included. All patients treated with more than one drug were taking a beta-blocker. Four (30.8%) patients with dual therapy were taking flecainide concomitantly, four (30.8%) digoxin, three (23.1%) amiodarone and two (15.4%) diltiazem. 7.3% of the patients received the drug as a single dose, 9.8% started treatment the week before, 2.4% the month before and 12.2% in the last 3 months. Ten (24.4%) presented altered creatinine clearance and 17 (41.5%) had chronic renal failure.

In 14 (34.1%) patients one drug was suspended, in five (12.2%) two were suspended, in five (12.2%) the drug was changed, in seven (17.1%) the dose was decreased and in 10 (24.4%) treatment was not changed. Pacemakers were placed in 11 (26.8%) patients. 12 (29.3%) patients revisited the EU 30 days after discharge and 6 (50%) were admitted. Four (9.8%) patients consulted for an episode related to the previous one: 1 due to vasovagal syndrome after implantation of pacemaker without changes in treatment, 1 due to bradycardia after suspending bisoprolol but continuing with amiodarone and 2 due to AF after suspending any drug.

Conclusion and relevance Beta-blocker drugs were the main cause of pharmacological bradycardia, being used in most of the episodes as monotherapy and to treat atrial fibrillation. This group of patients presented with a high frequency of revisits at 30 days even after previous intervention. This is a potential group that could benefit from pharmacist follow-up after discharge.

REFERENCES AND/OR ACKNOWLEDGEMENTS

Conflict of interest No conflict of interest

4CPS-356 COST MINIMISATION ANALYSIS OF THE USE OF NIVOLUMAB AND PEMBROLIZUMAB

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Background and importance Different studies have shown the equivalence of the dosage regimen for pembrolizumab adjusted to the patient's body weight (DPC: 2 mg/kg/3 week) and the fixed dose (DF: 200 mg/3 weeks), and the equivalence between nivolumab's DF (240 mg/2 weeks) and its DPC (3 mg/kg/2 weeks).

Aim and objectives To estimate the savings achieved by using DPC up to maximum doses of 200 mg for pembrolizumab, and 240 mg for nivolumab, in a medical oncology service of a third level hospital.

Material and methods A mathematical model was developed that included the cost of pembrolizumab/nivolumab (based on the laboratory's sales price), as well as the anthropometric characteristics of the patients, to estimate the economic impact using a cost minimisation analysis, on administration of DF versus DPC for oncological patients. All patients who received pembrolizumab for 2 years (2018–2020) and nivolumab for 3 years (2017–2020) were included in the study.

Results A total of 84 individuals were included:

- 65.5% (n=55) received nivolumab for the treatment of melanoma, (34.5%); non-small cell lung cancer (NSCLC) (23.6%); head-neck carcinoma (23.6%); and other types of carcinomas (18.2%).
- 34.5% (n=29) received pembrolizumab for the treatment of NSCLC (89.6%) and urothelial carcinoma (10.3%).

The mean number of cycles received was 14.1(2–72) for nivolumab and 11.5(2–32) for pembrolizumab.

During the study period, the use of nivolumab administered as DF would have cost a total of 3 515 760€ (1 171 920€/year; 63 923€/patient). However, the DPC would have cost 2 994 296€ (998 099€/year; 54 442€/patient), which means an annual saving of 173 821€. The total cost of treatment with pembrolizumab as DF for this study period was 2 374 956€ (1 187 478€/year; 81 895€/patient), while DPC would have had a total cost of 1 625 739€ (812 869€/year; 56 059€/patient), which means an annual saving of 374 608€.

Conclusion and relevance The introduction of immunotherapy in the oncological field has supposed an improvement in the survival of patients, but with a relevant economic impact. The search for strategies of this type can help optimise health resources without compromising the effectiveness of treatments. With the present study, we wanted to show one of these strategies that would allow a saving of 23% (548 429€/year) in the expenditure associated with pembrolizumab and nivolumab.

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4CPS-357 CLINICAL CHARACTERISTICS AND MORTALITY OF COVID-19 IN A LONG TERM CARE FACILITY

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Background and importance Older patients living in long term care facilities (LTCFs) were the most vulnerable population during the pandemic caused by SARS-CoV2. It has been estimated that as many as half of all deaths from COVID-19 in Europe occurred in care homes.

Aim and objectives To describe a coordinated programme in response to a COVID-19 outbreak in an LTCF, the clinical and epidemiological characteristics, and the mortality rate.

Material and methods The study was performed from 20 March to 30 June 2020 in a single 264 bed LTCF in Spain. In response to the COVID-19 outbreak, we created a multi-disciplinary team to implement a coordinated programme to avoid high risk contagion with 12 interventions: (1) training on infection prevention and control, (2) screening of all staff members for symptoms, (3) communal activities and visit restrictions, (4) locating a clean room for equipment, (5) providing personal protective equipment, (6) resident cohorting, (7) assessment of all residents for symptoms and implementation of communication tools with families, (8) strengthening the workforce, (9) provision of equipment, materials and drugs with a minimum of supplies, (10) establishment of a consultation circuit with the local hospital, (11) compliance of protocols and (12) laboratory testing.