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
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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

patients with DPD mutation and 41.9% without DPD mutation presented AE. The most common AE in this population were gastrointestinal such as nausea (25.7%), constipation (14.3%), diarrhoea (11.4%) and vomiting (11.4%). No withdrawal treatments were registered.

Conclusion and relevance Patients with DPD polymorphisms in our population completed treatment with 50% of the dose. AE were more prevalent in DPD mutation group. Determination of variants of DPD can help avoid serious or fatal EA.

REFERENCES AND/OR ACKNOWLEDGEMENTS

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4CPS-117 APPROPRIATENESS OF ANTIBIOTIC PRESCRIPTIONS IN A LONG-TERM CARE FACILITY

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Background and importance Antimicrobials are the most frequently prescribed drugs in long-term care facilities (LTCF). Antibiotic prescriptions may be unnecessary; but even when necessary, the antibiotics prescribed are often excessively broad-spectrum or longer duration.

Aim and objectives To evaluate appropriateness of antibiotic prescriptions in a LTCF and analyse possible factors related to inappropriateness.

Material and methods An 18-month prospective study was conducted in a 264-bed LTCF. Antibiotic prescriptions for suspected lower respiratory tract infection (LRTI), skin and soft tissue infection (SSTI) or urinary tract infection (UTI) initiated for LTCF residents were included. We excluded confirmed positive COVID-19 infections without suspected bacterial/fungal co-infection and prophylactic antibiotic prescriptions. We obtained demographic and clinical characteristics of residents, variables related to infection and antibiotic prescription, microbiology data and setting of prescription initiation. Each antibiotic prescription was assessed for appropriateness and classified as unnecessary, inappropriate and suboptimal antimicrobial use.[1] Associations of variables with inappropriate antibiotic prescribing were estimated using logistic regression.

Results We included 416 antibiotic prescriptions (out of 489) corresponding to 159 residents, 43.6% women, mean age 83.2 (SD 9.6) years. Fosfomycin-tromethamine was the most commonly prescribed antibiotic (25.0%), followed by cephalosporins (18.8%), amoxicillin-clavulanic acid (15.9%) and fluoroquinolones (13.0%). Polytherapy: 2.6% of episodes. Infections: UTI (43.3%), LRTI (34.6%), SSTI (22.1%). Targeted therapy: 16.8%. Median treatment duration: 5 (IQR 1–7) days; 9.4% prescriptions for >7 days. Sample collection was carried out in 29.6%. Positive result: 82.9% of cultures. The most prevalent microorganisms isolated were the Gram-negative bacteria (87.3%). The majority of antibiotic prescriptions were initiated within the LTCF (84.1%), with 12.7% by the emergency department (ED) and 3.2% by hospital or primary care (HPC). Overall, 46.6% of antibiotic prescriptions were judged unsuitable: unnecessary (16.9%), inappropriate (70.6%), suboptimal (12.5%). Multivariable analysis showed that empirical therapy, some classes of antibiotics (cephalosporins, fluoroquinolones, fosfomycin calcium, macrolides) and prescription initiation in the emergency department were independent predictors of antimicrobial inappropriateness.

Conclusion and relevance Almost half of antimicrobials prescriptions are inappropriate. Antibiotics initiated in the ED constitutes a small but not unimportant percentage of all prescriptions. Antimicrobial stewardship programmes should include interventions in this setting because of the high inappropriate use.

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4CPS-119 REAL-WORLD EXPERIENCE WITH PCSK9 INHIBITORS PROTOCOL FOR HYPERCHOLESTEROLAEMIA

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Background and importance PCSK9 inhibitors (PCSK9i) are drugs that reduce low-density lipoprotein (LDL) levels. Due to their high cost and restrictive indications, a drug use evaluation (DUE) was performed.

Aim and objectives Evaluate a protocol for PCSK9i use and patients' follow-up developed in our centre.

Material and methods Our PCSK9i protocol establishes criteria for new prescriptions and clinical monitoring according to European guidelines. After doctor prescription and hospital pharmacist (HP) validation, patients have an appointment with the HP to review whole treatment, dietary and exercise habits. LDL-levels are reviewed by the HP after 1 month of treatment, and annually.

Patients not reaching the desired outcome are cited with the HP, to check causes of treatment failure (lack of adherence, ineffective dosing, change of habits, etc.) and referred to the doctor to evaluate treatment optimisation if needed.

All patients with PCSK9i were included. We recorded sex, age, last appointment with the doctor, LDL-levels before treatment (LDL-1), LDL-levels after 1 month (LDL-2) and, in patients with more than 1 year of treatment, date and results of the last LDL analytic (LDL-3). A descriptive analysis was performed using measures of central tendency, dispersion and position for quantitative variables, and frequency distribution for qualitative variables.

Results 161 patients were included, 67.7% male. Medium age was 60±8,7 years. Follow-up ranged from 2 months to 5 years. Treatment regimens were: evolocumab 140 mg biweekly: 30 patients (18.6%); alirocumab 75 mg biweekly: 96 (59.6%) and 150 mg biweekly: 35 (21.7%).

Abstract 4CPS-119 Table 1 LDL results

	Minimum (mg/dL)	Maximum (mg/dL)	Medium (mg/dL)
LDL-1 (n=161)	66	344	132.5 ±47.3
LDL-2 (n=158)	8	188	60.49 ±34.04
LDL-3 (n=122)	7	160	61.59±33.96