Background Despite the expanding knowledge base, much remains to be understood about effective treatments to treat the many symptoms of anti-NMDA receptor encephalitis (anti-NMDA RE).
Purpose To describe the treatment options for a case of refractory status epilepticus associated with non paraneoplastic anti-NMDA RE.
Materials and Methods Revised drug-treatment history of the patient.
Results A 22-year-old woman with a family history of epilepsy and an arteriovenous malformation (AVM) of the brain, presented a generalised tonic-clonic without clear focal onset and post-critical confusion. She was in non-convulsive status epilepticus.

Treatment was initiated with various intravenous drugs during the 50 days of the status: diazepam, phenytoin, valproic acid, levetiracetam, clonazepam, midazolam, propofol, lacosamide, ketamine, and lidocaine.

It was decided to proceed with induction of barbiturate coma three times, requiring supratherapeutic doses in the second one. Oxcarbazepine was administered via feeding tube.

With these treatments, momentary remission status was achieved although epileptiform activity reappeared when the pharmacological effect expired.

Thirty days after admission, it was decided to repeat computed tomography for development of AVM and investigate again whether the cerebrospinal fluid was positive for anti-NMDA. This being the case, teatment was initiated with methylprednisolone and immunoglobulins.

She continued with clinical status, but electrical brain activity began to fade at the same time that the patient was starting to tolerate enteral nutrition and so oxcarbazepine possibly began to be absorbed.

After discontinuing sedation the patient awoke and opened her eyes. Electroencephalogram was repeated and epileptiform activity had disappeared completely. Facial dyskinesias were treated with clonazepam.
Conclusions Whereas the best treatment approach for anti-NMDA RE encompasses a combination of immunotherapy, intensive care, and rehabilitation, there is a dearth of information regarding management of psychiatric and behavioural symptoms [1]. The possibility of resolving the status by oxcarbazepine gavage opens a window into the use of drugs by this route in the event of failure of standard treatment.
Reference
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No conflict of interest.

CPC-141 TOLERABILITY AND SAFETY OF CARBOPLATIN-BASED CHEMOTHERAPY IN A HEMODIALYSIS PATIENT WITH BREAST CANCER

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Background The oncology pharmacist was consulted about the neoadjuvant carboplatin-based chemotherapy regimen for a 59-year-old woman with triple negative stage IIA breast cancer and stage 4 chronic kidney disease. She was undergoing haemodialysis three times a week, on a Tuesday-Thursday-Saturday schedule. The chemotherapy regimen was docetaxel 75 mg/m^2 IV D1, carboplatin AUC 5 IV D1, Q21D, 6 cycles. The major dose-limiting toxicity of carboplatin is myelosuppression, especially thrombocytopenia. As carboplatin is eliminated mainly through the kidneys, dosage adjustment and timing is required for patients with impaired renal function to prevent severe hematologic toxicity. Carboplatin is removed by haemodialysis.
Purpose To examine the tolerability and safety of carboplatin-based chemotherapy and the applicability of the Calvert formula in a haemodialysis patient with localised breast cancer.
Materials and Methods We reviewed the literature on the pharmacokinetics, efficacy, tolerability and dosage adjustment of carboplatin. In patients on chronic haemodialysis, the issue is how to evaluate the glomerular filtration rate (GFR) in the Calvert formula. We planned the administration of chemotherapy on a non-dialysis day and the following haemodialysis session to occur 24 hours afterwards. The GFR value was assumed to be 0 mL/min and the carboplatin dose calculated was 125 mg.
Results The first two chemotherapy cycles were found to be safe and well tolerated. Neither neutropenia nor thrombocytopenia occurred. After the first cycle, absolute neutrophil nadir count was 5.51 10e-3/mcL and platelet nadir count was 238 10e-3/mcL. Neither allergic or hypersensitivity reactions nor delayed nausea or vomiting occurred. CTCAE grade 3 diarrhoea was controlled with loperamide. Furthermore, a significant reduction in the tumour size was attained.
Conclusions Dosage adjustment and timing of carboplatin-based chemotherapy can result in a safe and well-tolerated preoperative treatment option in a haemodialysis patient with localised breast cancer.

No conflict of interest.

CPC-142 TOLERANCE TO THE BEAM PROTOCOL BEFORE AUTOLOGOUS HEMATOPOIETIC STEM CELLS TRANSPLANTATION IN CHILDREN TREATED FOR HODGKIN'S LYMPHOMA

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Background Patients with Hodgkin's lymphoma and refractory to the first line of treatment or in relapse, received the BEAM conditioning regimen (carmustine, etoposide, cytarabine, melphalan) followed by transplantation of hematopoietic stem cells.
Purpose To define the characteristics of patients who received this protocol, evaluate its effectiveness, and analyse the tolerance in relation to the carmustine, a cytotoxic agent responsible for many side effects.
Materials and Methods We conducted a retrospective study on patients who received this treatment between January 2001 and September 2011 in the paediatric haematology oncology ward.
A data collection document was created to list the patients' characteristics and information related to the protocol (tolerance, efficacy and previous chemotherapy).
Results 14 children with Hodgkin's lymphoma aged between 5 and 17 were given BEAM protocol transplantation conditioning after a relapse (79%) or after tumoural progression during the previous chemotherapies (21%).

Following the BEAM protocol treatment, the overall remission rate was 57%.

Carmustine treatment led to adverse effects in 66% of patients during the infusion. During the 3 months after the transplantation, the main adverse effects were digestive disorders, fever and hematemesis. In the longer term, various pulmonary disorders were observed (pneumonia, pulmonary tuberculosis, breathlessness on exertion, etc.).
Conclusions This protocol resulted in remission in approximately two thirds of the cases regardless of the disease stage. The overall