Abstract 4CPS-125 Table 1

	GRADE	CPC n (%)	5-FU n (%)
Anorexia	G1-2	4 (12.5)	8 (18.2)
	G≥3	0 (0.0)	0 (0.0)
Diarrhoea	G1-2	7 (21.9)	15 (34.1)
	G≥3	1 (3.1)	0 (0.0)
Dysgeusia	G1-2	1 (3.1)	2 (4.6)
	G≥3	0 (0.0)	0 (0.0)
Fatigue	G1-2	14 (43.8)	19 (43.2)
	G≥3	0 (0.0)	0 (0.0)
Haematologic alteration	G1-2	0 (0.0)	2 (4.6)
	G≥3	0 (0.0)	0 (0.0)
Maculopapular rash	G1-2	1 (3.1)	2 (4.6)
	G≥3	0 (0.0)	0 (0.0)
Mucositis	G1-2	2 (6.3)	3 (6.8)
	G≥3	0 (0.0)	0 (0.0)
Nausea/vomiting	G1-2	3 (9.4)	5 (11.4)
	G≥3	0 (0.0)	0 (0.0)
PPE	G1-2	4 (12.5)	3 (6.8)
	G≥3	1 (3.1)	1 (2.3)
Administration	–	–	2 (4.6)

Conclusion While the CPC group had a lower incidence of AE except for PPE, they had more dose reduction and treatment interruption. A posterior analysis showed that dose reduction and treatment interruption in the CPC group happened in the last week of treatment. In disagreement with previous studies, 5-FU patients had a higher incidence of diarrhoea.

REFERENCES AND/OR ACKNOWLEDGEMENTS

No conflict of interest.

4CPS-126 EFFECTIVENESS AND SAFETY OF NAB-PACLITAXEL IN PATIENTS WITH METASTATIC ADENOCARCINOMA OF THE PANCREAS IN A REAL-WORLD SETTING

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Background Nab-paclitaxel was approved for the treatment of metastatic adenocarcinoma of pancreas (mPAC), as a first treatment in combination with gemcitabine

Purpose To evaluate the effectiveness and safety of nab-paclitaxel in patients with mPAC in a real-world setting.

Material and methods Retrospective observational study of mPAC patients treated with nab-paclitaxel 125 mg/m²+gemcitabine (March 2013 to September 2018). Variables: age, sex, ECOG, treatment line, number of cycles and dose reduction. Efficacy endpoints: progression-free survival (PFS) and overall survival (OS). For safety profile assessment, adverse effects (AE) that forced a dose reduction or treatment suspension were collected, also hospital recovering caused by nab-paclitaxel toxicity.

Results Thirty-six patients were included, 56% males. Average age: 64±10 years. Thirty-three per cent started with

ECOG 0% and 67% with ECOG≥1. The treatment lines were: first (47%), second (36%) and ≥third (17%). The average number of cycles was 3.7±2. The median duration of treatment was 16 weeks (95% CI: 11 to 22). The median OS was 36 weeks (95% CI: 24 to 47), data for 33% of the patients was censored. The median PFS (mPFS) was 20 weeks (95% CI: 11 to 30). mPFS was compared in different groups: 33 weeks versus 20 in the first line compared to second or later lines (p=0.443) and 24 weeks versus 20 in ECOG 0 patients compared to ECOG≥1 (p=0.295).

Dose reduction was performed in 72% of patients. Causes: neurotoxicity (38%), blood toxicity (58%), poor tolerance to previous cycles (8%) and bad performance (3%). Sixty-one per cent of patients were hospitalised because of nab-paclitaxel toxicity and nine had to discontinue treatment because of neurotoxicity (n=3), blood toxicity (n=2), performance worsening (n=3) and hepatic toxicity (n=1).

Conclusion The results obtained in our study are consistent with the ones obtained in the pivotal trial: mOS 36 versus 34 weeks, mPFS 20 versus 22 weeks, duration of treatment 16 versus 16 weeks. The results of PFS seem to be better when nab-paclitaxel is used as a first line and in patients with ECOG 0, but the differences are not statistically significant (p=0.443, p=0.295). A bigger sample would be needed to confirm all results. The AE described were similar to those published in the literature.

REFERENCES AND/OR ACKNOWLEDGEMENTS

No conflict of interest.

4CPS-127 DEVELOPMENT OF A STRATIFICATION MODEL FOR AMBULATORY ONCOLOGY PHARMACY PATIENTS

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Background To our knowledge, there is no pharmacy stratification model for patients in the oncology ambulatory setting.

Purpose To develop a tool to stratify oncology patients that helps us to implement ambulatory clinical pharmacy services.

Material and methods Phase I: a literature review was performed to identify risk factors for hospital admissions or emergency department (ED) visits in oncology patients and patients with care coordination requirements. Phase II: a panel of experts selected the variables of the model based on their impact on clinical pharmacy services and the feasibility of obtaining the data. Relative weight of each of the variables was assigned. Phase III: the stratification model was retrospectively tested on the population of patients that received care in the unit on a random day (13 June 2018). Three cut-offs were established to provide different levels of patient needs.

