Conclusion and relevance It seems that adjusted doses of anthracyclines in obese paediatric patients can be effective and safety but due to limited data, this recommendation must be taken with caution.

REFERENCES AND/OR ACKNOWLEDGEMENTS

No conflict of interest.

4CPS-085 IMPROVED ACCESS TO CHEMOTHERAPEUTIC TREATMENT IN PATIENTS WITH MULTIPLE MYELOMA

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Background and importance A hospital complex has a reference centre that is a tertiary hospital to which is attached a regional hospital located 75 km away. In 2018, in coordination with the pharmacy and haematology service, it was decided to implement a monographic consultation for patient with multiple myeloma in the regional hospital, with the proposal to improve the accessibility of patients to chemotherapeutic treatments and avoid displacement to the centre of reference.

Aim and objectives To describe the activity carried out within the scope of a programme to improve accessibility for patients with multiple myeloma. User satisfaction with this new feature was evaluated.

Material and methods A retrospective descriptive study was conducted in April 2018 and September 2019. The following variables of the chemotherapy management programme (Farmis-Oncofarm) were recorded: number of patients treated, number of chemotherapy cycles administered and type of chemotherapeutic scheme. To evaluate patient satisfaction, we obtained 30 anonymous and voluntary evaluations in which total satisfaction was rated from 1 to 10 and also satisfaction per item.

Results A total of 46 patients were treated during the study period: 58% were men and average age was 62 years. A total of 382 cycles of parenteral chemotherapy and 145 cycles of oral chemotherapy were administered. The schemes used were: VTD (bortezomib-thalidomide-prednisone), VMP (bortezomib-melfalan-prednisone), bortezomib-dexamethasone, daratumumab-bortezomib-dexamethasone, maintenance lenalidomide and Rd (lenalidomide-dexamethasone). Overall satisfaction by patients was 9.4. The best rated items were accessibility to the centre, proximity between the different units (haematology consultation, pharmacy and oncology day hospital) and waiting time.

Conclusion and relevance The implemented programme has been highly valued by patients. Seeking strategies aimed at improving the accessibility of patients to hospital treatments should be a priority for the health system. In our case, the pathology required frequent and repeated cycles of chemotherapy in fragile and elderly patients. This added to the ease of administration (subcutaneous and oral routes) making multiple myeloma a candidate pathology to follow-up in a regional hospital without jeopardising patient safety.

REFERENCES AND/OR ACKNOWLEDGEMENTS

No conflict of interest.

4CPS-086 IMATINIB DOSE OPTIMISATION THROUGH THERAPEUTIC MONITORING IN CHRONIC MYELOID LEUKAEMIA AS PART OF PHARMACEUTICAL CARE

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Background and importance Chronic myeloid leukaemia was the first haematological neoplasia to benefit from imatinib targeted therapy. The standard dose of imatinib is 400 mg/day, although it is related to interpatient variability in plasma exposure. The relationship between treatment outcomes and plasma exposure has been established; predose plasma concentrations (C_{min}) ≥1000 ng/mL are associated with improved clinical response, which supports dose optimisation through therapeutic monitoring.

Aim and objectives Our aim was to describe the degree of implementation of C_{min} assessment based on response status and individual tolerance and to determine the impact of imatinib therapeutic monitoring in daily clinical practice in a tertiary hospital.

Material and methods This was an observational retrospective study in a university hospital. All patients being treated with imatinib between December 2016 and March/2019 were reviewed. Demographic and clinical data were collected (sex, diagnosis age, imatinib starting time, C_{min}, BCR-ABL ratio and information concerning medical and pharmaceutical care consultation). C_{min} was quantified by the nanoparticle agglutination immunoassay in human plasma.

Results Eighty-seven patients received active treatment (56% men). Age of diagnosis was 52±17 years and 74% (65/87) of patients were treated with imatinib. Treatment monitoring occurred in 66% (43/65) of patients. Time between treatment start time and C_{min} monitoring was 60.8 (2.5–509) months and 2 (1–7) samples were analysed per patient: 63% (27/43) of patients had C_{min} ≥1000 ng/mL since the first monitoring: 1156 (1033–2972) ng/mL (74% treated with 400 mg/day, 15% 300 mg/day, 7% 200 mg/day and 4% 600 mg/day). In 15% (4/27) of patients where appropriate C_{min} was reached from the beginning, the dosage was reduced, maintaining them within optimal concentrations. In 38% (16/43) of patients, C_{min} was <1000 ng/mL in the first monitored sample: 673 (444–999) ng/mL (75% treated with 400 mg/day and 25% 300 mg/day). In 88% (14/16) of patients with subtherapeutic C_{min}, a new C_{min} was studied: 939 (363–1352) ng/mL. In 43% (6/14) dose interventions were done (dose increased in 50% (3/6), 67% reached C_{min} ≥1000ng/mL). In 57% (8/14) of patients with subtherapeutic levels, the dose was not modified due to a good treatment response (680 (525–999) ng/mL).

Conclusion and relevance Most patients reached optimal imatinib plasma concentrations with a standard dose. The

results showed an outstanding implementation in clinical practice since the Cmin quantification technique was used in our hospital, mostly because of newly diagnosed patients. Recording imatinib concentrations during follow-up would help achieve 100% monitored patients. Benefits of dose optimisation include reducing the dose, keeping optimal concentrations, or increasing dose in case of subtherapeutic levels.

