treatment for HCC between June 2017 and December 2018. Both monoinfected and coinfected HIV patients were included, having completed DAA treatment. We collected demographic (gender, age) and clinical (virus genotype, fibrosis degree, mono- or coinfected, treatment and length of treatment, previous treatments in the case of relapse) variables. As an effectiveness variable, we set sustained viral response (SVR) at week 12 after finishing treatment, or undetectable viral load in those patients who did not achieve a SVR.

Data were obtained from the pharmacotherapeutic management programme Silicon and SAP.

**Results** A total of 146 patients, mean age 54 years, were included. There was 34.93% women, 25.34% coinfected and 88.36% naïve.

The most frequent genotype (G) was G1a (31.94%), G1b, 29.86% and G3, 19.44%. Depending on hepatic damage, patients presented with different levels of fibrosis (F): F0–1, 66.44%; F2, 15.75%; F3, 6.16%; F4, 5.48%; and cirrhosis, 2.05%. Treatments were glecaprevir/pibrentasvir in 57.53%, sofosbuvir/velpatasvir in 3.03% and elbasvir/grazoprevir in 41.38%. Length of treatment was chosen according to what was said in the technical.

Effectiveness (SVR) evaluated 12 weeks after finishing treatment or undetectable viral load after finishing treatment in monoinfected patients was 75.93% and 24.07%, respectively. Regarding coinfection, we could not follow-up with one patient and the other patient’s results are still pending (SVR 92.11%). Relapse was detected in patients who had been previously treated with ombitasvir/paritaprevir/ritonavir+dasabuvir (2.05%), sofosbuvir/ledipasvir (0.68%, n=1) and elbasvir/grazoprevir (0.68%), and reinfection was detected in a patient previously treated with sofosbuvir/daclatasvir. Relapses were treated with sofosbuvir/velpatasvir/voxilaprevir (2.74%).

**Conclusion and relevance** Use of DAA was common in our hospital. Effectiveness data and population characteristics were equal to those obtained in the available bibliography. It is crucial to confirm SVR in week 12 after finishing treatment to make sure the disease has been cured.

**REFERENCES AND/OR ACKNOWLEDGEMENTS**

No conflict of interest.

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**4CPS-069 EVALUATION OF PALIVIZUMAB AS PROPHYLAXIS AGAINST RESPIRATORY SYNCYTIAL VIRUS INFECTION**

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**Material and methods** This was a retrospective, descriptive study from October 2012 to February 2019. Patients with palivizumab administration were included. The data collected were administrations of palivizumab per patient, administration dates, admitted patients for respiratory infection, date of admissions per patient, positive RSV cultures in admitted patients and need for oxygen therapy. The severity of the admission was assessed according to the need for oxygen therapy.

**Results** A total of 125 patients were included, with an average age of 2.84 months at the start of treatment and a mean of five administrations. Twenty-four patients (19.2%) were admitted for a respiratory cause of whom 7 (29.17%) had more than one admission. In the admitted patients, 5 (20.83%) had positive cultures for RSV. In these patients, median administrations was 5 (IQR 3–5) and median time from last administration to positive culture was 290 days (IQR 276–300). From the total patients admitted, 20 (83.33%) needed oxygen therapy but only 5 patients (25%) required oxygen at high flow. No deaths were recorded.

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Conclusion and relevance Admissions for respiratory infections were low in children with palivizumab administration. Furthermore, a small percentage of these admissions had positive cultures for RSV, which confirms the effectiveness of palivizumab. Most patients admitted for respiratory causes needed oxygen therapy.

REFERENCES AND/OR ACKNOWLEDGEMENTS
No conflict of interest.

4CPS-071 ANALYSIS OF EFFECTIVENESS: USE OF PERTUZUMAB AND TRASTUZUMAB IN NEOADJUVANT TREATMENT IN PATIENTS WITH HER2 POSITIVE BREAST CANCER AND ITS CORRELATION WITH PLASMA LEVELS OF TRASTUZUMAB

Background and importance The use of pertuzumab with trastuzumab in neoadjuvant therapy in breast cancer treatment is supported by two phase II clinical trials (NeoSphere and Tryphaena) that showed better rates of pathological complete response. In addition, Cobleigh et al described how the response to trastuzumab could be conditioned by their plasma levels.

Aim and objectives We analysed the rates of pathological response to neoadjuvant treatment under usual clinical practice conditions.

Material and methods A prospective study was conducted in women diagnosed with HER2 positive (HER2+) breast cancer who completed treatment from 2016 to 2019. To perform the assay, 2 mL of blood, corresponding to the first Cmin of trastuzumab were taken. Determination of the presence of ADA-trastuzumab was carried out with an ELISA immunoaassay. Informed consent was obtained from all patients.

Results A total of 40 patients (women) were studied with a median age of 50.6 years (39–71). The chemotherapy scheme used was adriamycin–cyclophosphamide (AC) followed by taxane with trastuzumab and in some cases pertuzumab.

In the pertuzumab group (n=27), response rates and mean levels of trastuzumab in the first Cmin (µg/mL) were:
- Complete pathological response (RCBO) in 17 (62.9%, n=17), (Cmin=22.30 µg/mL).
- Minimum residual response (RCRII) in 25.9% (n=7) (Cmin=23.50 µg/mL).
- Moderate residual response (RCBII) in 11.1% (n=3) (Cmin=22.30 µg/mL).

In the trastuzumab group (n=13), responses were:
- RCBO in 76.9% (n=10) (Cmin=16.40 µg/mL).
- RCRI in 15.4% (n=2) (Cmin=29.18 µg/mL).
- RCBII in 7.7% (n=1) (Cmin=18.7 µg/mL).

In our study, no difference was found between pathological responses and plasma levels of AD (Pearson 0.033, p=0.840), which supposes a scarce correlation between plasma concentrations of AE and the pathological response obtained. There were no differences between the pathological responses obtained and the plasma concentrations of AD (p=0.639).

Conclusion and relevance Previous studies by our team were unable to identify, under usual clinical practice conditions, differences in the pathology response of neoadjuvant treatment with trastuzumab versus trastuzumab with pertuzumab in patients with infiltrating ductal breast carcinoma HER2+. In the present, we have shown that the plasma levels of trastuzumab do not seem to correlate with this response.