Material and methods In June 2018 the patient's data were collected from the electronic medical records (WHospital) in our hospital: the literature was reviewed using the Pubmed database.

Results A 50 years' old male, with perianal CD since 2000, was diagnosed with APL in March 2018 after a bone marrow biopsy for grade 3/4 neutropaenia during an episode of pulmonary embolism and deep vein thrombosis. Infliximab therapy began in 2003 and was intermittent, with discontinuation in 2004 and 2006 because of good therapy response. He was unresponsive to these prior therapies: steroids, azathioprine and adalimumab. In 2015 he was enrolled for a few months, without good response, in a clinical trial with ustekinumab. After APL diagnosis, infliximab was discontinued and induction therapy for APL with arsenic trioxide and tretinoin (ATO + ATRA) was started. Remission began in April 2018, maintenance ATO + ATRA therapy was started and was still continuing in June 2018. The review of the literature found five reports of leukaemia cases after infliximab therapy in patients with CD (three), rheumatoid arthritis (one) and ankylosing spondylitis (one); three were males and two were females; the mean age of the patients was 46. The review also showed a higher risk of the occurrence of malignancies in patients on immunosuppressive therapy and/or with autoimmune/inflammatory disorders.

Conclusion Our patient presented APL after a long exposure to infliximab, which raises the concern that infliximab may be involved in leukaemia development. The presence of an autoimmune disease, such as CD, and prior immunosuppressive therapies, such as azathioprine and TNF- α inhibitors, may also have caused the development of leukaemia. Risk estimation is difficult. However, we suggest prompt evaluation for patients who develop haematological abnormalities when treated with infliximab.

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No conflict of interest.

5PSQ-073 MUCORMYCOSIS INDUCED BY INAPPROPRIATE USE OF ORAL CORTICOIDS – A CASE REPORT

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Background Invasive fungal infections such as Mucormycosis are considered opportunistic infections that occur almost exclusively in immunosuppressed patients, causing high morbidity and mortality. The use of long-term steroids may favour the state of immunosuppression, increasing the likelihood of acquiring this type of severe infections. The errors of therapeutic compliance are one of the possible causes of long-term treatment with corticosteroids.

Purpose The aim of the study was to discuss, through a clinical case, the consequences of an error in compliance with corticosteroid therapy.

Material and methods Observational, retrospective and descriptive case report of a patient diagnosed with mucormycosis due to the inappropriate use of corticoids. The data were obtained

by review of the electronic clinical history (JARA) and the pharmacy service managing software (FARMATOOLS).

Results The patient was a 47 years' old male with a clinical history of arterial hypertension, dyslipaemia, morbid obesity, with smoking and alcoholic habits. In August 2018, he was operated on for an acute subdural haematoma. After being discharged from the hospital, the doctor prescribed Dexamethasone 4 mg every 12 hours, descending gradually. Due to the patient's misunderstanding, he kept the same medication dose (8 mg Dexamethasone daily) and did not comply with the gradual withdrawal of the medication. Fifty days' later, the patient was admitted to hospital with acute hepatitis, necrotising fasciitis in the right lower limb after trauma and intense palate pain. Suspecting mucormycosis and bacterial infection, the patient was treated with the empirical treatment: liposomal Amphotericin B, Isavuconazole, Daptomycin, Amikacin and CLindamycin. The presence of *Rhizopus spp.* was confirmed and invasive rhinosinus mucormycosis secondary to immunosuppression due to the continued dose of corticosteroids was diagnosed. Finally, the patient died nine days after hospital admission due to multiorgan failure.

Conclusion In this case, the main cause of the development of mucormycosis came from a medication error in corticosteroid therapy compliance. Aiming to improve this kind of medication error, it is important to highlight the need to enhance pharmacotherapeutic monitoring, information and education for patients with the aim of improving therapeutic compliance.

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5PSQ-074 CANAKINUMAB IN FAMILIAL MEDITERRANEAN FEVER AND SECONDARY AMYLOIDOSIS: A CASE REPORT

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Background Familial mediterranean fever (FMF) is an autosomal recessive disease characterised by repeated and self-limited seizures of fever and serositis. Classically, FMF has been treated with colchicine, although currently we have interleukin-1 δ inhibitors such as anakinra or canakinumab.

Purpose To describe a case of FMF and secondary amyloidosis in current treatment with canakinumab.

Material and methods Description of a case of FMF, in follow-up in our hospital and in current treatment with canakinumab. Data was collected from the electronic medical record and analytics were reviewed in the laboratory application. The variables analysed were sex, age, neutrophil value, haemoglobin, C-reactive protein (CRP) and renal function before and after treatment with canakinumab and adverse reactions to treatment.

Results A 74-year-old female diagnosed with FMF, chronic kidney disease and hypertensive heart disease was followed up in our hospital since 2006. Treatment with colchicine 0.5 mg daily since then. Febrile episodes in 2009. Period 2010–2014 practically asymptomatic, with some episodes of fever that were self-limited with acetaminophen. She was admitted to hospital in December 2014 due to a fever outbreak and amyloidosis with renal insufficiency. In January 2015, anakinra