who initiated one of the checkpoint inhibitors. Blood samples were taken before immunotherapy treatment. Endocannabinoid (eCB) levels from various lipid families, were evaluated in a subgroup of 36 patients. Safety and effectivity of cannabis treatment in advanced cancers commencing treatment with immune checkpoint blockers was evaluated with time to tumor progression (TTP) used as a post hoc primary endpoint and overall survival (OS) and eCB concentrations as secondary endpoints with a minimum follow-up time of 7 months.

Results: Kaplan Maier curve showed a significant difference in TTP [I-G 13.1m (95%CI 6.0-NAm) vs. IC-G 3.4m (95%CI 1.8-6.0m), p=0.0025] and OS [IG 28.5m (95%CI 15.6-NAm) vs. IC-G 6.4m (95%CI 3.2-9.7m), p=0.0009]. After adjusting for the line of treatment, Cox regression analysis showed that cannabis consumption decreases OS (HR= 2.18, 95%CI 1.241-3.819. p=0.007) and TTP (HR= 1.95, 95%CI 1.17-3.26. p=0.011). The use of cannabis reduced grade ≥2 immune-related adverse events (iAE) (I-G 39% vs. IC-G 21%, p=0.057). Further analysis of baseline levels of circulating eCB from various lipid families showed no significant changes in their overall concentrations. However, analyzing a cohort comparing patients with progressive disease to those with complete remission correlates baseline eCB levels and expected OS, suggesting that the eCB system may play a role in immunotherapy outcomes.

Conclusions: Initiating immunotherapy with cannabis use negatively affects OS and TTP of cancer patients treated with immunotherapy.

Clinical trial identification: Prospective observational study- not registries in the NIH. Israel IRB Certification 0089-16-RMB.

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1853P Real-world evidence of quality of life effects (QoL) of the antiemetic NEPA: Final data in patients receiving oxaliplatin-based chemotherapy within the AkyPRO-trial

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Background: Oxaliplatin (Ox) is associated with Ctx induced nausea and vomiting (CINV), in particular delayed nausea. There is limited data from randomized trials and a lack of QoL for Ox based Ctx. NEPA, an oral fixed dose combination of netupitant 300 mg and palonosetron 0,5 mg has been approved for the prevention of acute and delayed Ctx-induced nausea and vomiting (CINV) in pts receiving highly (HEC) or moderately emetogenic Ctx (MEC). The primary objective of the prospective, non-interventional study (NIS) AkyPRO was the evaluation of QoL in adults receiving NEPA as primary prophylaxis for CINV associated with MEC or HEC. Here, we present an analysis of QoL, patient reported outcomes and effectiveness in the subgroup of pts receiving NEPA during Ox-Ctx.

Methods: The prospective NIS enrolled in total 2.429 pts. In this post-hoc analysis we evaluated pts receiving 3 consecutive cycles of Ox-Ctx. Primary endpoint was no impact of vomiting or nausea on daily life (NIDL), documented by Functional Living Index—Emesis (FLIE) questionnaires. Effectiveness was reported in pts diaries. Complete response (CR) was defined as no emesis and no rescue medication. Non-significant nausea (NSN) was no or mild nausea. Pts and physicians documented overall antiemetic effectiveness on a 4-point scale. Adverse events (AEs) were reported on d1—21 of each cycle.

Results: 167 pts with Ox-CT were evaluable. Pts demographics: Med age 69 years; 38% female, 94% ECOG 0-1, 54% received Ox-Ctx in the palliative setting. Tumor entities were colon 38%, stomach 21%, pancreatic 17%, rectum 15%, others 10%. Overall, 82% of pts reported that vomiting had NIDL during cycle 1, this high rate was maintained in subsequent cycles. Nausea was more difficult to control than vomiting with two-thirds of the pts reporting NIDL due to nausea. CR was high, with over 84%, while over 69% of pts reported NSN all 3 cycles. Comparison of pts' and physicians' perception of antiemetic effectiveness was comparable. NEPA was well tolerated. Low-grade constipation (3 %) and diarrhea (3.6%) were the most frequent treatment-related AEs.

Conclusions: NEPA was highly effective in the prevention of CINV during Ox-Ctx in this real world study and QoL was maintained.

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1854P A randomized-controlled trial to evaluate the effect of reduced dose olanzapine on nausea/vomiting and addition of aprepitant on vomiting in patients receiving highly emetogenic chemotherapy

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Background: Evaluated the efficacy and safety of reduced dose of olanzapine(5mg)(OLN) with full dose of olanzapine(10mg) and addition of aprepitant(APR) in achieving complete response(no emetic episodes and no use of rescue medicine) in patients on highly emetogenic chemotherapy.(HEC).

