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.

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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