (GE). The survey collected information on four domains: demographics, screening practices, treatment practices, and knowledge of the latest guidelines of ID/IDA. Analysis was conducted using descriptive statistics.

Results: A total of 108 (55 GE, 19 SO, and 34 MO) of the 872 (12.4%) invited physicians completed the survey. A greater proportion of GE (70.9% compared to 36.8% of SO, and 26.5% of MO) measured baseline iron parameters. Of these, a slight trend of iron parameters were being measured mainly at initial consult (61.5% of GE, 85.7% of SO, and 44.4% of MO), with little continuing surveillance throughout treatment course. Most physicians who measured iron parameters relied on ferritin mainly (82.1% of GE, 100% of SO), while MO were evenly distributed in their evaluation of ferritin (88.9%), serum iron (100%), total iron binding capacity (100%) and iron saturation (88.9%). The majority supplemented iron if ID/IDA was identified prior to systemic/surgical oncologic treatment (94.2% of GE, 85.7% SO, and 66.7% of MO). Of these, parenteral iron was the preferred modality for SO (85.7%), while oral iron was preferred among GE (82.8%) and MO (55.6%). The majority of physicians (81.3%) were not aware of the ASH/ASCO guidelines regarding the use of erythropoiesis stimulating agents in conjunction with parenteral iron supplementation for treatment anemia in this setting (92% of GE, 66.7% of SO, and 80.9% of MO).

Conclusions: Results from this Canadian survey suggests a disparity in practice pattern for IDA management between different specialties caring for GI oncology patients. Moreover, there appears to be a gap in knowledge and thus a gap in care surrounding evidence-based IDA management principles which may be contributing to poor clinical outcomes. Focused knowledge translation and exchange efforts are required to improve treatment of ID/IDA in patients with GI cancer nationally.

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