- 65.4% received hospice services before death from cancer (at least 55.0%).
- 8.6% were admitted to a hospice within 3 days of death (limit≥8%).

**Conclusion** According to Earle et al. indicators, the patients were excessively treated with antineoplastic drugs at the end of life, which demanded more healthcare services. However, they received good support care from palliative care at the end of life. There are no European studies including all indicators for patients with solid tumours near death. Standards to assess the aggressive care at the end of life would be helpful in improvingstrategies at the end of life.


**REFERENCES AND/OR ACKNOWLEDGEMENTS**

DOI:10.1200/JCO.2003.03.059
DOI:10.1093/intqhc/mzi061
No conflict of interest.


## 4CPS-113 DRUG COST SAVING RESULTING FROM METASTATIC MELANOMA CLINICAL TRIALS


FJ García Moreno*, E González-Haba Peña, MN Sánchez Fresneda, E García Martín, S García Sánchez, B Marzal Alfaro, R Collado Borrell, A Mur Mur, A Herranz Alonso, M Sanjurjo Sáez. *Hospital General Universitario Gregorio Marañón, Pharmacy Department, Madrid, Spain*


10.1136/ejhpharm-2019-eahpconf.262

**Background** The development of checkpoint inhibitors-based immunotherapy has completely changed the therapeutic approach of metastatic melanoma (MM). In parallel, research activity concerning this tumour continues at a very high level through a large number of active industry-funded clinical trials.
**Purpose** To estimate the cost saving in MM therapy attributable to clinical trials (CT) in a university tertiary hospital during the period 2016–2017.
**Material and methods** Observational, retrospective study that took into account those CT that were financed by a sponsor. The standard therapy (ST) comparison was chosen for each trial according to the investigator's brochure and National Comprehensive Cancer Network Guidelines.

The duration of ST was equated with the time of permanence of the participant in the trial. The number of days of treatment (in oral therapy) or complete cycles received (intravenous therapy) of ST were estimated. The dose of ST was established according to body surface area or weight at recruitment to trial. The costs of ST were estimated using the hospital-specific tender price on 1 January of each year. It was considered a maximum reuse of vials.

Limitation: we did not consider the cost of working in aseptic conditions and the cost of administering the drugs.
**Results** Eleven CT reached our inclusion criteria with a total of forty-seven patients treated. The estimated cost saving per year was: € 8 09 630 (2016) and € 8 04 349 (2017).

The therapeutic alternatives in MM that have a high budget impact are:

Inmunotherapy (anti-PD1 and anti-CTLA4 antibodies). It was the ST in five CT with 34 active participants between 2016–2017. The total saving was € 1,195,294. The amount of savings was equivalent to 99.4% of our hospital spending on immunotherapy used to treat MM between 2016–2017. Oral antineoplastic drugs (BRAF and MEK inhibitors): ST in four CT with seven active participants and a saving of € 4 17 565 (equivalent to 44.2% of the spending on BRAF/MEK inhibitors during this period).
**Conclusion** CT using investigational medicinal products provided by the sponsor gave a considerable saving for our healthcare system within the context of clinical research and innovation. This saving has remaining constant in our study between 2016 and 2017.


**REFERENCES AND/OR ACKNOWLEDGEMENTS**

No conflict of interest.


## 4CPS-114 DOSING OF PLATINUM AND TAXANES IN OBESE PATIENTS: A SYSTEMATIC REVIEW


A Casas*, B Torroba, B Tapia, MA Garcia-Del-Barrio. *Clinica Universidad de Navarra, Hospital Pharmacy, Pamplona, Spain*


10.1136/ejhpharm-2019-eahpconf.263

**Background** Platinum and taxane-based chemotherapy dosing, as in other anticancer agents, is based on body surface area, except in the case of carboplatin that is more often based on the area under the curve. Both parameters depend on weight, and obesity (body mass index >30 kg/m$^2$) could lead to overdose. Some guidelines recommend using actual body weight (ABW) avoiding arbitrary dose reductions that can compromise efficacy. Therefore, this issue remains a challenge.
**Purpose** To analyse the evidence and recommendations available concerning the dosage of platinum-based (cisplatin, carboplatin, oxaliplatin) and taxane-based (paclitaxel, docetaxel, nab-paclitaxel) chemotherapy in obese patients.
**Material and methods** We performed a systematic review for each drug on Pubmed, Scopus and Web of Science using 'obese or obesity' in the title and the drug name in the title/abstract/keywords. Eventually, we limited the search by language (English/Spanish).
**Results** We included 18 articles about cisplatin, 58 about carboplatin, 15 about oxaliplatin, 43 about paclitaxel, zero about nab-paclitaxel and 41 about docetaxel. For cisplatin, the most usual recommendation was to use ABW justified by an increased clearance and volume of distribution in obese patients. More controversy was found related to carboplatin (using the Calvert dosing formula). To calculate the glomerular filtration rate (GFR), both ABW or adjusted body weight were recommended to be used, while other authors proposed to limit the GFR to a maximum of 150 mL/min. Related to oxaliplatin it is advised to use ABW for monitoring the possible risk of neurotoxicity. For paclitaxel and docetaxel, the use of ABW is recommended too. In the articles reviewed usually there was no distinction by the degree of obesity, but when body composition was taken into account, sarcopenic obese patients tended to suffer more toxicity than non-sarcopenic obese patients.
**Conclusion** For platinum and taxane-based chemotherapy, the use of ABW for dosing in obese patients is the most accepted proposal according to the analysed literature. For carboplatin, depending on the GFR obtained, this should be limited to a maximum of 150 mL/min or use of an adjusted body weight for dosing. Furthermore, analysis of body composition could be used for dosing or reducing the risk of toxicity in sarcopenic patients.


**REFERENCES AND/OR ACKNOWLEDGEMENTS**

No conflict of interest.