Methods: Randomized-controlled trial done in patients on HEC to OLN 5mg v/s 10mg with dexamethasone(DEX)polensetron/granisetron(POL/GRAN)) on control of vomiting. 280 patients randomly assigned in 1:1:1:1 in 4 arms receiving OLN5mg, POL/GRAN and DEX(O5PD),OLN10mg, POL/GRAN and DEX(O10PD),APR OLN 5mg,POL/GRAN and DEX(AO5PD) and APR,OLN10mg,POL/GRAN and DEXA(AO10PD) arms.-Nausea prevention in patients on HEC at acute (0-24 hrs post chemotherapy), delayed(25-50 hrs post chemotherapy) and overall periods(0-120 hrs post chemotherapy) were primary end points and complete response(CR) as secondary end point.

Results: CR rates 78.5%,80%,81.4% and 84.3% in O5PD,O10PD,AO5PD and AO10PD arms respectively.Patients without nausea O5PD:84.3% acute,80% delayed and 78.6% overall periods, for O5PD: 87.1% acute,82.9% delayed and 80% overall periods, for AO5PD: 87.1% acute,81.4% delayed and 80% overall periods,For AO10PD:88.5% acute,85.7% delayed and 84.3% overall periods.O5PD was comparable to O10 PD in control of CINV. The differences between the two arms were not significant with respect to CR rates and control of nausea and vomiting in both acute and delayed phases.(p>0.05), addition of APR was not significant(AO5PD and AO10PD) with respect to emesis and nausea in both acute and delayed periods when compared to OPD5 and OPD10 arms(p>0.05). The most common treatment related adverse event with olanzapine was sedation seen in 54 patients(19.2%). 17 patients(6.07%) received olanzapine dose 5mg and 37 patients received olanzapine dose of 10 mg shows grade1/2 sedation(p<0.05).

Conclusions: Reduced dose OLN 5mg comparable to OLN 10 mg with respect to efficacy but 10 mg dose olanzapine causes increased risk of sedation. Addition of apripitant does not cause significant impact on efficacy of olanzapine in combination of dexamethasone and polensetron/granisetron.

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1855P Music therapy can reduce both anxiety and chemotherapy-related nausea and vomiting in patients with early stage colorectal cancer treated with adjuvant infusion chemotherapy: A controlled, randomized study (PEGASUS study)

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Background: Music therapy is a non-pharmacological approach that can be used in the management of symptoms and side effects in patients with cancer. It is aimed to show the effect of music therapy performed on anxiety and chemotherapy (CT)-related nausea/vomiting in this study.

Methods: A total of 62 patients with stage II and III colon cancer who experienced CT-related nausea and vomiting during the previous cycle and afterwards were randomized to 1: 1. Patients whose music therapy was added to infusion CT were named as the study group (Group 1), and patients who received only infusion CT were named as the control group. Initially, State-trait anxiety inventory (STAI) and Beck depression inventory were filled. Classical music was played to the patients in the study group with a personal headset 3 times a day. After CT was completed, STAI and other study measurements were repeated. Statistical analysis was done using SPPS v19 program and p value was found <0.05 for statistical significance.

Results: In the evaluation made before and after the chemotherapy was completed in Group 1 patients, it was found that there was a significant decrease in both STAI-1 and STAI-2 scores and music therapy significantly changed their anxiety levels. However, no significant difference was found in study measurements related to anxiety in Group 2 patients. In Group 1 patients with music therapy, there was a significant reduction in the number of patients experiencing both nausea and vomiting during chemotherapy. However, there was no significant change in the incidence of nausea and vomiting in Group 2 patients. Music therapy was found to be an independent factor affecting the decrease in nausea-vomiting degree and anxiety (OR 2.98 (1.11-4.07), p=0.029).

Conclusions: It was concluded that music therapy with classical music integrated into the CT session can reduce the degree of nausea/vomiting and anxiety levels.

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1856P Clinical relevance of pancreatic enzyme replacement therapy (PERT) in patients affected by advanced pancreatic ductal adenocarcinoma (PDAC) undergoing first-line chemotherapy

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Background: Loss of pancreatic parenchyma and/or the obstruction of the main duct may cause pancreatic exocrine insufficiency (PEI), resulting in maldigestion and malabsorption of nutrients. Despite the importance of treating PEI and malnutrition, evidence suggests that their early detection and management are usually overlooked in clinical routine. The current analysis aims to investigate the use of PERT and its effects on survival in patients (pts) affected by advanced PDAC undergoing chemotherapy.

Methods: A retrospective analysis was conducted on non-consecutive pts with advanced pathologically confirmed PDAC. All pts were treated with Gemcitabine plus Nab Paclitaxel-based first-line chemotherapy at two academic medical institutions from March 2015 to October 2018. Descriptive statistics was adopted. Data were correlated with overall survival (OS) using a Cox regression model. Kaplan-Meier curves were compared with Log-Rank test.

Results: Data from 110 pts (57 males [51.8%], 53 females [48.2%]) were gathered (median age 65 years [range 37-81], with a median follow-up of 12 months (range 2-55). More than 65% had symptoms that could be related to malabsorption, like abdominal discomfort, bloating and steatorrhea. PERT was administered in 55 pts (50%), with no significant differences in baseline characteristics (age, gender, surgery, stage, weight loss, Performance Status) with those who did not receive PERT. Median OS for the entire group was 12 months (95%CI 9-15). At multivariate analysis, surgery of the primary (HR 3.12, 95% CI 1.51-6.44, $p = 0.02$) and PERT (HR 2.08, 95% CI 1.26-3.45, $p = 0.004$) were independent significant predictors of OS. Particularly, pts who received PERT had significantly longer 1-year OS (61.8% vs 32.5%, $p = 0.0001$).

