combination presented benefit in terms of OS and PFS in untreated metastatic squamous NSCLC (mSNSCLC), regardless of PD-L1 expression. No randomised clinical trials (RCTs) of Pb-CT versus Pb alone have been done.

Aim and objectives To assess the comparative efficacy of Pb and Pb-CT in untreated mSNSCLC patients with PD-L1 ≥50% using an adjusted indirect treatment comparison (ITC).

Material and methods A bibliographic search was conducted in the Pubmed database (2 October 2019). Inclusion criteria were phase III RCTs, Pb and Pb-CT treatments, similar mSNSCLC population (with PD-L1 ≥50%), follow-up period and end points(OS or PFS). Exclusion criteria were mSNSCLC population with EGFR or ALK mutations. An ITC was developed using Bucher's method. Delta value (Δ), maximum acceptable difference as a clinical criterion of no inferiority, was set at 0.70 (and its inverse, 1.43), used to calculate the sample size in the Pb-CT trial. The Shakespeare method was used to estimate the probability of the results out of the Δ margins.

Results Two studies, one for each regimen,[1] [2] were found in the literature search. Limitations found between Pb-CT and Pb trials included populations (all patients vs only patients with PD-L1 ≥50%, respectively, subgroup data used for ITC) and small size of the squamous subgroup. No OS data were available for the squamous subgroup in the Pb trial. PFS was taken as the primary end point for ITC. Results of RCTs and ITC are shown in table 1.

Abstract 4CPS-076 Table 1

Reference	PFS
Pb-CT vs CT[1]	HR=0.37 (95% CI 0.24–0.58, PD-L1 ≥50% subgroup)
Pb vs CT[2]	HR=0.35 (95% CI 0.17–0.71, squamous subgroup)
Pb-CT vs Pb (ITC)	HR=1.06 (95% CI 0.46–2.45)

No significant differences in PFS between Pb-CT and Pb were found. The 95% CI exceeded Δ on both sides (high level of uncertainty). The probability of a result out of Δ were 24.14% below and 16.54% above.

Conclusion and relevance ITC did not show significant differences in PFS between Pb-CT and Pb. No evidence of clinically relevant benefit from one or other regimen was found. Considering the toxicity related to the addition of CT, Pb monotherapy would be preferable in untreated mSNSCLC with PD-L1 ≥50%.

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No conflict of interest.

4CPS-077 DETECTION AND COMMUNICATION OF CONCOMITANT USE OF CAPECITABINE AND PROTON PUMP INHIBITORS

AB Guisado Gil, IM Carrión Madroñal*, E Sánchez Gómez, MD Santos Rubio. *Hospital Juan Ramón Jiménez, Ugc Farmacia, Huelva, Spain*

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Background and importance Recent data suggest that the concurrent use of proton pump inhibitors (PPI) may reduce the efficacy of capecitabine by decreasing its absorption. It was associated with poorer progression free survival (PFS) and overall survival in a secondary analysis of the TRIO-013 trial.

Univariate analysis of a retrospective study of patients treated with capecitabine for colorectal cancer found that PPI use was associated with a decrease in 5 year PFS. Although the authors concluded that a significant interaction exists, after multivariate analysis, PPI use was no longer associated with worse PFS. No interaction was observed with magnesium–aluminium hydroxide containing antacid. According to this, the probability of interaction may be doubtful. However, because the possible outcome may be serious, we suggested an intervention to alert oncologists.

Aim and objectives A protocol was implemented to detect the concurrent use of PPI in outpatients treated with capecitabine and to communicate the drug interaction to oncologists. The aim of this study was to describe the pharmacist intervention and its results.

Material and methods Pharmacists developed the following protocol: (1) Identification of patients treated with capecitabine and PPI: pharmacists actively reviewed the electronic clinical records for the presence or absence of PPI prescriptions for each patient treated with capecitabine.

(2) Designing an informative note: the note included information about the possible drug interaction and patients identified in the previous phase. We recommended monitoring the effectiveness of capecitabine, routinely ascertaining the need for PPI use and PPI suspension or replacement with an alternative antacid treatment, whenever possible.

(3) Diffusion of the information to oncologists via email.

Results Over 1 year, we detected 71 patients treated with capecitabine, of whom 46 (65%) presented concomitant use of PPI (78% omeprazole, 13% pantoprazole, 7% esomeprazole and 2% rabeprazole). The reasons for capecitabine prescription were: 52% colorectal, 24% gastric or oesophageal, 13% breast and 11% pancreatic cancer. In all patients, monitoring the effectiveness of capecitabine was the preferred option.

Conclusion and relevance Most patients treated with capecitabine were also receiving treatment with PPI. In our case, oncologists preferred to monitor the effectiveness of capecitabine rather than discontinue PPI. This study reflects how pharmacists, as part of the multidisciplinary team, can participate in achieving better health outcomes.

REFERENCES AND/OR ACKNOWLEDGEMENTS

No conflict of interest.

4CPS-078 EFFECTIVENESS AND SAFETY OF ERIBULIN FOR ADVANCED BREAST CANCER TREATMENT

I Cavada Carranza*, M Carrasco Gomariz, M Moreno Garcia, R Diez Fernandez, T Molina Garcia. *Hospital Universitario De Getafe, Pharmacy Department, Madrid, Spain*

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Background and importance Eribulin is used, as monotherapy, in the secondline treatment of locally advanced or metastatic breast cancer (mBC) in patients who have previously received an anthracycline and a taxane or these are contraindicated.

ESMO-MCBS scores eribulin as level 2 (low clinical benefit) according to the EMBRACE study (Cortes *et al*, 2011).

Results in a non-controlled setting are usually worse than those obtained in clinical trials.

Aim and objectives We aimed to assess progression free survival (PFS) and safety of eribulin in clinical practice.

