Conclusion and relevance Our data confirmed the modest benefits for highly pretreated patients, consistent with previously published clinical trials.

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No conflict of interest.

4CPS-102 INFLUENCE OF PALBOCICLIB TOXICITY IN REAL WORLD CLINICAL PRACTICE

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Background and importance Palbociclib was approved by the EMA for the treatment of hormone receptor positive, human epidermal growth factor receptor 2 (HER2) negative locally advanced or metastatic breast cancer in combination with an aromatase inhibitor or fulvestrant.

Aim and objectives To study the adverse events (AEs) and their impact on dosing and cycle delays in patients treated with palbociclib. To characterise the safety of palbociclib in clinical practice.

Material and methods This was a retrospective observational study (March 2018–July 2019). Patient demographics, clinical and treatment related data and AEs were analysed. Toxicity was classified by common terminology criteria for adverse events.

Results A total of 41 women were included, mean age was 59 (37–78) years and mean number of cycles received was 8.5 (1–18). Thirty-seven patients (90%) presented with AEs. The most common AEs were haematological (68%): neutropenia (58.5%), leucopenia (12%), anaemia (7%) and thrombocytopenia (5%). Among the non-haematological AEs, general disorders (asthenia, fatigue) were the most common (51%) followed by gastrointestinal events (34%), skin and subcutaneous tissue disorders (15%), musculoskeletal and connective tissue disorders (10%), metabolism and nutrition disorders (5%), and hepatobiliary disorders (5%).

In response to treatment related AEs, 17 patients (41%) required dose reduction. In 13 cases (32%) the cause of the modification was neutropenia; other causes were anaemia, fatigue, cholelithiasis and pruritus. Five patients required a second dose reduction and the reasons were the same (4 because of neutropenia and 1 because of fatigue). The mean interval between reductions was 5 cycles (3–10) and currently all are continuing treatment with palbociclib.

As a result of the AEs, 27 patients (67.5%) have required cycle delays. The main cause was neutropenia (50%), followed by anaemia (5%) and fatigue (5%). Other causes were leucopenia, thrombocytopenia, diarrhoea, pruritus and non-treatment reasons.

Ten patients discontinued treatment (24%), 9 due to disease progression and the 1 left because of hypertransaminasaemia produced after the first cycle which triggered early suspension.

Conclusion and relevance Due to proper management of toxicities, the majority of patients did not need to discontinue treatment and palbociclib may be an option in these patients. However, some patients presented AEs which led to delays in the cycles and dose modifications.

REFERENCES AND/OR ACKNOWLEDGEMENTS

No conflict of interest.

4CPS-103 IS THERE A ROLE FOR THE PHARMACIST IN SCREENING FOR METABOLIC SYNDROME?

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Background and importance Evidence for a pharmacist role in the screening of MetS has been shown to be effective in at risk populations.[1] Despite migrants being an at risk group for the development of MetS, no literature has described screening of migrants by pharmacists.

Aim and objectives To identify the impact of the pharmacist role in screening migrants on arrival in a Middle Eastern country and following 24 months of residency in the Middle East.

Material and methods This was a prospective longitudinal observational study. Migrants aged 18–65 years were informed about the research and consented to participate by pharmacists. Baseline screening for MetS risk factors was conducted. Parameters included glycated haemoglobin (HbA1c), triglycerides (TG), high density lipoprotein cholesterol (HDL-C), blood pressure (BP) and waist circumference (WC). All migrants with identified metabolic abnormalities at this screening stage were referred to physicians by the pharmacist for further management. Migrants with normal metabolic parameters at baseline were invited to be re-screened by pharmacists. This will allow identification of an increase if any incidence of MetS and will allow for earlier intervention and management.

Results Of the 1379 identified migrants, 460 consented to participate; 70% were men and 82.2% (378) were Asians. Pharmacist led screening revealed 13.9% (64) with abnormal BP, 6.7% (31) with pre-diabetes, 21.4% (91) with elevated TG, 25% (115) with low HDL–C, 47% (219) with high WC and 16% (75) were found to have MetS and referred to the physician for follow-up. These participants were consequently identified as at risk for development of MetS at a much earlier stage. A total of 199 migrants with normal metabolic parameters will be followed-up following 24 months of residency in the Middle East. Throughout the study, migrants with metabolic abnormalities were referred by pharmacists to physicians for further management.

Conclusion and relevance The study indicates that pharmacist screening is effective for early identification and potential early management of MetS in this migrant population.

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No conflict of interest.