Results The variables were categorised under four domains (table 1).

Abstract 4CPS-127 Table 1

	Variable	Weight
Patient characteristics	Age >65 years	1
	ECOG>1	1
	Body mass index <20.5	1
	Pregnancy/breastfeeding	Highest priority
	Patient included in the regional programme for complex chronic needs – PCC/NIA	Highest priority
Treatment-related variables	Number of chronic medications >6	1
	Ambulatory high-risk drug	2
	High-emetic risk chemotherapy	1
	Oral antineoplastic agent	Highest priority
Clinical variables	Gastrointestinal tumour	1
	Chronic diseases	2
	Treatment line >1	1
Previous utilisation of resources	ED visit or hospital admission in the previous 30 days	1

The model was tested on a population of 43 patients (48.8% were male; median of age: 64 (IQR:52–73) years; median of ECOG=1 (IQR:0–1)). Patients were on six (IQR: 3.5–10) drugs, and 20 (45.5%) patients took one or more high-risk ambulatory medications. Eleven (25.6%) patients had one or more chronic diseases. Only one patient was identified as PCC/NIA. Three patients were treated with oral antineoplastic agents. Five (11.6%) patients visited the ED or were admitted to hospital in the past 30 days, while 12 (27.9%) were in the following 30 days. The distribution by categories was as follows: high priority (12–8 points; four patients), medium priority (7–5 points; 12 patients) and low priority (4–0 points; 27 patients).

Conclusion The model can be a useful tool for detecting patients that could benefit from clinical pharmacy services, although it needs further validation.

REFERENCES AND/OR ACKNOWLEDGEMENTS

No conflict of interest.

4CPS-128 ADEQUACY OF NIVOLUMAB AND PEMBROLIZUMAB IN NON-SMALL-CELL LUNG CANCER

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Background Between 2016 and 2017 the National Agency of Medicines and Medical Devices regulated the use of nivolumab and pembrolizumab for the treatment of non-small-cell lung cancer (NSCLC).

In clinical trials conducted, patients with ECOG 0–1 and a life expectancy of at least 3 months were included since the benefit of immunotherapy can be delayed and even present a response after progression (pseudoprogression).

Purpose To analyse characteristics of patients with NSCLC treated with nivolumab and pembrolizumab for less than 3 months at our centre.

Material and methods Observational descriptive study was conducted. Patients diagnosed with NSCLC treated for less than 3 months (with six or less cycles of nivolumab and four or less cycles of pembrolizumab) from the approval date of these drugs until October 2018 were included.

Data from clinical and pharmacotherapeutic records was collected: age, sex, ECOG, histology, brain metastases, PDL-1 expression, number of previous lines, time elapsed since previous treatment if any and reason for discontinuation.

Overall survival (OS) and progression-free survival (PFS) medians were calculated with SPSS 22.0 using the Kaplan–Meier method.

Results Sixty-two patients were included (males 64.5%, mean age 68±9.7), 82.1% ECOG 0–1, 75.4% non-squamous histology and 14.5% with brain metastases). PDL-1 expression was positive in 100% of patients treated with pembrolizumab and in 4.8% of those treated with nivolumab (57.1% of them without determination).

75.8% had received previous treatment, 61.7% of them in less than 3 months and with less than three previous lines (97.2%). Forty-one patients were treated with pembrolizumab and 21 with nivolumab. The median treatment duration was 42 days (3–115).

Seven patients discontinued due to drug toxicity.

The global median OS and PFS were 361.5 and 61.5 days, with no statistically significant differences between both treatments ($p=0.191$ and $p=0.279$ respectively).

Conclusion With the aim of improving the rational use of medicines and optimising results, these findings encourage us to carry out studies with a larger sample of patients in order to select the patients who would benefit most from these therapies.

The possible presence of pseudoprogression in those who did not reach at least 3 months of treatment constitutes a limitation on observing the possible clinical benefits.

REFERENCES AND/OR ACKNOWLEDGEMENTS

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4CPS-129 CHEMOTHERAPY NEAR THE END OF LIFE IN ONCO-HAEMATOLOGICAL ADULT PATIENTS

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Background The use of chemotherapy close to the end of the life is not advisable, especially when the probabilities of improvement are limited. The intensity of anticancer treatment at this stage has been suggested as one of the factors influencing quality of life. Data at a European level are scarce, but show signs of overly aggressive treatment.

Purpose To analyse the proportion of patients receiving chemotherapy within the last 2 weeks of life in a Haematology and Oncology setting. To describe the clinical variables of the patients receiving chemotherapy at the end of life, including the type of treatment.

Material and methods A retrospective observational study was conducted in a tertiary hospital. Electronic records were used (HCIS, HospiWin).