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 $\geq$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.

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Conflict of Interest No conflict of interest

4CPS-226 CONTINUOUS INFUSION OF VANCOMICYN: 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.