but that there were isolated cases described in the bibliography. No response was obtained for two drugs.

Conclusion and relevance The information collected in the EPAR is insufficient to resolve doubts for an oncohaematological pharmaceutical care consultation in most cases and it is necessary to perform bibliographic searches to obtain quality information. Laboratories should provide all available information and implement trials to evaluate the efficacy of drugs in real practice.

REFERENCES AND/OR ACKNOWLEDGEMENTS

Conflict of interest No conflict of interest

4CPS-284 TREATMENT OF CYCLIN INHIBITOR INDUCED NEUTROPENIA: IMPACT ON PROGRESSION FREE SURVIVAL

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Background and importance The incidence of neutropenia in cyclin inhibitor (CI) treatment of luminal metastatic breast cancer (LMBC) is very high and leads to a reduction or delay in the required dose.

Aim and objectives To analyse the efficacy of granulocyte colony stimulating factor (G-CSF) in CI treatment. We used filgrastim as G-CSF.

Material and methods A retrospective study of patients that initiated CI treatment between March 2018 and April 2020 was conducted.

Results The cohort included 69 LMBC patients treated with CI. Median age was 65 years (41–89), 20 (29%) patients had a metastatic debut, 21 (30%) progressed during endocrine adjuvant treatment and 28 (41%) had progressed after 5 years of hormonal treatment. 44 patients (63%) received CI treatment as firstline treatment, 10 (15%) after progression to firstline with hormonotherapy and 15 (22%) after progression to chemotherapy. The visceral disease was present in 41%. 48 patients received adjuvant systemic treatment, of whom 35 received adjuvant chemotherapy. 58 patients presented with neutropenia (ANC <1500 cells/μL) of whom 39 received filgrastim (median 780 μg; range 330–1000 μg).

Global median progression free survival (PFS) was 10.88 months (95% CI 5.8 to 15.9) with 38 events. Patients treated as firstline had a PFS of 14 months compared with 8 months for secondline (log rank 0.134). Patients with neutropenia had a superior PFS (15 vs 8 months; log rank $p=0.006$); 16 versus 9 months for firstline and 13 versus 5 months for secondline. We did not find any correlation between G-CSF use and clinical variables, such as firstline or secondline, visceral metastasis, or diagnosis and metastatic interval. PFS in patients with or without filgrastim was similar (14 vs 12 months).

Conclusion and relevance CI induced neutropenia is a widespread complication and correlated with PFS in our patient cohort: 15 versus 8 months in the whole group. G-CSF treatment did not affect PFS but can help to maintain treatment

and avoid early relapses. Whether neutropenia induced by treatment with CI behaves as a prognostic factor and whether the use of G-CSF could provide clinical benefit should be studied.

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4CPS-285 MULTIDISCIPLINARY ORAL THERAPY OUTPATIENT CLINIC: AN ITALIAN SINGLE CENTRE EXPERIENCE

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Background and importance The increasing use of oral anti-cancer drugs (OAD) has led to new challenges for clinicians. The traditional therapeutic horizon has changed, but data about new cancer care models are still scarce. Multidisciplinary management involving three distinct figures (medical oncologist, hospital pharmacist and nurse) could improve compliance and treatment (trt) safety.

Aim and objectives The aim of this analysis was to describe the oral therapy outpatient clinic (OOC), a multidisciplinary project performed at our oncology unit. A multidisciplinary approach focused on prescription, therapeutic education, drug interaction, monitoring and follow-up, to improve patients awareness, addressing medication safety, trt adherence and adverse events (AEs) management.

Material and methods OOC was limited to patients with gastrointestinal (GI) tumours. Three professional figures (medical oncologist, hospital pharmacist and nurse) performed joint visits (each with specific tasks), with a schedule based on patient and trt characteristics.

Results Between March 2019 and April 2020, 359 visits were performed in 49 patients: 23 (46.9%) were men, 100% were ECOG PS 0–1 and median age was 66 years (range 34–80). Overall, 22 patients (44.9%) received adjuvant trt and 27 patients (55.1%) trt for advanced disease. 8 patients (16.2%) had received ≥ 2 previous trt lines. 32 patients (65.3%) had colorectal cancer, 5 patients (10.2%) had hepatocarcinoma, 7 patients (14.3%) had biliary tract carcinoma and 5 patients (10.2%) had other types of GI tumours. Capecitabine was the most frequent CT (73.5%). 6 patients (12.2%) received trifluridine/tipiracil, 5 patients (10.2%) sorafenib and 2 patients (4.1%) regorafenib. Only 19 patients (38.8%) started a full dose trt (33.3% among patients aged >70 years vs 41.9% in patients aged ≤ 70 years). 29 patients (59.2%) had to delay ≥ 1 trt cycle (61.1% aged >70 years vs 58.1% aged ≤ 70 years). 27 patients (55.1%) required ≥ 1 dose modification due to toxicity, including haematological, cutaneous and GI AEs (50.0% >70 years vs 58.1% ≤ 70 years). 35 patients (71.4%) took ≥ 4 concomitant drugs: ≥ 1 drug interaction was found in 32 patients, requiring trt adjustment in 29 patients.

Conclusion and relevance OAD require comprehensive and integrated patients management. Multidisciplinary simultaneous visits involving an oncologist, pharmacist and nurse could