Conclusions: Our analysis suggests that previous surgery and PERT are independently associated with survival outcomes in pts with advanced PDAC receiving first-line chemotherapy. However, patterns of PEI assessment and PERT prescription are inconsistent and specific algorithms should be implemented, in light of the potential impact on survival and QoL.

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1857P Oncology dedicated emergency department: Patient delineation and utility of care: A retrospective study

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Background: Emergency care in oncology constitutes a significant burden for both patients and the healthcare system. The purpose of this study was to correlate clinical characteristics of patients with effective treatment in an oncology-dedicated emergency department (OED), as compared with a general emergency department (GED).

Methods: Electronic files of cancer patients who visited the OED and GED between April - June 2017 were retrospectively collected from the hospital registry, and efficacy parameters were compared between groups. Data obtained from a representative sample of patients in the OED were analyzed using descriptive statistics and logistic regressions to determine which factors were associated with successful or insufficient management in the OED alone.

Results: The full cohort included 799 patients treated in both emergency settings. A total of 479 patients (60%) presented initially to the OED, and of these, 50 (10.4%) required referral to the GED. Compared with the OED, treatment in the GED was significantly associated with more consultations, imaging and hospitalizations (88% vs 16% $p<0.001$). In the OED, most patients were male and above age 60. Common diagnoses were lung (33%) gastrointestinal (30%) and breast (11%) cancer; 85% were metastatic. Treatment modalities included chemotherapy (59%), immunotherapy (16%) and biologics (16%). Pain was the most frequent chief complaint (45%), followed by gastrointestinal (33%), malaise (18%) and respiratory (15%). Most admissions were for management of disease symptoms (30%) and treatment side effects (18%). Characteristics associated higher referral to the GED included genitourinary cancer (56% $p=0.031$), biological therapy (64% $p<0.001$), back pain (80% $p<0.001$), neurological (60% $p=0.010$), and suspected oncological emergencies (79% $p<0.001$). Conversely, disease symptoms were well controlled in the OED (86% $p=0.003$), as treatment side effects and minor procedures.

Conclusions: The OED provides convenient, efficacious, cancer focused care. However, careful triage of patients is recommended, as diagnosis, symptoms, and admission type can predict referral to the GED. High-risk patients should avoid admission to the OED, which is better suited for urgent than emergent care.

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1858P Role of depression and quality of life (QOL) status as predictors of hospital length of stay (HLOS) and overall survival (OS) in hospitalized oncologic patients (pts)

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Background: Prognostic factors for oncologic pts after surgery or curative systemic treatment have been described, including malnutrition, ECOG status or tumour staging. However, there is no solid evidence on which parameters predict outcomes after hospitalization of unselected cancer pts.

Methods: A review of the prospective database PLANTOLOGY of all hospitalized oncology pts between January and April 2020 at Vall d'Hebron Hospital was conducted. Clinical factors such as ECOG, comorbidities and analytical parameters were collected at admission. Mental status (depression and anxiety) and QOL were assessed through the HADS and EORTC-QLQ30 questionnaires, respectively. The identification of the optimal cut-off points was set by the maximization of the log-rank test. HLOS and overall survival (OS) since the first day of admission were calculated with the Kaplan-Meier method and univariate and multivariate Cox models were fitted to estimate hazard ratios (HR) with CI95%.

Results: Overall, 206 pts were included, median age was 65 years, 44% were active smokers, 57% had an ECOG $\leq$1, most frequent tumour types were lung (24%) and colorectal (15%) cancer, median Charlson comorbidity index was 9 (4 - 13) and 33% were treated under clinical trial prior to admission. Median number of treatment lines was 2 (1 - 8) with median follow-up of 2.2 months (m). The median HOLS was 8 days (CI95% 8 — 10) and median OS was 2.8 m (CI95% 2.1 — NA). Longer HOLS was observed in pts with ECOG$\geq$2 (HR: 1.33, $p=0.04$) and albumin $<$3.3 mg/dL (HR: 1.61, $p<0.001$). In OS analysis, EORTC-QL30$\geq$65, HADS$\geq$11, LDH$\geq$365, ECOG$\geq$2, Stage=4 and albumin$<$3.3 were associated with worse OS (all p-values <0.05). In the multivariable analysis, the most parsimonious model included: HADS, stage and ECOG. HADS depression scale $\geq$11 was an independent factor for worse OS after adjusting for ECOG and stage (HR: 2.17; (1.08 — 4.36), $p= 0.001$).

Conclusions: In our cohort, QOL and depression scores measured with standardized tests were associated with OS after oncology ward admission, independently of stage and ECOG status. Factors linked to nutritional status and disease aggressiveness remain strong predictors of HOLS and OS.

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