4CPS-104 SWITCHING ORAL ANTIANDROGENIC TREATMENT IN PATIENTS WITH CASTRATE METASTATIC PROSTATE CANCER: AN ANALYSIS

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Background and importance Abiraterone is used in combination with prednisone, is metabolised by the liver (CYP3A4) and is an enzyme inhibitor (CYP2D6/CYP2C8). Enzalutamide is metabolised by the liver (CYP2C8/CYP3A4) and is a potent enzyme inducer (CYP3A4/CYP2B6/CYP2C9/CYP2C19). Both are used to treat castrate metastatic prostate cancer (CMPC).
Aim and objectives To analyse switching between two antiandrogenic drugs, abiraterone and enzalutamide, in patients with CMPC.
Material and methods This was an observational, retrospective, descriptive, unicentre study. The study included 127 patients with CMPC who began treatment with abiraterone or enzalutamide from January 2015 to March 2019. Clinical data from an outpatient pharmacy database and from the medical history were analysed. Reasons to switch were classified as safety, pharmacological interactions and galenic advantages.
Results A total of 127 patients were analysed: 50 began treatment with abiraterone and 77 with enzalutamide. Four of the 50 patients who started with abiraterone switched to enzalutamide (8%) for safety reasons (100%, n=4) because of side effects: digestive intolerance and diarrhoea (50%, n=2), oedema (25%, n=1) and uncontrolled diabetes (25%, n=1). The last case was probably due to prednisone.

Ten of the 77 patients who started treatment with enzalutamide switched to abiraterone (13%) for safety reasons in six patients (60%) because of side effects: memory loss and disorientation (20%, n=2), asthenia (10%, n=1), depression and anxiety (10%, n=1), hypertension (10%, n=1) and parkinsonism (10%, n=1). In three patients (30%) switching was due to drug interactions, which modified the efficacy and safety of enzalutamide and the other drug involved. Four drugs were involved, 2 (50%) were antihypertensives (manidipine and verapamil) and 2 (50%) were anticoagulants (rivaroxaban and acenocoumarol). In one patient (10%), switching was due to the galenic advantage of the smaller number and size of abiraterone tablets compared with enzalutamide capsules because of difficulty in swallowing in a case of oesophageal neoplasm.
Conclusion and relevance Switching between abiraterone and enzalutamide in our patients was mostly for safety reasons. Some side effects of the treatment with abiraterone and prednisone may have a steroidal origin. Enzalutamide is involved in pharmacokinetic and pharmacodynamic interactions with clinical relevance, so this is an important reason to switch. The smaller number and size of tablets could be a galenic advantage.

REFERENCES AND/OR ACKNOWLEDGEMENTS

No conflict of interest.

4CPS-105 TOLERANCE PROFILE TO ANTITHYMOCYTE IMMUNOGLOBULIN TREATMENT AND ITS RELATION TO INFECTIOUS PARAMETERS IN PAEDIATRIC PATIENTS

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Background and importance Rabbit antithymocyte immunoglobulin (ATG) is used to prevent or treat graft versus host disease (GVHD). There have been few studies on tolerance to administration of ATG in paediatric patients. It is related to immunomodulatory manifestations that cause an inflammatory response capable of triggering clinical and analytic manifestations similar to those of an infection, resulting in the administration of antibiotic in most patients.
Aim and objectives To describe the tolerance to administration of ATG in paediatric patients who underwent bone marrow transplantation (BMT) and to analyse its relationship with clinical and analytic manifestations similar to an infection.
Material and methods This was an observational retrospective study involving paediatric patients with BMT that received ATG (December 2010–February 2019). Variables collected were demographics (age/sex), BMT related variables (pathology, sources of haematopoietic stem cells (HSC), donor type), clinical symptoms (fever (secondary to ATG if 0–72 hours post-infusion), temperature), treatment (dose, premedication, side effects), analytics (maximum procalcitonin (PCT) and C reactive protein (CRP), liver and kidney function markers) and blood cultures. Variables were obtained from electronic/paper medical records and the oncohaematologic electronic prescribing programme.
Results Fifty-six patients were enrolled, 55.35% (31) men, with a median age of 7 years, and 92.8% (52) received ATG as prophylaxis and 7.2% (4) as refractory treatment of GVHD. The doses recorded were 1.25–2.5 mg/kg, with 2 mg/kg the most common dose (85.7%; 48) over 3 days (2 days if haploidentical BMT). All patients received premedication, full dose and no reduction in the rate of administration or discontinuation. The most frequent underlying diseases were oncological, mainly acute lymphoblastic leukaemia (57.1%; 32), and haematological (9 patients), mainly medullary aplasia (33.3%; 3). The main source of HSC was peripheral blood (50%; 28) and donor type was mismatched unrelated donor (39.28%; 22).

In 73.2% (41) of patients, fever (38.5°C±0.5) appeared 11.28 hours after the start of infusion and lasted 1.77±0.84 days; 82.9% (34) of these patients received broad spectrum antibiotic treatment (mostly cefepime, amikacin, teicoplanin) over 7.61±3.79 days, with positive blood culture in 7.3% (3). Markers of infection were altered in most patients, with average values for CRP of 97.55±59.45 mg/dL and PCT of 35.57 ±28.55 ng/dL.