The variables studied were sex, age, ECOG stage, treatment duration, reason for discontinuation and percentage of dead patients at the end of the study.

Data were collected through the electronic clinical record and the onco-haematological prescription program. Statistical analysis was performed with SPSS v.22.0. The Kaplan-Meier method was used to calculate OS and PFS.

**Results** A total of 30 patients were analysed (100% women). The median age was 58 (range, 48 to 66) years. The 66.7% of patients (N=20) had ECOG 0–1 and the 33.3% (N=10) had ECOG 2.

The median number of cycles received were 8 (range, 3 to 16) and the median treatment duration was 6 (range, 3 to 12) months.

The reasons for the treatment discontinuation were: 53,3% progression (N=16), 6,7% toxicity (N=2) and 10% death (N=3).

At the end of the study, the 30% of patients (N=9) continued with the treatment and the 48,3% (N=14) had died.

The median OS obtained was 16,80 months (95% CI 7,64 to 25,96) and the median PFS was 10,27 months (95 CI% 5,34 to 15,35).

In the study TDM4450g/BO21976, the median of PFS and OS were 9,4 and 30,9 months, respectively. In the pivotal trial TDM4370g/BO21977, the median PFS was 14,2 months and the OS could not be estimated.

**Conclusion and Relevance** The median OS in patients with HER2-positive MBC treated with T-DM1 reported in our study was similar than the pivotal trials. However, the median OS was substantially lower than the study TDM4450g. This difference could be mainly due to the sample size. Moreover, patients included in the previous study had a better functional status (100% ECOG 0–1) than our patients at the start of the treatment.

**REFERENCES AND/OR ACKNOWLEDGEMENTS**

Conflict of Interest No conflict of interest

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**4CPS-221** ASSESSMENT OF CLINICAL BENEFIT OF CANCER TREATMENTS ACCORDING TO THE EUROPEAN SOCIETY FOR MEDICAL ONCOLOGY SCALE

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**Background and Importance** The European Society for Medical Oncology – Magnitude of Clinical Benefit Scale (ESMO-MCBS) is a tool designed to evaluate the clinical benefit of cancer treatments and can facilitate decision-making.

**Aim and Objectives** To analyse which of the cancer treatments started providing a substantial magnitude of clinical benefit according to the ESMO-MCBS. Know the prevalence of patients who have started some low benefit treatment. Assess whether the ESMO-MCBS could be a good indicator of the prescription’s quality.

**Material and Methods** Retrospective observational study that included all cancer treatments that were started in a tertiary care hospital from 03/01/22 to 06/30/22. The variables were collected: patient, treatment(s) prescribed, indication and ESMO-MCBS rating. The ESMO-MCBS score is considered in two different therapeutic settings: potentially curative treatments (A, B and C) and non-curative treatments (1 to 5). Substantial magnitude of clinical benefit was graded as A, B, C.
and 4. The variables calculated were: % of treatments with scores of greater clinical benefit and % of patients with at least one treatment of low benefit.

Results A total of 245 starts of treatment were reviewed, of which only 75 (31%) had an ESMO-MCBS rating. In 63% of the cases (n=47), treatments considered to be of relevant clinical benefit were started. Of these, 3 (6%) were treatments with curative intent (all level A) and 44 (94%) with palliative intent (level 4–5). Of those rated at level 4–5, pembrolizumab (n=14; 32%) in non-small-cell lung cancer and nivolumab (n=4; 9%) in head-neck cancer were predominant. 37% (n=28) of the patients started some low benefit treatment (level 1–3), being the most frequent atezolizumab (n=5; 18%) in small-cell lung cancer and nab-paclitaxel (n=5; 18%) in pancreatic adenocarcinoma.

Conclusion and Relevance More treatments with substantial benefit are started than those with less clinical benefit. All treatments with curative intent were level A. The non-curative setting presents a greater number of treatments with doubtful benefit. For most of the treatments classified as low benefit, there is no better therapeutic alternative, so we cannot assume that it is an indicator of poor prescription. Furthermore, we cannot classify most treatments because many of them do not have an ESMO-MCBS classification assigned.

