Conclusion and relevance Electronic prescription and pharmacist validation allowed us to detect potential medication errors, promoting patient safety in vaccine administration. This circuit is applicable to all hospitals with an EPP and should allow them to detect and prevent potential medication errors.

REFERENCES AND/OR ACKNOWLEDGEMENTS

Conflict of interest No conflict of interest

5PSQ-149 DRUG INTERACTION IN BREAST CANCER TRIPLE NEGATIVE THERAPY: DOCETAXEL AND FLUVOXAMINE. A CASE REPORT

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Background and importance To alert clinicians to the potential problems of combining docetaxel (and taxanes in general) with fluvoxamine.

Aim and objectives To report a live conditioning interaction between docetaxel and fluvoxamine in a breast cancer patient.

Material and methods A 60-year-old woman (60 kg, 164 cm) was diagnosed with triple negative right breast ductal carcinoma (TNM stage T1N0M0). The treatment plan consisted of four cycles of neoadjuvant chemotherapy with cyclophosphamide 600 mg/m² and epirubicin 95 mg/m² (EC) biweekly, four cycles of carboplatin AUC5 and docetaxel 75 mg/m² followed by pegfilgrastim 6 mg on day +2 and surgical intervention. After completion of the EC scheme, the patient showed haematological tolerance and clinical improvement. The patient completed the first dose of the carboplatin-docetaxel regimen with proper tolerance. However, before the second cycle, the patient experienced syncope, asthenia and hyporexia. A complete blood count (CBC) was performed at the second consult, showing that the patient was in range to receive chemotherapy. However, due to the syncopal episode and suspicion of neutropenia on that day, the oncologist decided to decrease the dose of docetaxel to 70 mg/m². On day +9, the patient presented to the emergency room with a recurring syncopal episode and neutropenia, and was admitted with septic shock. Blood cultures were obtained and were positive for *Pseudomonas aeruginosa*. Meropenem was started. Furthermore, it was discovered that the patient had started taking fluvoxamine as an antidepressant the same day she started the first cycle of docetaxel-carboplatin. The interaction between docetaxel and fluvoxamine was assimilated, and fluvoxamine was discontinued and exchanged for mirtazapine.

Results Fluvoxamine is an inhibitor of the CYP3A4 isoenzyme. Docetaxel is metabolised through CYP3A4, and the concomitant use may increase concentrations, leading to toxicity. Although the score was 4 (possible) for the drug interaction probability scale, if pharmacokinetic analysis had been performed, we could have proven that the AUC of docetaxel had reached toxic levels.

Conclusion and relevance Although SSRIs are often prescribed to combat depression, in breast cancer patients they can also be used to control hot flushes. It is mandatory to avoid using SSRIs that are metabolised through CYP3A4, such as fluvoxamine, fluoxetine, paroxetine, sertraline and venlafaxine

in the setting of docetaxel. Therefore, it would be best to recommend SSRIs such as mirtazapine, citalopram and escitalopram.

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Conflict of interest No conflict of interest

5PSQ-150 DISSEMINATED INTRAVASCULAR COAGULATION AFTER PD-1 BLOCKADE WITH NIVOLUMAB IN ADVANCED MELANOMA: A CASE REPORT

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Background and importance Immune checkpoint inhibitors (ICIs) represent a milestone therapy in many types of cancer, such as melanoma. Nivolumab is a programmed death receptor-1 (PD-1) blocking antibody with antitumour activity in melanoma. Only a few studies have investigated the relationship between ICIs and disorders of the coagulation-fibrinolysis system.

Aim and objectives To report a case of disseminated intravascular coagulation (DIC) in a metastatic melanoma patient treated with nivolumab. A 50-year-old woman was diagnosed with melanoma stage IB and resected in 2008. In December 2019, she relapsed (pulmonary and intracardiac metastasis). Then, she underwent treatment with nivolumab 240 mg/14 days, 14 cycles (last cycle 26 June 2020), with greater tumour partial response. During the last nivolumab cycles she had asthenia and thrombocytopenia and nivolumab was stopped. She was treated with methylprednisolone, but low platelet count persisted and she had extensive haematomas. She was admitted to hospital on 27 July due to probable DIC as an immune related adverse event (IrAE).

Material and methods Laboratory tests on admission showed grade 3 thrombocytopenia ($36 \times 10^9/L$ platelet count) and disordered coagulation (35 mg/dL fibrinogen, 75 468 ng/mL D-dimer). International normalised ratio for prothrombin time and activated partial thromboplastin time were in the normal range. PCR for SARS coronavirus screening and blood tests for mycobacteria were both negative.

Results The patient was treated with fibrinogen. There was no evidence of tumour progression or signs of infection. Furthermore, the patient had no history of other blood disorders, and there were no signs of trauma or sepsis. She was diagnosed with DIC related to nivolumab and she received gamma globulins, fresh frozen plasma and platelet transfusion with negative clinical evolution; so, she began treatment with infliximab and methylprednisolone pulse, without signs of bleeding, except for the persistence of haematomas and low levels of fibrinogen and platelets. The patient's condition deteriorated, and platelet count decreased despite therapy with fibrinogen, anticoagulants, transfusions of blood and antibiotic-antifungal therapy. Finally, the patient showed neurological damage related to cerebral haemorrhage due to the low platelet count and she died in hospital.

Conclusion and relevance Disseminated intravascular coagulation had the highest proportion of death outcomes among the top 10 most frequently reported ICI associated haematological IrAEs. For this reason, clinicians need to be careful, paying