the remaining RCT, checklist recommended a 'null' application of subgroup analysis for PFS because of inconsistency of results.

Conclusion and relevance No differences in OS or PFS according to baseline hepatic function should be considered for daratumumab based combinations in patients with untreated MM. Patients with normal hepatic function and HI could benefit from treatment. Application of subgroup analysis should be considered with caution.

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Conflict of interest Corporate sponsored research or other substantive relationships

MDG-S: membership of an advisory board (consultation fees) and lecture for Janssen Pharmaceutica (reimbursement for attending symposia). The other authors have no conflicts of interest to declare

2SPD-035 BIOLOGICAL THERAPIES EFFECTIVENESS COMPARISON FOR PATIENTS WITH SEVERE–MODERATE PSORIASIS

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Background and importance The current treatment of psoriasis aims to maintain control of skin involvement and systemic inflammation, as well as prevention of the onset or progression of systemic comorbidities and depends on the severity of the disease.

Aim and objectives The objective was to perform a comparison of the most common therapies in the treatment of patients with moderate to severe psoriasis used as an alternative to tumour necrosis factor-alpha inhibitors (anti-TNFα).

Material and methods The therapies included were found after a systematic search performed in Pubmed. The analysis included randomised, double-blind, phase III controlled trials, non-TNF targeted therapies and PASI75 measurement after 12–16 weeks of treatment. The analysis was performed using the R software to estimate Bayesian statistics, with risankizumab taken as a reference for the comparison.

A delta value of 14%, as provided by the regulatory agencies FDA and EMA, was used to determine the margin (maximum acceptable difference as a non-inferiority criteria), and the average PASI75 response was set at 12 weeks of risankizumab at 79% (95% CI 74 to 84) (ULTIMMA1 and ULTIMA2 trials). To establish therapeutic positioning, the ATE (equivalent therapeutic alternatives in Spanish) guide criteria were applied.

Results 20 clinical trials were included, containing the following drugs: risankizumab, tildrakizumab, guselkumab, brodalumab, ixekizumab, secukinumab and ustekinumab. An equivalence margin expressed as odds ratio (OR) was established from 0.46 to 2.11. The results of the different treatments against risankizumab (reference) expressed as OR (95% CI) were: 1 (0.89 to 1.21) for brodalumab, 1.39 (1.13 to 1.94) for ixekizumab, 0.84 (0.0.68 to 1.13) for secukinumab, 1.21 (0.79 to 2.15) for guselkumab, 0.35 (0.28 to 0.41)for tildrakizumab and 0.47 (0.3 to 0.75) for ustekinumab.

Conclusion and relevance Brodalumab and secukinumab were identified as risankizumab equivalent. For ixekizumab, it can be considered as a clinical equivalent, even though statistically significant differences (ixekizumab > risankizumab) were observed but they were clinically irrelevant. In the case of guselkumab, it can be labelled as a possible clinical equivalent as the 95% CI exceeded the equivalence margin, but it is unclear if such a difference exists (being statistically non-significant). Ustekinumab and tildrakizumab cannot be considered equivalent; the former had likely relevant and statistically significant differences (50% of its 95% CI was outside the equivalence range), and tildrakizumab had clearly relevant and statistically significant differences as all of its 95% CI was outside the equivalence range.

REFERENCES AND/OR ACKNOWLEDGEMENTS

Conflict of interest No conflict of interest

2SPD-036 CENTRALISED PROPOFOL RECONDITIONING PROCEDURE DURING COVID-19

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Background and importance Because of the current pandemic, it was necessary to create an intensive care unit (ICU) in our hospital. This meant an increase in the consumption of propofol and the associated supply problems. It was necessary to develop a procedure to rationalise its use and administration.

Aim and objectives To describe the centralisation in the hospital pharmacy service of the reconditioning of propofol in bags to optimise its administration in the ICU during the COVID-19 pandemic.

Material and methods The ICU contacted the pharmacy service to express the need for higher volume presentations of propofol. In response, a literature review was conducted to ascertain the possibility of reconditioning propofol in higher volume containers. The stability of propofol in different primary packaging materials was reviewed to select the most appropriate. The risk matrix for sterile preparations from the 'Guide to good practice in the preparation of medicines in hospital pharmacy services' was applied to draw up the standard working procedure and to establish the processing conditions, stability of the preparation and storage conditions. A centralised propofol reconditioning procedure (CPRP) was established in the pharmacy service: under sterile conditions, transfer the propofol into an ethylene-vinyl-acetate bag to obtain a final volume of 500 mL (10 mg/mL) (using a 0.22 µm filter if the initial packaging is glass). It was sealed, labelled and packed in a photo protective bag. The established stability was 7 days refrigerated or 30 hours at room temperature.

A descriptive retrospective study was carried out from its implementation (20 March 2020) to the date of closure of the ICU (5 May 2020) to determine the volume of reconditioned propofol and number of patients treated. Data were collected from the electronic medical record and pharmacy programmes.

Results During this period, 258 propofol bags were produced. Reconditioned propofol was dispensed to 16 patients (median