Conclusion SAE have led some oncologists to systematically screen for DPD and/or UGT1A1 deficit before the initiation of chemotherapy by 5-fluorouracil and/or irinotecan in order to prescribe individualised and optimised dosages. This personalised medicine takes all its significance from the new concept of care's eco-conception.

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No conflict of interest.

5PSQ-051 ANALYSIS OF CARDIOVASCULAR EVENTS ASSOCIATED WITH CARFILZOMIB IN PATIENTS WITH MULTIPLE REFRACTORY MYELOMA

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Background In the pivotal authorisation trial of carfilzomib, patients with severe cardiovascular abnormalities (NYHA III or IV), clinically significant and uncontrolled, were not included.

Purpose The aim of this study was to analyse the cardiovascular events (CVAE) associated with carfilzomib in patients in whom an electrocardiogram was performed prior to starting treatment and compare these data with those of the pivotal trial.

Material and methods Retrospective observational study in which all patients treated with carfilzomib were included. The data obtained from the electronic medical record were: age and comorbidities at diagnosis, schemes used prior to carfilzomib, dose of carfilzomib and development of CVAE after the use of carfilzomib.

Results Thirty-six patients (19 males) with a median age 59 years (RIQ 53–67) were included. Seventy-eight per cent had comorbidities at the time of diagnosis, the most frequent being arterial hypertension (HTA) (16), followed by diabetes mellitus and dyslipaemia (seven in both). The average of previous regimens was one (30), with VCD (bortezomib, cyclophosphamide and dexamethasone) in 28 patients. In 34 patients the scheme used was KRd (carfilzomib, lenalidomide and dexamethasone) at a dose of 27 mg/m². In two patients the dose was reduced due to adverse effects (hepatotoxicity and non-specific toxicity).

The incidence of all grades CVAE was 19.4% (three congestive heart failure, two paroxysmal atrial fibrillation, and one transient ischaemia and new onset HTA). Of all of them, 71% presented as comorbidity to the diagnosis of hypertension. Median age of patients was 65 years (RIQ 65–76). Two patients discontinued the treatment, three patients required modification of the diuretic treatment and in one patient the infusion time of carfilzomib was modified.

Conclusion As in the ASPIRE study, patients are referred to the cardiology service prior to starting treatment and the expected results are similar (19.4% vs 22.3% in ASPIRE). The most vulnerable patients of developing CVE were those over 65 years of age, since they present more comorbidities pre-treatment. However, it should be mentioned that myeloma

itself, or the corticosteroids, can also contribute to cardiovascular deterioration.

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5PSQ-052 THE ERROR ROOM: A FUN TRAINING TOOL FOR THE PHARMACEUTICAL CHEMOTHERAPY UNIT

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Background A significant part of hospital activity is now dedicated to the handling of oncology, and the chemotherapy production by the pharmacy is an essential stage. This activity is still currently human-dependent and one error can therefore have serious consequences. Through a 'room of errors', a participating training in real-work conditions can improve ongoing staff training and the security of this cytotoxic production path.

Purpose To evaluate the critical capacity of the pharmacy technicians to track the major deviances in the preparation of injectable anticancer drugs.

Material and methods A list of errors was established by the pharmacist and the resident and then implemented in the controlled atmosphere zone. A level of criticality had been assigned to each error. The usual technicians and pharmacist could participate in this 'room of errors'. The time left to find errors was 15 min by participants. An information sheet was filled anonymously. In the following days, an error analysis and debriefing were conducted to discuss the most critical errors.

Results The six usual technicians and one pharmacist participated in this 'room of errors'. Fourteen errors were distributed in the area. On average, 7.7 errors out of 14 total errors were discovered by the seven participants. Four out of seven participants reported 50 per cent or fewer errors. Nine errors out of 14 were classified as high criticality level. For these nine high criticality errors, one error was not found by any of the participants, four errors by less than five participants and three errors by all participants. Only one-third of this category of high-risk error was detected by all manipulators.

Conclusion It was the second time we had this experience. This 'room of errors' is a fun way to train staff to minimise and prevent potential errors related to the production of chemotherapy. It is also an opportunity to provide reminders of good manufacturing practices. In view of the results, it would be interesting to continue training by this approach or other learning process such as e-learning. This would maintain and bring new knowledge to pharmacy technicians to ensure the safety of the patient in their care process.

REFERENCES AND/OR ACKNOWLEDGEMENTS

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