REFERENCES AND/OR ACKNOWLEDGEMENTS
Conflict of Interest No conflict of interest

4CPS-224 IMPACT OF AUGMENTED RENAL CLEARANCE ON ANTIMICROBIAL DOSING IN SEVERELY BURNED PATIENTS
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Background and Importance Augmented renal clearance (ARC) is a phenomenon characterised by increased renal filtration with mean creatinine clearance (CrCl) of more than 130 mL/minute, commonly observed in critically ill patients. Neurologic injury, trauma and burns are other factors consistently identified as at risk of ARC. Subtherapeutic drug concentrations and antibacterial exposure in ARC patients are the main reasons for clinical treatment failure, especially when it comes to antibiotics that undergo renal elimination.

Aim and Objectives The aim of this observational study was to describe the prevalence of ARC in a cohort of severely burned patients and the potential impact on the dosage of antibiotic treatment.

Material and Methods Retrospective observational study that includes critically ill burned patients admitted to the burn unit between January/2020 and November/2021 in a tertiary hospital. Patients were classified as having ARC if an included sample taken during their length of stay had a creatinine clearance ≥130 mL/min. This value was obtained through the Cockcroft-Gault equation. Data was collected from the clinical history. Continuous variables are expressed as medians (range) and categorical variables as cases (percentage).

Results Forty-eight patients were included, 17 (35.5%) females, with a median age of 45 (16–85) years. Forty (87.5%) had third degree burns, burned body surface area was 22% (5–85) and Abbreviated Burn Severity Index (ABSI) was 8 (3–13). The main cause of admission was due to flame in 45 (93.4%) and there was smoke inhalation in 26 (54.1%). Length of stay was 32 (2–208) days and overall mortality 14.6% (n=7).

Median serum creatinine was 0.65 [0.3–2.1] mg/dL and CrCl was 152 [44.8–256.3] ml/min. 60.4% (n=29) had ARC, 29.2% (n=14) had normal filtration and 10.4% (n=5) were in acute renal failure.

In patients with ARC, 24 (82.8%) received antibiotic therapy and were all treated with beta lactams during their stay. Other hydrophilic antibiotics were aminoglycosides (29.2%), daptomycin (20.8%), linezolid (16.7%), and teicoplanin (20.8%).

Conclusion and Relevance Our findings provide further evidence that severely burned patients, as observed with other subsets of critically ill patients, frequently exhibit ARC. Almost two-thirds of our patients presented ARC and the majority of them were being treated with antibiotic therapy that could potentially be underdosed. Pharmacists can play an important role in identifying these patients and optimising the dosage taking this phenomenon into account.

REFERENCES AND/OR ACKNOWLEDGEMENTS
Conflict of Interest No conflict of interest

4CPS-226 CONTINUOUS INFUSION OF VANCOMYCIN: WHO ARE THE PATIENT CANDIDATES AND HOW SAFE IT IS?
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Background and Importance Data about the efficacy and toxicity of vancomycin used by continuous infusion (CI) compared to intermittent infusion (II) are still controversial.

Aim and Objectives To compare the profile of patients treated with II or CI of vancomycin and the frequency of nephrotoxicity within a therapeutic drug monitoring (TDM) programme.

Material and Methods Retrospective pharmacokinetic (PK) study in adult patients treated with II/CI of vancomycin and undergoing TDM in a university hospital during 2022.

Data collected demographics, clinical (serum creatinine (Cr) and estimated glomerular filtration rate (CKD-EPI) (eGFR) at baseline and end of treatment) and pharmacokinetic data (PK).

TDM samples: before dose (Cmin,ss) and 1h after the end of the intravenous infusion (Cmax,ss) (II) or at any time (Css) (CI). Mean area under the curve in plasma (AUC24h) was estimated by a Bayesian software.

Results Patients included: 128: 62.7(14.6) years, 88(68.8%) males, 61 (47.7%) directed treatments. Most frequent pathogens: 22 (17.2%) S. epidermidis, 14 (10.9%) E. faecium and 7 (5.5%) MRSA.