(ALT), gamma glutamyl transferase (GGT), alkaline phosphatase (ALP) and total bilirubin (TB)), dose, diagnosis, age and sex were registered.

Microsoft Excel was used for the statistics calculation.

Results 68 determinations in 38 patients (73.75% men; aged 64.84 ±11.29 years).

Diagnosis: probable disease 21 (55.28%), possibility 12 (31.57%), prophylaxis 5 (13.15%).

6 (15.8%) patients needed a change in treatment. 5 (83.33%) had the dose changed in order to maintain plasma levels between 1 and 5.5 µg/mL. In 1 patient (16.66%) voriconazole was substituted.

28 (73.7%) started treatment with the dose of 200 mg/12 hours, whereas the rest (26.3%) has a higher dose. 60% of dose changes were in patients taking 200 mg/12 hours.

A positive correlation existed between plasma levels of voriconazole and liver enzymes as well as with cholestasis markers (AST: r^2=0.1817; ALT: r^2=0.1118; GGT: r^2=0.2528; PA: r^2=0.2444 and TB: r^2=0.4637).

The Chi-square statistic was significant at $p<0.05$ for plasmatic levels over 3 µg/mL and AST/ALT over physiological range (35 U/L).

The relative risk of presenting ALT over the physiological range is 3.12 and for AST 2.31 in patients with plasmatic levels of voriconazole >3 µg/mL respects the ones whose plasmatic levels were <3 µg/mL.

Conclusion and relevance Voriconazole TDM is a tool that can help to avoid treatment failure and adverse events. Its relationship with liver toxicity, which shows our data, TDM would help to prevent these side effects.

REFERENCES AND/OR ACKNOWLEDGEMENTS

Conflict of interest No conflict of interest

4CPS-113 REAL-LIFE DATA ON THE USE OF ABIRATERONE/ENZALUTAMIDE IN CASTRATION-RESISTANT PROSTATE CANCER

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Background and importance Abiraterone and enzalutamide are used for treating castration-resistant prostate cancer (CRPC). The lack of direct comparisons makes the selection and positioning of these drugs difficult.

Aim and objectives To compare abiraterone and enzalutamide use in metastatic CRPC, and to provide real clinical data on effectiveness and safety.

Material and methods Retrospective observational study conducted in a tertiary hospital in patients with metastatic CRPC.

Patients evaluated and treatment initiated between January 2015 and September 2021.

The primary effectiveness variable was progression-free survival (PFS). Overall survival (OS) and survival probabilities were also estimated. Survival parameters were estimated with the Kaplan–Meier test and compared by the log-rank test using R-software (v.4 - 2021).

As safety variables, the percentage of patients with adverse events (AE) and grade according to the Common Terminology Criteria for Adverse Events (CTCAE) were collected.

Results 99 patients were included (abiraterone=70 and enzalutamide=29; disproportionality due to the prospective design). No significant differences were observed in the patients' baseline characteristics: mean age (75.6±9.1 years vs 75.8±7.5, respectively) and number of metastases at baseline. These were mainly bone (36.34%) and lung (6%). Gleason at baseline was ≥8 in 45.7% of those treated with abiraterone and 31% with enzalutamide. 92.9% in the abiraterone group had Eastern Cooperative Oncology Group (ECOG) 0–1 and the comparable figure was 89.7% for enzalutamide.

62.9% with abiraterone presented ≥1 AE. Most frequent AE were G1-asthenia (22.3%) and G1-hypertension (12.3%). 8.6% were AE≥G2. In the enzalutamide group, 69% presented ≥1 AE(10.3% ≥G2). Common were G1-asthenia (62.1%) and G1-headache (13.8%).

Median PFS for abiraterone was 31 months (95% CI 20 to NA) and for enzalutamide 42 months (95% CI NA to NA); with no significant differences (p=0.5). Median OS was not reached in either group, with no significant differences (p=0.7). For overall survival, at month 13, 92.2% of patients did not reach the event in the abiraterone group and 81.5% in the enzalutamide group.

The power of the study for PFS was 0.038 and for OS 0.042, indicating that the power to detect differences is low.

Numerical disproportion between individuals makes enzalutamide more sensitive to events; however, the number of events remained proportional, with both curves being practically superimposable.

Conclusion and relevance Statistical differences in PFS were not found. Median OS was not reached in either group; AE were mild to moderate for both groups. We cannot affirm that there are differences in effectiveness and safety between these treatments.

REFERENCES AND/OR ACKNOWLEDGEMENTS

Conflict of interest No conflict of interest

4CPS-114 INTEGRATION OF A PHARMACIST INTO A GERIATRIC DEPARTMENT

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Background and importance Elderly chronic patients are usually pluripathological and polymedicated, which makes them vulnerable and complex to deal with. The review of their pharmacological treatment and their interactions, deprescribing and managing medications provides safety and improves their quality of life in a context of pharmacotherapy optimisation.

Aim and objectives To create a healthcare resource between the services of geriatrics and hospital pharmacy which facilitates clinical management of arranged patients for a medical consultation in outpatient geriatric clinic.

Material and methods Prospective study which included patients arranged for a geriatric consultation for the first time between May 2021 and August 2021. All these items were considered: pharmacotherapy, adherence to medical treatment, medical history, final analysis and last hospital admission. Treatment optimisation recommendations were mentioned to the geriatric physician. Primary care, specialised and

emergency consultations were recorded the month following the aforementioned changes.

