5PSQ-001 EFFICACY AND SAFETY OF THE COMBINATION OF ISATUXIMAB, CARFILZOMIB AND DEXAMETHASONE IN PATIENTS WITH MULTIPLE MYELOMA: A CASE REPORT

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Background and Importance Multiple myeloma is a neoplastic proliferation of plasma cells in the bone marrow. Isatuximab is a new IgG1 kappa monoclonal antibody directed against CD38, which has been approved by the EMA and FDA in combination with carfilzomib and dexamethasone (Isa-Kd) in patients with multiple myeloma who have received at least one prior line of therapy.
Aim and Objectives The aim of this study is to describe the efficacy and safety of the Isa-Kd combination in a patient with multiple myeloma refractory to previous lines.
Material and Methods Retrospective clinical case in which we followed the patient during treatment with Isa-Kd. Data were obtained from the electronic medical record.
Results We describe a 55-year-old male, weight 69 kg and height 173 cm. He was diagnosed with multiple myeloma in September 2017 and ever since has received 4 lines of treatment, not being a candidate for autologous haematopoietic progenitor transplantation due to psychiatric illness.

In July 2021 it was decided to start with Isa-Kd and since he has received 4 cycles of 28 days, following the IKEMA study scheme; during the first cycle, isatuximab was administered at 10 mg/kg on days 1, 8, 15 and 22, and from the second cycle onwards every 15 days. Carfilzomib was administered the first cycle at 20 mg/m^2 on days 1 and 2, at 56 mg/m^2 on days 8, 9, 15 and 16, and from the second cycle onwards at 56 mg/m^2 on days 1, 2, 8, 9, 15 and 16.

No adverse reactions were observed during infusion, such as hypertension, anaphylaxis or nausea. After Isa-Kd administration, the patient presented asthenia, but it did not prevent him from performing his usual tasks. During the 4 treatment cycles we did not detect a reduction in the erythrocyte count, nor any hospital admission for pneumonia.

After 4 months of treatment, Isa-Kd treatment was discontinued due to disease progression.
Conclusion and Relevance Isa-Kd administration achieved a progression-free survival of 4 months, much lower than the 19,5 months reached in the IKEMA study.[1] Nevertheless, Isa-Kd infusion in our patient has been shown to be safe in the treatment of refractory multiple myeloma.

REFERENCE

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5PSQ-009 EFFECTIVENESS AND SAFETY OF MONOCLONAL ANTIBODY SWITCHING IN MIGRAINE PATIENTS

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Background and Importance Monoclonal antibodies targeting the calcitonin gene-related peptide (CGRP-mAbs) are used in the prophylaxis of migraine. The therapeutic target is not exactly the same as Erenumab targets the CGRP receptor, whereas Galcanezumab and Fremanezumab target circulating CGRP. However, their relative effects in patients with prior migraine treatment failure remains uncertain.
Aim and Objectives To describe the use, effectiveness and safety of CGRP-mAbs switching in patients with migraine.
Material and Methods Retrospective observational study between 1-September-2019 and 30-September-2022 in a third-level hospital. Data collected: sex, age, comorbidities, CGRP-mAbs prescribed, treatment duration, causes of suspension, adverse reactions (AR), Headache Impact Test (HIT) and Migraine Disability Assessment (MIDAS) scores, average number of migraine days per month (NMDM) and days with triptans at baseline, prior and concomitant preventive drugs. Data were obtained from electronic medical records and patients interviews. The study had been approved by the Ethics Committee. Informed consent was obtained from all participants.
Results Of 167 patients on treatment with CGRP-mAbs, 17.4% (89.7% women, median age: 45.1(37.4–53.8) years) switched to another mAb: Erenumab (38%), Galcanezumab (31%), Fremanezumab (31%). While 75.9% of patients discontinued due to ineffectiveness, 24.1% had AR. Most of them (77.4%) had chronic migraine, 22.6% high-frequency episodic migraine. The main comorbidities were anxious-depressive syndrome (19.3%) and fibromyalgia (12.9%). The average NMDM was 15 ± 7.7 days and 31.0% patients used triptans $\geq$7 days/month. All patients had >3 prior treatments: beta blockers (87.1%), calcium antagonists (100%), antidepressants (93.5%), antiepileptics (100%) and botulinum toxin (79.3%). Concomitant preventive drugs was used 75.8% of patients, concomitant botulinum toxin in 13.8%. Median treatment duration of the second line: 5(3.3–7) months.