REFERENCES AND/OR ACKNOWLEDGEMENTS

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4CPS-087 OPTIMISATION OF RESOURCES IN THE USE OF IMMUNOTHERAPY: NIVOLUMAB AND PEMBROLIZUMAB WEIGHT BASED DOSING INSTEAD OF FLAT DOSE

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Background and importance Nivolumab and pembrolizumab are highly selective blockers of anti-programmed death-1 (PD-1). Nivolumab was authorised to be administered in weight based dosing (WBD) schedules at 3 mg/kg every 2 weeks (w) for all indications, and pembrolizumab at 2 mg/kg every 3w in melanoma, urothelial carcinoma, Hodgkin lymphoma and secondline non-small cell lung cancer. In May 2018, the European Commission approved nivolumab 240 mg/2w or 480 mg/4w, and later pembrolizumab 200 mg/2w or 400 mg/8w flat dose (FD) for all indications, replacing WBD with equal efficiency and safety.

Aim and objectives To describe the economic impact of nivolumab and pembrolizumab WBD instead of FD.

Material and methods An observational, descriptive and retrospective study was performed in patients treated with nivolumab and pembrolizumab in a reference hospital from May 2018 to September 2019. In agreement with oncology, it was decided to prescribe nivolumab WBD for weight <80 kg and FD for weight >80 kg, and pembrolizumab WBD for weight <100 kg and FD for weight >100 kg, for the indications WBD was authorised to improve efficiency. We registered demographic data (sex, weight and age), number of cycles received and doses prescribed in the study period. Patient data were obtained from our chemotherapy prescription and preparation database software and digital clinical history. Direct costs between the use of WBD instead of FD were compared to calculate the economic saving.

Results Seventy-one patients treated with nivolumab (58) and pembrolizumab (13) were analysed during the study period, 42% men, median age 67.5 (range 43–86) years and median weight 74 kg (range 43–112). A total of 775 cycles of nivolumab and pembrolizumab were administered and 42/71 patients (59%) were treated with WBD instead of FD because of weight <80 kg (nivolumab) and <100 kg (pembrolizumab). The real cost of nivolumab and pembrolizumab WBD in the study period was 1 614 256€, instead of the theoretical cost of these drugs using FD (1 873 357€), meaning a reduction in costs of 259 101€ (13.83%).

Conclusion and relevance Despite the recommendation to prescribe FD of nivolumab and pembrolizumab, with equal efficiency and safety for our population, WBD means a reduction

in costs, with huge optimisation of the resources available in our hospital.

REFERENCES AND/OR ACKNOWLEDGEMENTS

No conflict of interest.

4CPS-088 CHECKPOINT INHIBITORS IN NON-MICROCYTIC LUNG CANCER: RESULTS IN COMMON CLINICAL PRACTICE

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Background and importance The guidelines recommend anti-PD-1/PD-L1 immunotherapy as secondline treatment in patients with locally advanced or metastatic non-small cell lung cancer (NSCLC), regardless of PD-L1 expression.

Aim and objectives To evaluate the effectiveness of treatment with checkpoint inhibitors (ICI) (nivolumab, pembrolizumab and atezolizumab) in the secondline treatment of metastatic NSCLC.

Material and methods This was a descriptive, transversal, retrospective research of all patients treated with ICI as a secondline treatment for metastatic NSCLC between November 2013 and September 2019. Variables collected were: age, sex, histology, PD-L1 expression, ECOG at the beginning of treatment, cycles received and duration of treatment. Effectiveness criteria were: median overall survival (OS), and OS at 2 and 3 years (Kaplan–Meier method). Data were obtained from the electronic clinical record and the onco-haematological electronic prescription programme (Oncowin). Analysis was done by SPSS Statistics.

Results A total of 119 patients were included (74.8% men), with a median age at the beginning of treatment of 67 years (48–86). Histology was adenocarcinoma in 59.48%, squamous in 37.07% and large cell in 3.45%. We found that 15.12% of patients had negative PDL-1 (<1%), 24.37% PDL-1 (1–50%) and 17.65% PDL-1 (>50%); in 42.86% of patients, expression was not determined. ECOG at the beginning of treatment was 47.31% for ECOG 0 and 52.69% for ECOG 1. A total of 53.78% of patients were treated with nivolumab, 14.29% with pembrolizumab and 31.93% with atezolizumab, with median number of cycles administered of 6 (1–57). Median OS was 8.89 months (95% CI 6.13–11.65). No significant differences were found in median OS based on expression of PDL-1 or drug. Variable that significantly influenced median OS were ECOG (ECOG 0 greater survival, $p=0.045$). OS at 2 and 3 years were 24.7% and 17.0%, respectively. In 29.41% of patients, thirdline chemotherapy was given: 57.14% taxane monotherapy, 11.42% pemetrexed, 14.28% carboplatin–pemetrexed and 17.16% other, with a median OS of 7.77 months (95% CI 4.37–11.17).

Conclusion and relevance Under usual clinical practice, ICI achieved an OS of 8.72 months, lower than that obtained in the pivotal trials, but the percentage of long term survivors was similar to the pivotal trials. Although the percentage of patients who were treated with a thirdline was low, their OS was considerable.

REFERENCES AND/OR ACKNOWLEDGEMENTS

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