performance status (PS) of 2 or worse ($p < 0.01$), the presence of lymph node metastasis ($p = 0.010$) and peritoneal metastasis ($p < 0.01$), a higher modified Glasgow Prognostic Score (GPS) of 2 ($p = 0.035$) and a high neutrophil-lymphocyte ratio >5 ($p = 0.032$). Primary tumour site was also significantly associated with survival ($p < 0.01$), with worse survival for right-sided tumours (6.6 months), compared to 14.0 months for left-sided/rectal tumours. Using multivariate analysis, independent prognostic markers were PS, presence of lymph node metastasis, presence of peritoneal metastasis and right-sided primary tumour location.

Conclusions: This is a representative cohort of BRAF V600E metastatic colorectal cancer patients, which confirms previously known clinical features. Of the common metastatic sites, peritoneal or lymph node metastases confer a poorer prognosis. There was not widespread adoption of more intensive triplet chemotherapy over the study time period. Overall survival is poor, and changed treatment strategies facilitated by recent clinical trial advances with targeted therapies may improve outcomes in this poor prognostic group.

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P-37 Has the COVID-19 pandemic lead to an upshift in emergency presentation and stage migration of colorectal cancer in Uruguay?

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Background: Effective Cancer screening is critical in reducing cancer related mortality in CRC by increasing the detection in earlier stages. Worldwide, practically all cancer pathways have been negatively affected by the implications of the COVID-19 pandemic. Oncological care has not escaped the effects of reprioritization of health care services to handle the surge of COVID-19 patients adequately. Cancer screening programs are no exception as many were temporarily halted to alleviate the pressure on overwhelmed health care systems. In Uruguay, the first COVID patients were detected in March 2020, and since then, the country's Public Health policies have been marked by the COVID-19 public health emergency. The aim of this study is to assess the impact of the COVID-19 pandemic on CRC diagnosis. We further aimed to analyze the effect on the clinical presentation and stage at diagnosis during 2020-2021 compared with previous years.

Methods: This was a single center retrospective cohort study performed at a tertiary center. Patients diagnosed and managed with colorectal adenocarcinoma during the years 2020-2021 were compared with patients from 2018 and 2019. Those enrolled in 2018-2019 were classified as the "pre-pandemic group", and those enrolled in 2020-2021 were classified as the "pandemic group". The primary outcome was the rate of stage IV disease at the time of diagnosis. Mann-Whitney test was used in the comparison of quantitative variables and Fisher's exact test was used for qualitative variables.

Results: A total of 369 patients were included in this study. From March 2018 to 2019 (pre-pandemic), 217 patients were considered, and from March 2020 to 2021 (pandemic), 152 patients. Median age of pre-pandemic and pandemic group was 64.4 and 65.6 years, respectively. There was no statistically significant difference in cancer obstruction or perforation at diagnosis. Other patient demographics were comparable ($p>0.05$). The percentage of surgical candidates was lower during the pandemic (69% vs 62%). There was a significant difference in TNM tumor distribution between pre-pandemic and pandemic subgroups with a higher incidence of advanced (cT4 or cN+ or M1) tumors. T4 tumors and node positive disease were equivalent in both groups but the incidence of disseminated disease (cM1) was significantly higher in the pandemic group (48% vs 36%, $p < 0.001$).

Conclusions: Our study demonstrates how cancer diagnostic variables, mainly stage at diagnosis, have been affected by the impact of the COVID-19 pandemic on cancer screening programs. Therefore, it is of utmost importance that cancer diagnosis and treatment pathways be reinstalled in full to return to and build on pre-pandemic priority to ensure the Uruguayan population benefits from earlier diagnosis and treatment.

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P-38 Proper size and timing of endoscopic dilation in anastomotic stricture after near-total esophagectomy

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Background: The size or timing of endoscopic dilatation for anastomotic stricture after near-total esophagectomy is not clear. The purpose of this study is to find out the target size and the timing of endoscopic dilatation for stenosis after near-total esophagectomy.

Methods: Medical records of patients with endoscopic dilatation for anastomotic stricture after near-total esophagectomy between January 2015 and April 2021 were reviewed. We analyzed the stricture recurrence rate and dilation-free period according to each diameter of dilation.

Results: In the study period, 78 endoscopic dilations in 24 patients were enrolled. The stricture recurrence rate was 91.4% in 13.5mm or less group, 57.9% in 15mm group, and 0% in 16.5mm group. The dilation-free period had a mean of 48.2 (range 14-679) days in 13.5mm or less group and 109.3 (range 14-347) days in 15mm group ($p = 0.045$). No perforation occurred in this study.

Conclusions: In patients with anastomotic stricture after near-total esophagectomy, safely consider 15mm as the target diameter of dilation, and if this is achieved, follow-up endoscopy and dilation can be considered after 3 months.

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P-39 Utility of circulating tumor DNA (ctDNA) to assess tumor response in patients with locally advanced rectal cancer undergoing neoadjuvant therapy

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Background: The current tools to assess tumor response in patients with locally advanced rectal cancer (LARC) undergoing neoadjuvant therapy (NAT) are suboptimal. As the 'watch and wait' (W&W) approach for patients who achieve complete clinical response (cCR) is being widely considered, accurate tumor response assessment is critical. We retrospectively explored whether circulating tumor DNA (ctDNA) can aid in tumor response assessment in patients with LARC undergoing NAT.

Methods: In this multicenter, retrospective study, patients aged ≥18 years with histologically confirmed LARC undergoing NAT, either with chemoradiotherapy (CRT) or total neoadjuvant therapy (TNT), a combination of systemic chemotherapy (CT) and CRT, were included. Patients had baseline (obtained within 7 days before starting NAT), and serial blood samples were drawn during and after the completion of treatment. A tumor-informed, personalized ctDNA assay (SignateraTM, bespoke mPCR-NGS assay) was utilized to measure plasma ctDNA level expressed as mean tumor molecules (MTM)/mL. Tumor response was assessed with imaging studies, including MRI and proctoscopic examination. A correlation between complete ctDNA clearance and tumor response was explored.

Results: The study included 12 patients with LARC (clinical stage II=5, stage III=7) with a median age of 56 years (range: 44 to 68 years); 59% of patients were male. Total 34 blood samples were collected from 12 patients. In this cohort, 4 patients were excluded from the analysis, due to insufficient tissue to design the ctDNA assay (n=2) and lack of detectable ctDNA at baseline (n =2). Among 8 patients who had a baseline ctDNA level, ctDNA clearance was observed in 7 patients after a median interval of 46 days (range: 30-76 days) from the onset of NAT. The patient with persistent ctDNA level discontinued treatment within 1 month of onset of NAT due to noncompliance unrelated to treatment toxicity. Among the patients who cleared ctDNA, 3 patients have completed NAT and achieved cCR, 3 patients are currently on NAT with interim pelvic MRI showing significant shrinkage of the tumors, and 1 patient was lost to follow-up before the completion of NAT with interim MRI showing considerable tumor response. There was an agreement between the ctDNA clearance and tumor response, indicating a Cohen's kappa of 1 for reliability.

Conclusions: In this small cohort of patients, a high degree of correlation was observed between ctDNA clearance and response assessed by MRI and proctoscopy. However, these data are preliminary and hypothesis-generating. Larger prospective studies are warranted to further explore the potential of ctDNA-based tumor response assessment in patients with LARC undergoing NAT.

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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 ofID/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 ofCanadian 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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