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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

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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.