Study variables were: age, sex, need for invasive and non-invasive ventilation, intubation days and oxygen therapy. Days in inpatient care, admission to intensive care units (ICU) and time spent there, adverse reactions and deaths were also obtained. Data were recollected from the electronic clinical records.

Results Data from 59 COVID-19 patients were collected in this study between March and May 2020. Median age (max-min) was 62.4 (48–74) years and 76.3% of patients were men. Comorbidities were: hypertension in 37.3%, dyslipidaemia in 20.3% and diabetes in 15.2%. Six patients had asthma and 5 had cardiopathy.

72 hours after TCZ administration, 54.2% of patients had respiratory improvement with a reduced need for oxygen therapy, 32.2% had stabilisation of their condition and 13.6% had worsening of their condition, requiring orotracheal intubation. Seven days after TCZ administration, 44 had clinical improvement with a reduced need for oxygen therapy, 6 remained stable with VNI and 9 had worsening of their condition (6 passed out, 3 were admitted to the ICU). TCZ was well tolerated with no adverse effects detected. 28 days after TCZ administration, mortality was 15.2%, 69.6% were discharged and 15.2% remained in hospital at the end of the study.

Conclusion and relevance The results of the study showed that TCZ was effective and safe in patients with COVID-19 pneumonia. Patient outcomes were favourable in most cases. During admission, patients showed clinical improvement with a reduced need for invasive ventilation and oxygen therapy. Due to the potential bias (patients received different treatments before and after TCZ) and the small sample size, it is necessary to confirm these results in controlled clinical trials.

REFERENCES AND/OR ACKNOWLEDGEMENTS

Conflict of interest No conflict of interest

4CPS-333 TREATING MULTIPLE SCLEROSIS PATIENTS WITH INFUSION OF DISEASE MODIFYING TREATMENTS DURING THE COVID-19 PANDEMIC

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Background and importance Multiple sclerosis (MS) secondline disease modifying treatments (DMT) cause lymphocyte or B cell depletion, such as therapy with natalizumab, ocrelizumab, alemtuzumab or rituximab. They can present a varying degree of immunodeficiency that can translate into an increased risk of infections. The decision making process should balance the risks of stopping an active treatment and the risk of COVID-19 infection.

Aim and objectives To evaluate the management of MS patients with secondline DMT via infusion with natalizumab, ocrelizumab, rituximab and alemtuzumab during the COVID-19 pandemic.

Material and methods An observational retrospective study was conducted between January 2020 and October 2020 of MS patients on active treatment with natalizumab, ocrelizumab, rituximab or alemtuzumab who were expected to receive new dosages in this period. For data collection, the electronic clinic history system (Selene) and the programme Farmatools were

used. Variables collected were: sex, age, expanded disability status scale (EDSS), COVID-19 diagnosis and type of MS. Treatment changes/delays due to COVID-19 were reviewed. In case of delay, the number of days was quantified.

Results 40 patients (65% women) treated with different infusion therapies were evaluated with a median age of 47.3 (SD 13.3). The average EDSS was 3.8 (SD 2.1). 29 patients had relapsing–remitting MS (72.5%), 7 had primary progressive MS (17.5%) and 4 had secondary progressive MS (10%). Five (12.5%) COVID-19 cases were diagnosed. No delays were registered in 13 infusions of natalizumab; 2 patients, due to a suboptimal response, were changed to ocrelizumab, reducing hospital visits, and one was transferred to another hospital.

Three patients were expected to receive alemtuzumab. No one received alemtuzumab and two were changed to ocrelizumab due to the European Medicines Agency (EMA) alert that recommended restricting the use of alemtuzumab during the COVID-19 pandemic. Two patients received rituximab in time; one was changed to natalizumab due to infusion reactions and in one case the dosing interval was extended to 36 days. Eight patients began ocrelizumab treatment, eight received their dose without delay, one died and in five cases the dosing interval was extended to 39 days (SD 23.8).

Conclusion and relevance According to the recommendations, a case-by-case analysis should be performed, but it seems that the COVID-19 pandemic has conditioned MS treatments as changes/delays were registered. Five (12.5%) COVID-19 cases were diagnosed, similar to the outcomes obtained in the seroprevalence study in the same region.

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4CPS-334 INFLUENCE OF ANTHROPOMETRIC, DEMOGRAPHIC AND THERAPEUTIC FACTORS ON SERUM CONCENTRATIONS OF ANTI-TNF DRUGS

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Background and importance Therapeutic drug monitoring is known to optimise clinical results in inflammatory bowel disease (IBD) patients receiving anti-tumour necrosis factor (TNF) drugs. The influence of several patient factors on these drug levels is not well established.

Aim and objectives To identify anthropometric, demographic and therapeutic variables that influence serum concentrations of anti-TNF drugs.

Material and methods A retrospective, observational, descriptive study was conducted at a tertiary hospital (2016–2019). IBD patients with infliximab (IFX) and adalimumab (ADA) trough steady state serum concentration (Cs) were included. Drug and anti-drug antibody concentrations were quantified using the ELISA assay (Promonitor). Explanatory variables were: anthropometric (body mass index (BMI)), demographic (age, sex), clinical (albumin, haemoglobin, leucocytes, C reactive protein (CRP) <5 mg/L or >5 mg/L) and therapeutic variables (dose intensity: intensified (>5 mg/kg/8 weeks for IFX or >40 mg biweekly for ADA) or non-intensified; anti-drug antibodies; immunomodulatory treatment; and treatment line (first vs second and beyond). Outcome variables were anti-