Material and methods An observational, retrospective and descriptive study was conducted. Patients with mBC treated with eribulin between April 2014 and May 2019 were included. Age, HER-2 and hormone receptor status, previous regimens for metastatic disease, number of eribulin cycles and time to progression or death were collected. Treatment related adverse events were also analysed.

Results

Thirty-four patients were included Median age was 54.1 (IQR 19.2) years; 82% were HER-2 negative and the other 82% were hormone receptor positive. Half (56%) of the patients had received three or more previous regimens. Median eribulin cycles was 5 (IQR 4.3). Median PFS was 3.5 months (IQR 4.2).

Fourteen patients (41.2%) suffered side effects, mainly neutropenia (20.6%), asthenia (14.7%), mucositis (11.8%), hepatotoxicity (8.8%), peripheral neuropathy (5.9%) and thrombocytopenia (5.9%).

Conclusion and relevance The benefit in PFS reported in the pivotal clinical trial was maintained in clinical practice. Adverse events were consistent with those reported in the EMBRACE study although the incidence was lower.

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No conflict of interest.

4CPS-079 SEQUENCING OF IBRUTINIB, IDELALISIB AND VENETOCLAX IN CHRONIC LYMPHOCYTIC LEUKAEMIA: EXPERIENCE IN A TERTIARY HOSPITAL

[1]R García-Fumero, [2]C Alarcón-Payer, [1]A Jiménez-Morales, [1]MDM García-Valdés, [3]JM Puerta-Puerta, [2]R Claramunt García*. [1]*Hospital Universitario Virgen De Las Nieves, Pharmacy, Granada, Spain*; [2]*Hospital Universitario De Jaén, Pharmacy, Jaén, Spain*; [3]*Hospital Universitario Virgen De Las Nieves, Haematology, Granada, Spain*

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Background and importance In managing chronic lymphocytic leukaemia (CLL), it is recommended that patients with TP53 deletion/mutation (TP53mut), who have a poor prognosis, are treated with ibrutinib as frontline therapy. Because of severe infectious complications, idelalisib combined with rituximab is only recommended for frontline therapy in patients not suitable for ibrutinib, if measures to prevent infection are followed. Patients unsuitable for ibrutinib/idelalisib may otherwise be treated with venetoclax.

Aim and objectives To evaluate the prescriptions and clinical outcomes of ibrutinib, idelalisib and venetoclax in a third level hospital.

Material and methods An observational, retrospective study was conducted including any prescriptions of ibrutinib, idelalisib and venetoclax for CLL from November 2015 to June 2019. We focused on TP53 mutation status, drug exposure, survival outcomes and reasons for drug switching or dose reduction, if applicable. Data were collected from electronic medical records.

Results Thirty patients receiving ibrutinib (n=23), idelalisib (n=13) and/or venetoclax (n=5) were recruited. Seventeen patients (56.7%) showed TP53mut. In the ibrutinib cohort, median drug exposure was 10.5 months and most patients (65.2%) had received it after conventional chemotherapy regimens (eg, FCR, R-CHOP, R-bendamustine). Only 5 patients (21.7%) showing TP53mut had taken ibrutinib as firstline therapy and 4 (17.4%) had received it after idelalisib; 2 of these patients because of disease progression and the other 2 because of adverse events (severe infections and colitis with weight loss). In the idelalisib cohort, median drug exposure was 4.45 months. Venetoclax was used for a median of 0.74 months and on ibrutinib failure in 4 patients (the remaining patient received prior idelalisib due to concomitant anticoagulant therapy). Dose reductions were needed in 11 patients on ibrutinib (causes: bruising, respiratory tract infections and neutropenia); in 4 receiving idelalisib due to severe diarrhoea (n=3) and pneumonia (n=1); and in 1 patient on venetoclax due to severe neutropenia. Neither median progression free survival nor median overall survival were reached at the data cut-off date. In fact, 59.5% of patients were still alive.

Conclusion and relevance Most patients received secondline ibrutinib and showed a long term response duration even when TP53mut was absent. Adverse effects resulted in frequent dose reductions/drug switching. However, venetoclax represents an appropriate option for patients whose CLL has failed to respond to ibrutinib/idelalisib.

REFERENCES AND/OR ACKNOWLEDGEMENTS

No conflict of interest.

4CPS-080 REAL LIFE TYROSINE KINASE INHIBITOR DISCONTINUATION IN PATIENTS WITH CHRONIC MYELOID LEUKAEMIA

[1]C Alarcon-Payer, [2]JM Puerta Puerta, [3]A Jiménez Morales, R Claramunt García*, F Horno Ureña. [1]*Hospital Universitario De Jaén, Servicio De Farmacia, Jaén, Spain*; [2]*Hospital Universitario Virgen De Las Nieves, Servicio De Haematología, Granada, Spain*; [3]*Hospital Universitario Virgen De Las Nieves, Servicio De Farmacia, Granada, Spain*

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Background and importance Currently, one of the most burning issues regarding the specific treatment of chronic myeloid leukaemia (CML) with interleukin-2 inducible T cell kinases (ITK) is whether in some patients who meet specific requirements treatment interruption could be attempted and molecular relapse free survival maintained without restarting treatment. This would mean a reduction in the side effects related to the medication and a progressive increase in the quality of life for patients.

Aim and objectives To analyse molecular relapse free survival after suspension of imatinib, nilotinib or dasatinib, which achieved and maintained a major molecular response (MMR) $\geq$4.5 log for at least 36 months.

Material and methods This was a prospective observational study of patients with chronic phase Ph+CML (CP-CML). Inclusion criteria were minimum ITK treatment time of 5 years, no resistance to a previous ITK, no accelerated phase diagnosis or blast crisis and those who had achieved and