Background and importance Vaccines are emerging as a fundamental tool in the prevention of COVID-19 disease but are not decisive in treating it, once contracted. Anti COVID-19 monoclonal antibodies (MAb) define a valuable and parallel resource for the treatment of coronavirus infection so it is useful to monitor the usage data, adverse reactions (ADRs) and percentage of hospitalisations after treatment.

Aim and objectives Purpose of the work was to provide data on safety and efficacy of anti-COVID MAb in consideration of their use in current clinical practice.

Material and methods Using a home-made database, the pharmacy extrapolated and reprocessed the data relating to the reports of patient recruitment by local and hospital clinicians, the number of patients who were treated, the specific therapies administered (bamlanivimab, etesevimab or casirivimab/imdevimab) and ADRs reported by doctors. In parallel, the infectious diseases department monitored the percentage of patients who still needed hospitalisation after the infusion of MAb.

Results Most of the recruitment reports were received from general doctors (82% vs 18% from hospitals) and, from March 2021 to September 2021, 104 patients were treated: 48 patients (46.2%) with bamlanivimab/etesevimab, 55 (52.9%) with casirivimab/imdevimab and 1 (0.9%) with bamlanivimab. 67% of patients were not vaccinated while 33% received at least one dose of vaccine (58%: first dose; 42%: two doses). The main comorbidity found was the cardiological/cerebral/vascular type. Following outpatient dosing, 2 ADRs have been reported: an emetic episode after bamlanivimab infusion and a subacute antero-septal myocardial infarction with acute pulmonary oedema occurring within hours after administration of casirivimab/imdevimab and in the presence of a septic event of bacterial origin. 9% of patients treated with anti-COVID-19 MAb still required hospitalisation due to COVID-19; the other patients recovered completely.

Conclusion and relevance Together with the home care protocol and vaccines, MAb constitute a valid weapon in the early phase of COVID-19 disease. It is an important opportunity for patients the virus to be faced in an active way, without waiting for the worsening of the patient’s clinical condition, and with a synergistic approach of hospital and territory that join forces against this great infectious disease challenge.

REFERENCES AND/OR ACKNOWLEDGEMENTS

Conflict of interest No conflict of interest

Background and importance Unresectable locally advanced non-small cell lung cancer (LA-NSCLC) long-term survival is poor. Durvalumab is approved as consolidation treatment in unresectable LA-NSCLC, without progression after chemoradiotherapy including platinum, with PD-L1 ≥1%.

Aim and objectives To analyse the effectiveness and safety of durvalumab in the treatment of unresectable LA-NSCLC compared with the results of the pivotal study (PACIFIC). Secondary objective was influence of PD-L1 expression on effectiveness.

Material and methods Retrospective observational study of patients with unresectable LA-NSCLC treated with durvalumab in a tertiary hospital (August 2018–October 2021).

Variables studied (electronic medical history): sex, age, Eastern Cooperative Oncology Group (ECOG), smoking, PD-L1, histology, disease stage. Variable to evaluate effectiveness: progression-free survival (PFS) from the start of treatment. For safety: adverse events (AE) and toxicity grade according to the Common Terminology Criteria for Adverse Events v5.0. Statistical analysis performed with SPSS v.23 software.

Results Thirty-one patients were included, mean age 66.45 (±9.45) years, male (74.2%), smokers (64.5%), ex-smokers (35.5%), World Health Organization (WHO) performance status: ECOG 0 (74.2%), ECOG 1 (25.8%). Disease stage IIIA (25.8%), IIIB (48.4%), IIIC (25.8%), squamous histology (41.9%), adenocarcinoma (41.9%) and unspecified (16.1%). 41.9% received induction chemotherapy. Most common chemotherapy was cisplatin-vinorelbine (48.4%). Durvalumab was initiated a median of 55 (35–70) days after chemoradiotherapy. After initiating durvalumab, the median follow-up was 15 (5–22) months. Received a median of 13 (8–26) cycles. 35.5% (n=11) of patients completed 12 months of treatment, 29% (n=9) remain on treatment. Treatment discontinuation was 22.6% (n=7) due to disease progression and 12.9% (n = 4) due to severe toxicity. 51.6% (n = 16) presented toxicity ≥2 due to severe toxicity. 51.6% (n = 16) presented toxicity associated with durvalumab: 68% (n=11) grade 2 toxicity. Main AEs: thyroid (19.32%) and cutaneous (22.54%) alterations.

Median PFS was 14 (95% CI 7.59 to 20.4) months, with a PFS rate at 12 months (PFS12m): 70.6%. PFS12m was: 25% in PD-L1 <1% (n=4); 50% in PD-L1 1%–49% (n=10) and 73.33% in PD-L1 ≥50% (n=15).

Conclusion and relevance Our results showed, compared with the PACIFIC study, a lower median PFS (14 vs 17 months) and a higher PFS12m (70.6% vs 55.7%), results that seem comparable. In terms of safety, the results are similar to those of the PACIFIC study, so there is a good safety profile in our patients. The data analysed showed a lower effectiveness in PD-L1 <1%. However, a larger sample and follow-up are required to obtain conclusive results.

REFERENCES AND/OR ACKNOWLEDGEMENTS

Conflict of interest No conflict of interest