Results 33 patients were included, of whom 64% were women, mean age 86 (SD 4.4) years. 113 interventions were carried out (3.4 per patient), most of which were due to therapeutic optimisation (23%), excessive treatment duration (21%) and medical interactions (13%). Also, no specific therapeutic indications (11%) and incorrect dosage (4%) were noted. A dose adjustment was proposed in 40% of the interventions and the modification of therapeutic agents in 14%. Changes were accepted in 65% of the proposals. 26 pharmacotherapeutic groups were involved in the interventions, with antihypertensives, lipid-lowering drugs and benzodiazepines being the most affected ones. The month following the intervention, only 3 patients needed to go to the doctor due to the changes made: high blood pressure (n=1) and insomnia (n=2) were the problems reported. None of the patients required emergency assistance.

Conclusion and relevance The introduction of the figure of the hospital pharmacist into a multidisciplinary approach for elderly, fragile patients enables an optimisation of their pharmacotherapy in order to achieve an effective detection of medical problems, all of which results in an improvement of their quality of life.

REFERENCES AND/OR ACKNOWLEDGEMENTS

Conflict of interest No conflict of interest

4CPS-115 NABPACLITAXEL PLUS GEMCITABINE VERSUS FOLFIRINOX IN METASTATIC PANCREATIC CANCER: REAL-WORLD DATA EXPERIENCE

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Background and importance Pancreatic cancer (PC) is a highly lethal malignancy although palliative systemic chemotherapy can improve disease-related symptoms and prolong survival. In our hospital the most used treatment regimens for this pathology are nabpaclitaxel plus gemcitabine (GemNab) and FOLFIRINOX. There are no studies that directly compare the two schemes, making the choice empirical.

Aim and objectives To assess the effectiveness and safety of GemNab versus FOLFIRINOX in metastatic PC.

Material and methods A descriptive retrospective study from January 2016 to September 2021 was conducted. Variables collected were age, sex, Eastern Cooperative Oncology Group (ECOG) stage, treatment regimen, and number of cycles. As efficacy endpoints, progression-free survival (PFS) and overall survival (OS) were used. Analysis was performed using the Kaplan–Meier curve (SPSS Statistics v.24 program). Security was evaluated based on adverse effects (AEs), delays of therapy, reductions of doses, and suspensions associated with the treatment scheme.

Results Forty-one patients were included with median age 61.5 (47–79) years. There were 75.9% men and 24.1% women. ECOG stage was 0–1 in all cases. Twenty-eight patients received GemNab and thirteen FOLFIRINOX scheme. The median number of cycles was 4 (1–14) in GemNab group and 6 (1–18) in FOLFIRINOX population. Median PFS was 8 months (95% CI, 4 to 11) in GemNab group and 8 months (95% CI, 3 to 12) in FOLFIRINOX arm. Median OS was 7 months (95% CI, 2 to 11) in GemNab group and 8 months (95% CI, 3 to 12) in FOLFIRINOX population. The main AEs observed were asthenia (64.3%), neurotoxicity (25%) and diarrhoea (25%) for GemNab. This combination drug presented delays and reductions of doses in 60.7%, respectively, including suspensions due to AEs in 17.9%. Neurotoxicity (38.5%), diarrhoea (30.8%) and neutropenia (23.1%) were the AEs frequently reported in patients with the FOLFIRINOX scheme. Regarding tolerance of FOLFIRINOX, 84.6% delayed the cycle, 61.5% reduced the doses and 38.5% had treatment suspended.

Conclusion and relevance In our metastatic PC population, GemNab and FOLFIRINOX showed similar effectiveness. With respect to safety profile, more than half of the patients presented delays of therapy and reductions of doses in both groups and more patients discontinued treatment with the FOLFIRINOX regimen due to AEs.

REFERENCES AND/OR ACKNOWLEDGEMENTS

Conflict of interest No conflict of interest

4CPS-116 ASSOCIATON OF DIHYDROPYRIMIDINE DEHYDROGENASE DEFICIENCY WITH CAPECITABINE TOLERANCE

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Background and importance Dihydropyrimidine dehydrogenase (DPD) is the first of the enzymes in the fluoropyrimidine metabolic pathway. It is the rate-limiting enzyme in the catabolism of fluoropyrimidine drugs. Patients with partial or total deficiency in DPD activity can not adequately degrade fluoropyrimidines, increasing the risk of serious toxicity.

Aim and objectives To assess the rate of deficiency of the metabolising enzyme DPD in our population and describe the management of these patients in clinical practice.

Material and methods The study was conducted between January 2020 and August 2021. Patients diagnosed with colorectal cancer receiving capecitabine were included. Age, gender, Eastern Cooperative Oncology Group (ECOG), regimen treatments and number of cycles were collected from the electronic clinical history. To determine the variants of DPD, a pharmacogenomics analysis was performed using a real-time polymerase chain reaction (PCR) technique. The polymorphisms studied were rs3918290, rs55886062, rs67376798 and rs56038477. Regarding the management of patients, the doses reduction, adverse events (AE), and withdrawal treatments were recorded.

Results A total of 35 patients in treatment with capecitabine were selected for the analysis of DPD activity. The study population comprised 24 men (68.6%) and 11 women (31.4%). The average age was 60 (27–87) years. ECOG 0–1 was observed in 97.1% of cases. Oxaliplatin plus capecitabine was the initial cancer therapy in 74.3% of patients, and 25.7% were treated with capecitabine in monotherapy. A mutated allele heterozygote was detected in 11.4% of patients: rs67376798 (8.6%) and rs56038477 (2.9%). A 50% dose reduction was prescribed initially according to pharmacogenetics recommendations in DPD deficiency and this dose was maintained throughout the entire treatment. In patients without mutation a dose reduction was required in 22.9%. All