

5PSQ-055 **FILGRASTIM IN EARLY STAGE BREAST CANCER: DIFFERENCES BETWEEN TWO SMALL HOSPITALS**

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**Aim and objectives** To analyse the management of chemotherapy associated neutropenia in early stage breast cancer patients and compare differences in two small hospitals in the same health area.

**Material and methods** A multicentre, retrospective, observational study was conducted in patients with early stage breast cancer who began treatment during 2018. Data collected were age, tumour histology, hormone receptor status, human epidermal growth factor receptor 2 (HER2) status, chemotherapy regimens, neutropenia grade (common terminology criteria for adverse events (CTCAE) V.5.0) and filgrastim use.

**Results** During 2018, 38 patients started treatment (hospital A 23 patients, hospital B 15 patients). Median age was 53.7 years (hospital A 52.3 years; hospital B 55.7 years). Fourteen patients were hormone receptor positive, HER2 positive; 13 were hormone receptor positive, HER2 negative; 10 were triple negative; and only one was hormone receptor negative, HER2 positive.

Twenty-three patients received adjuvant therapy (accounted for 73.9% of hospital A) versus 15 neoadjuvant (60% of hospital B). Chemotherapy regimens most used were adriamycin-cyclophosphamide (AC) followed by weekly paclitaxel, adding trastuzumab±pertuzumab in HER2 positive patients. In hospital A, the four patients >65 years received docetaxel plus cyclophosphamide (TC) instead of AC. A triple negative patient was treated with AC followed by carboplatin plus nab-paclitaxel.

A total of 65.8% (hospital A 65.2%; hospital B 66.7%) of patients experienced grade 2 neutropenia or higher. Grade 4 neutropenia appeared in 23.7% of cases (hospital A 21.7%; hospital B 26.7%).

The use of filgrastim as prophylaxis was used in only one patient in hospital A with no record of neutropenia. On the other hand, hospital B had three patients who developed neutropenia grade 3 or 4. Only 33.3% of the neutropenias were treated in hospital A versus 60% in hospital B. No grade 2 was treated in hospital A, but all were treated in hospital B. Patients treated with TC had no neutropenia > grade 2.

**Conclusion and relevance** The greatest differences were the major use of neoadjuvant therapy and not using TC in hospital B. With a similar sample, significant variability existed in the practice with respect to filgrastim administration. Apparently, the widespread use of filgrastim in hospital B did not reflect an improvement. It is necessary to establish a protocol in order to standardise filgrastim use and also administration of TC in elderly patients.

#### REFERENCES AND/OR ACKNOWLEDGEMENTS

No conflict of interest.

5PSQ-056 **EXPERIENCE WITH TOFACITINIB AND BARICITINIB IN RHEUMATOID ARTHRITIS**

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**Background and importance** Tofacitinib and baricitinib were recently approved for rheumatoid arthritis (RA) treatment. This was a breakthrough because of their oral administration and new mechanism of action.

**Aim and objectives** To analyse tofacitinib and baricitinib treatment for RA and adverse effects (AE) after starting treatment in a second level hospital.

**Material and methods** A retrospective observational study was conducted in all patients starting baricitinib and tofacitinib treatment until September 2019. The collected variables were sex, age, previous disease modifying antirheumatic drugs (DMARD) and biological treatments, and AEs detected (through review of electronic medical history).

**Results** Forty-seven patients were included (12.8% men; mean age 57±12.6 years). Twenty-six (53.2%) received baricitinib. All patients had been previously treated with any DMARD. Twenty-six (55.3%) patients had received any biologic agent, and the average number of previous biological treatments was 1.7. Twenty-four AEs were detected in 15 different patients (31.9%). Eight patients with baricitinib (30.8%) presented any of the following AEs: upper respiratory tract infection (4), fatigue (2), changes in blood pressure (2), skin and mucous lesions (2), oesophageal candidiasis (1), headache (1), anxiety (1), arthralgia (1) and hair loss (1). Six patients treated with tofacitinib (28.6%) presented any AEs: headache (2), fatigue (2), respiratory infection (1), herpes infection (1), joint swelling (1) changes in blood pressure (1), pruritus (1), insomnia (1) and blurred vision (1).

In two cases, baricitinib was suspended for no clinical improvement, and in four cases for AEs (two for skin and mucous lesions, one for hair loss and fatigue, and other for fatigue). Tofacitinib was suspended for inefficacy in four cases and one AE (insomnia), leading to a dose reduction in one patient.

**Conclusion and relevance** The population that started RA treatment with tofacitinib and baricitinib in our hospital were mostly middle aged women with at least one previous treatment with DMARD. More than half of the patients had received some biologic previously. In spite of the limitations of this study (probable underestimation of AEs because they were not always recorded on the clinical history), tofacitinib and baricitinib showed an acceptable profile of adverse reactions, similar to those described on both technical data sheets.

#### REFERENCES AND/OR ACKNOWLEDGEMENTS

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