DOSE BANDING – OPTIMISING DOSES IN CETUXIMAB OR BEVACIZUMAB REGIMENS

S Machado*, G Cairén, N Landeira, M Pereira. Hospital Espírito Santo Évora – EPE, Pharmacy, Évora, Portugal

10.1136/ejhpharm-2019-eahpconf.266

Background The dosage of antineoplastic drugs has been historically based on body surface area or patient’s weight.

Lack of resources and increased workload at an Oncology-Haematology Day Hospital (ODH) are leading to the development of new strategies to optimise the processing. One of those approaches is the dose-banding (DB) method.

Purpose Calculate Cetuximab (Cet) and Bevacizumab (Bev) doses using the DB method;

Compare initially calculated doses (ICD) with those obtained through DB and assess the economic impact.

Material and methods All ODH patients with ≥18 years, Cet prescription from November 2017 to August 2018 or Bev from January 2018 to August 2018 were included. Patients with <45 kg or >100 kg were excluded.

The ICDs were initially calculated according to the summary of product characteristics. Then, using National Health Service England DB tables, ICDs were adjusted to a dose obtained by DB (DDB). The range recommended for dose adjustments is 5%–10%.

ICDs and DDBs were recorded.

Using the average price of the drug in our hospital, expenditures made were with and without DB were calculated.

Results Doses for 150 preparations of Cet and 406 preparations of Bev were calculated.

For Cet, the DDB were 2.8% lower than ICD, so less drug was used, which represents savings of €16,409/year.

Regarding Bev, the DDB were 3.1% lower than ICD, which generates savings of €63,343/year.

Conclusion We found that the introduction of DB to have a noteworthy impact on oncology service total expenditures.

Dose adjustments made were within the recommended range. The method has been used in Europe which has studies that support its applicability.

In our ODH there is a policy of using one vial for more than one patient, so the estimated savings may be slightly lower.

Additionally, DB adds another factor of variability to the final dose that will be administered to the patient.

The DB promotes rational drug use.

This may be a future approach to other drugs in oncology.

REFERENCES AND/OR ACKNOWLEDGEMENTS


No conflict of interest.

EXPERIENCE OF NAB-PACLITAXEL AND GEMCITABINE USE IN METASTATIC PANCREATIC CANCER

1E Mateos Egido*, 1F Lombardo Pin, 1A Alamo Medina, 2C García Piñeiro, 2D Dorta Vera, 1Complejo Hospitalario Universitario Insular-Materno Infantil, Pharmacy, Las Palmas de Gran Canaria, Spain; 2Complejo Hospitalario Universitario Insular-Materno Infantil, Oncology, Las Palmas de Gran Canaria, Spain

10.1136/ejhpharm-2019-eahpconf.268

Background Nab-paclitaxel is approved for first-line treatment of patients with metastatic pancreatic cancer (mCP).

Purpose To evaluate the efficacy and safety of treatment with nab-paclitaxel and gemcitabine in patients with mCP.

Material and methods Retrospective observational study of mCP patients treated with nab-paclitaxel and gemcitabine...

No conflict of interest.
during the past 5 years. Collected variables: age, sex, ECOG, adjuvant chemotherapy, treatment line, dose reduction and adverse events (AE). Efficacy endpoints were progression-free survival (PFS) and overall survival (OS) obtained by the Kaplan–Meier method. Adverse effects (AE) were collected for safety profile assessment. Descriptive statistical analysis was performed using the SPSS Statistics program V22.0.

**Results** Forty-seven patients (30 men and 17 women) were included. The median age was 59 years (29–82). At the beginning of the treatment, more than 80% presented ECOG 0–1: 23.4% had received previous adjuvant chemotherapy (gemcitabine and/or fluoropyrimidines). They were treated with nab-paclitaxel 125 mg/m² and gemcitabine 1000 mg/m² on days 1, 8 and 15 every 28 days. In 89.4% of the patients it was prescribed as first-line treatment. Dose reduction was performed in 68.1%. The median duration of treatment was 4.5 months (0.5–22.9), with four long survivors (longer than 15 months). The median PFS was 9.1 months (95% CI 8.36 to 9.73) and the median OS was 9.11 months (95% CI 4.0 to 14.2). Eighty-three per cent of patients (n=39) had AE of some grade and 17% (n=8) of grade 3–4. The most common AE were: asthaenia (n=17), neutropaenia (n=16), thrombocytopaenia (n=15), neuropathy (n=13), alopecia (n=5), diarrhoea (n=7), mucositis (n=3), vomiting (n=3), oedema (n=3) and dermatitis (n=2). These were grade 3–4: neutropaenia (n=7), thrombocytopaenia (n=4), mucositis (n=1), alopecia (n=1) and neuropathy (n=1). The causes of treatment discontinuation were mainly due to progression in 42.6% and deterioration of general health in 29.8%. At the end of the study, five patients continued treatment.

**Conclusion** The PFS obtained in our study is greater than those described in the pivotal trial MPACT or CA046. This difference may be due to the four patients with a considerably longer treatment than the average and a small sample. Regarding OS, there are no significant differences with the pivotal trial. The AE described were similar to those published in the literature.

**References and/or acknowledgements**

No conflict of interest.

**4CPS-120 ERLOTINIB IN NON-SMALL-CELL LUNG CANCER WITHOUT EPIDERMAL GROWTH FACTOR RECEPTOR ACTIVATING MUTATIONS**

D Yáñez Feria, IM Carrion Madroñal, MT Garrido Martinez, O Montero Pérez*, MD Santos Rubio. Juan Ramon Jimenez Hospital, Pharmacy, Huelva, Spain

10.1136/ehjpharm-2019-ehahphconf.269

**Background** Erlotinib is indicated in patients without epidermal growth factor receptor (EGFR)-activating mutations who have had at least one previous chemotherapy treatment that has failed and when other treatments are considered unsuitable.

**Purpose** To analyse the effectiveness and safety of erlotinib in non-small-cell lung cancer (NSCLC) in patients without EGFR-activating mutations

**Material and methods** A retrospective observational study was conducted in a third-level hospital. We included patients treated with erlotinib without EGFR-activating mutations from August 2012 to August 2018.

Following variables were recorded: age, sex, ECOG, histopathology, progression-free survival (PFS), smokers/non-smokers or ex-smokers, type of previous chemotherapy regimens, reported adverse events (AEs) and dose reductions between cycles.

We obtained data from electronic clinical records, the software where we register chemotherapy treatments (chemotherapy management software Oncogest) and the optimised computerised order entry ATHOS software.

AEs were classified according to the National Cancer Institute of Canada Common Toxicity Criteria v4.0.

**Results** Thirty-seven patients were included, with a median age of 64 years and 70% men. Fifty-seven per cent of patients presented ECOG 0 and the rest ECOG 1–2. Seventy-eight per cent of patients were smokers and/or ex-smokers. Ninety per cent of patients received erlotinib as the second line of treatment or subsequently, and the median PFS was 9.3 weeks. Previous chemotherapy regimens used before erlotinib in NSCLC were: taxane-based-chemotherapy 60%, platinum-based-chemotherapy 83% and both 74%. Forty-eight per cent of patients had at least one AE during treatment. The most frequent was skin rash g1–2 (60%). Thirty per cent of patients had dose reductions due to toxicity.

**Conclusion** In our patients, erlotinib median PFS was lower than in the BR21 trial. It could be explained because our patients received more previous regimens of chemotherapy for metastatic disease as well as our sample size was smaller. Regarding safety, erlotinib was well tolerated and in most of the cases, the AEs did not force a dose reduction.

**References and/or acknowledgements**

No conflict of interest.