patients). The potential percentage of use was about 17% of the total. DOR+FTC/TAF or DOR+FTC/TDF represented a cost of 851.55€ and 642.90€ /patient/month, respectively. RVP/FTC/TAF, EFV/FTC/TDF or DRV/COBI/FTC/TAF would cost 673.57, 262.58 or 857.51€ /patient/month, respectively.

Conclusion and relevance DOR would be beneficial in those patients with CNS disorders due to EFV and high viral load (>100 000 copies) or in polymedicated patients because of the lower profile of interactions. In the remaining cases, there are alternatives already available in the hospital (following recommendations of the GESIDA guidelines).

REFERENCES AND/OR ACKNOWLEDGEMENTS

Conflict of interest No conflict of interest

2SPD-031 SUBGROUP ANALYSIS ABOUT EFFICACY OF EARLY USE OF REMDESIVIR IN COVID-19

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Background and importance A greater benefit was suggested with early treatment with remdesivir against COVID-19.

Aim and objectives To develop a systematic review and methodological interpretation of subgroup analyses according to timing of use of remdesivir in COVID-19.

Material and methods A bibliographic review in MEDLINE was conducted up to 10 October 2020. The 'Clinical Queries/Narrow' tool was used with the search strategy: ((Therapy/Narrow[filter]) AND (remdesivir AND COVID)). Randomised clinical trials (RCTs) with subset analysis about early and late use of remdesivir (≤10 vs >10 days from symptom onset, or ≤9 vs >9 days) were selected. The rest of the studies were excluded. All endpoints with subgroup analysis regarding timing of remdesivir use were assessed. Two methodologies were applied. The first considered statistical interaction among subsets, prespecification, biological plausibility and consistency of the subgroup analyses of similar RCTs.[1] The second methodology was a validated tool with preliminary questions to discard subset analysis without minimal relevance, and a checklist.[2] This checklist assigned a score related to a recommendation for applicability of subgroup analysis in clinical practice.

Results 20 results were found after review; 16 studies were excluded because they were not RCTs and 1 study had no efficacy evaluation of remdesivir. Therefore, three RCTs were selected. Endpoints considered were: time to clinical improvement, mortality, viral load, and clinical status at days 11 and 15. According to the first methodology, no statistical interaction was observed in the outcomes of the RCTs. Prespecification was established in time to clinical improvement, and clinical status at day 15 of an RCT. Biological plausibility was described in the subset analysis of each endpoint of the RCTs. No consistency of subgroup analyses were found. The second methodology discarded the applicability of the subset analysis through preliminary questions in two RCTs because of the absence of minimal relevance. For the third RCT, 'null' recommendation (score −3 points) of clinical applicability was reached for clinical status at day 11.

Conclusion and relevance No differences were found between early and late use of remdesivir in COVID-19. We developed the first study with a systematic review and methodology about subgroup analysis of timing of use of remdesivir.

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Conflict of interest No conflict of interest

2SPD-032 NETWORK META-ANALYSIS OF THERAPEUTIC ALTERNATIVES IN UNTREATED METASTATIC SQUAMOUS NON-SMALL CELL LUNG CANCER

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Background and importance Multiple therapeutic alternatives are used in untreated metastatic squamous non-small cell lung cancer (umSNSCLC). Paclitaxel–carboplatin–pembrolizumab combination (PC-pembrolizumab) has recently been authorised for this indication.

Aim and objectives To assess the comparative efficacy among different therapeutic alternatives used in mSNSCLC through a network meta-analysis (NMA).

Material and methods A search was conducted on 19 February 2020 with the following inclusion criteria: phase II/III randomised clinical trials (RCT), including drugs used in umSNSCLC, and overall survival (OS) as the efficacy endpoint. Exclusion criteria: mSNSCLC population with EGFR or ALK mutations and RCTs without a comparator common to the evaluated alternatives. Pooled hazard ratios (HR) were calculated by Bayesian methods, through the combination of direct and indirect evidence by the NMA. Fixed and random effects were evaluated. Deviance information criteria (DIC) statistics were used to compare the models. The agreement of direct and indirect estimations was assessed by node splitting models to evaluate the consistency of NMA. Delta value, maximum acceptable difference as clinical criterion of non-inferiority, was set at 0.70 (and its inverse, 1.43), used to calculate the sample size in the PC-pembrolizumab trial.

Results Nine RCTs were selected. PC was the common comparator. The DIC value for the fixed effects model was more favourable. No statistically significant differences between direct and indirect evidence were found, and therefore NMA was consistent. The PC-pembrolizumab combination was considered as the reference (treatment with the greatest magnitude of effect). HR for OS were: 1.4 (95% CI 0.89 to 2.3) versus carboplatin–gemcitabine; 1.6 (1.2 to 2.1) versus PC; 1.5 (1.1 to 2.1) versus nab–PC-atezolizumab; 1.8 (1.3 to 2.5) versus PC-figitumumab; 1.4 (0.96 to 2.0) versus PC-motesanib; 1.3 (0.66 to 2.5) versus PC-necitumumab; 2.1 (0.86 to 5.0) versus PC-olaratumab; 2.9 (1.7 to 4.8) versus PC-sorafenib and 1.2 (0.82 to 1.7) versus pembrolizumab monotherapy. Carboplatin–gemcitabine, PC-motesanib, PC-necitumumab, PC-olaratumab and pembrolizumab did not present statistically