and 1. All patients who received olaparib had mutated BRCA, while those who received niraparib had BRCA wildtype. Median follow-up was 15.6 (IQR 9.8–29.5) months.

Eighty-five point three per cent of our patients received maintenance treatment with an iPARP after relapse. Median PFS and OS were not reached in the olaparib group. Median PFS with niraparib was 11.30 (95% CI = 2.65–19.95) months and median OS was 36.01 (95% CI = 13.37–58.64) months.

On olaparib group, 93.3% of patients experienced an AE. Of these, 20% required temporary discontinuation and 20% required dose reduction due to toxicity. All niraparib-treated patients reported AEs, 57.9% required temporary discontinuation and 52.6% required dose reduction. Grade ≥3 AEs occurred in 33.3% patients on olaparib group and 63.1% with niraparib. No patient discontinued treatment due to toxicity.

Conclusion and Relevance Olaparib and niraparib achieve relevant results in patient survival. The differences respect to pivotal trials could be explained by a greater knowledge on the use of these drugs, which allows a better selection of the patients to be treated. In terms of safety, most patients experience some AEs during treatment, which are reversible and controllable with dose reduction.

REFERENCES AND/OR ACKNOWLEDGEMENTS

Conflict of Interest No conflict of interest

4CPS-130 EVALUATION OF TIXAGEVIMAB-CILGAVIMAB IN PRE-EXPOSURE PROPHYLAXIS OF COVID-19

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Background and Importance In the context of pre-exposure prophylaxis of COVID-19 in adults and adolescents aged 12 years and older (> 40 kg), tixagevimab-cilgavimab is currently included in clinical guidelines. The recommended dose is administered as two separate sequential intramuscular injections (150 mg of tixagevimab and 150 mg of cilgavimab), preferably in the gluteal muscles. Due to their recent authorisation, effectiveness and security of this treatment is not well known.

Aim and Objectives The aim of this study was to analyse the effectiveness and security of tixagevimab-cilgavimab in patients with COVID-19 risk after a complete vaccination regimen, collated with the data from PROVENT clinical trial.

Material and Methods Retrospective observational study in a cohort of COVID-19 risk patients. Electronic medical record and prescription application were used to collect the following data: sex, age, comorbidities, anticoagulation, and titles of anti-Spike antibodies, and COVID-19 infections after administration.

Results The study includes 41 patients (52.5% women, median age 64.5 years (SD 13.5)), who were candidates to prophylaxis because of their comorbidities: anti-CD20 active treatment (21), solid organ transplantation (renal (10) and pulmonary (14)), chronic kidney disease (2), immunosuppression (1), cytotoxic chemotherapy (1) or haematopoietic Stem Cell transplant (1). After the last vaccination, 97.5% of the patients had low antibodies (< 260 BAU/mL), which demonstrates an inadequate response to active immunisation. These comorbidities and clinical conditions were similar in PROVENT.

In PROVENT, the duration of protection is estimated to be at least 6 months (0.2% COVID-19 positive cases after administration prior to day 183). In our study population, 3 patients were COVID-19 positive (7.5%) prior to day 90 after administration without severe or critical symptomatic illness.

As with any other intramuscular injections, should be given with caution to patients with thrombocytopenia or coagulation disorders; 5 patients were on anticoagulation therapy and no bleeding events were recorded. Therefore, non-hypersensitivity reactions have been observed.

Conclusion and Relevance Effectiveness and security of the pre-exposure prophylaxis with tixagevimab-cilgavimab was adequate in most of the patients treated, and similar to the data of the clinical trials. Even so, pre-exposure prophylaxis is not a substitute for vaccination. Nevertheless, further studies were necessary to establish the effective and security profile.

REFERENCES AND/OR ACKNOWLEDGEMENTS

Conflict of Interest No conflict of interest

4CPS-135 MELANOMA ADJUVANT THERAPY: FROM TRIALS TO CLINICAL PRACTICE

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Background and Importance Clinical trials show that recurrence-free survival (RFS) is significantly improved in melanoma patients treated adjuvantly with immune checkpoint inhibition (ICI) and targeted therapy (TT).The Stage of disease is an important factor in risk assessment of RFS and also influences theclinician's decision.The adjuvant therapy in melanoma BRAF V600 mutated involves two treatment strategies: anti-PD-1 (nivolumab or pembrolizumab) and BRAF- MEK inhibitors (dabrafenib and trametinib).

Aim and Objectives Real World Data were collected from 01/08/2019 to 31/03/2021 in an Italian Oncological Hospital, in order to observe the time of RFS and toxicities.

Material and Methods 168 patients were included (11 stage IIIa,19 IIIB, 64 IIIC, 12 IIID, 5-V), of which 65 were women and 103 men (median age: 56). In particular, 76 patients received nivolumab (6 patients V600E mutated, 2 mut-NRAS, 3 mut-V600K), 28 pembrolizumab (1 pts mut-V600k and pK6001E, 1 pts mut-V600E) while 64 received TT.

Results Among the 64 pts treated with TT, 9 of them discontinued therapy, of which 5 for toxicity and 4 for progression disease (PD).In the nivolumab setting, 9 patients discontinued therapy, 6 because of toxicity (1undifferentiated arthritis) and 3 for PD. In the pembrolizumab setting only 1 patient discontinued for toxicity and 1 for PD. In 33 pts with recurrence, the median time from start of adjuvant treatment to 1st recurrence was18 months in TT (10), 14 months in nivolumab chort (19), 8 months in pembrolizumab chort (4). IIIC was the stage of disease that manifested the greatest risk of recurrence both among the cohort of patients treated with TT and in ICI. However, the number of patients going into PD was greater among those treated with ICI. Duration of therapy was the highest in pts treated with Nivolumab.