Fifteen patients (51.7%) switched to a third line: Erenumab (6.6%), Galcanezumab (60.0%), Fremanezumab (33.4%). Median treatment duration: 4 (1.7–4) months. The retention rate after the second switch was 93.3%. No AR were observed.
Conclusion and Relevance Some migraine patients who did not respond to a first drug responded initially to the switch, however half of them need to switch to a third mAb. Although non-responders to treatment may profit from a switch of antibody class, more studies are needed to describe which patients will respond to CGRP-mAb switching. Considering the low number of AR, treatment with CGRP-mAbs can be considered safe.

REFERENCES AND/OR ACKNOWLEDGEMENTS

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5PSQ-015 PERSISTENCE OF TREATMENT WITH JAK INHIBITORS IN RHEUMATOID ARTHRITIS IN PATIENTS ALREADY TREATED WITH THEM

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Background and Importance Different JAK inhibitors (JAKi) are recently marketed at Spain for the treatment of

rheumatoid arthritis (RA). However, there is little data about their persistence when a previous JAKi has been used on RA treatment, which could influence pharmacotheraphy with these drugs.

Aim and Objectives To analyse the persistence to treatment with a second JAKi treatment in RA patients which have previously been treated with a first JAKi.

Material and Methods Observational, retrospective study including all patients with RA treated with more than one JAKi until August 31, 2022. Demographic variables, median disease duration, median time on treatment (mToT) of JAKis including causes of end of treatment (loss of effectiveness or adverse reaction). Persistence was measured through mToT.

Results 18 patients (16 women), median age of 48 years [interquartile range (IQR):40–55] were included. Median time from diagnosis 9.4 years (IQR:6.3–11.8). Concomitant treatment: methotrexate (n=7) or leflunomide (n=2). Before first JAKi treatment, 12 patients were treated previously with at least a biologic disease-modifying antirheumatic drug (bDMARD). 4 patients were treated with at least a bDMARD after finishing first JAKi, rest of patient switched directly to another second JAKi.

Total mToT with the first JAKi: 12.1 months (IQR:3.3–31.3). Causes of end of treatment: loss of effectiveness (n=11; mToT: 15.7 months, IQR:11.9–35.3) and adverse effects (n=6; mToT: 2.5 months, IQR:1.4–4.7); a patient changed JAKi treatment due to cardiovascular risk.

Among patients who finished first JAKi due to loss of effectiveness (n=11), mToT with second JAKi was 9.6 months (IQR:4.1 -14.2; 6/11 continue treatment; 1/11 loss of follow-up). Considering only patients who finished both first and second JAKi due to loss of effectiveness (n=4), mToT was 12.5 months (IQR: 8.0 -17.7) vs 6.6 (IQR:3.1–16.1) respectively.

33% of patients (2/6) who finished first JAKi treatment because of adverse effects did not tolerate neither the second JAKi (mToT: 2.5 months, IQR:1.4–140; 3/6 continue treatment).

Conclusion and Relevance Persistence is higher with first JAKi when treatment with both first and second JAKi finished due to loss of efficacy, however data is still immature. Patients who do not tolerate treatment with a first JAKi seems to have a higher chance of not tolerating a second JAKi.

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5PSQ-017 IMMUNE-MEDIATED ADVERSE EFFECTS OF CHIMERIC ANTIGEN RECEPTOR T CELLS (CAR-T) THERAPY IN REAL LIFE POPULATION: WE CONTINUE TO LEARN

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Background and Importance Treatment with CD19-targeted chimeric antigen receptor T-cells (CAR-T) is transforming the therapeutic landscape of some B-cell malignancies, achieving high rates of responses. However, they have a new toxicity profile identified in the clinical trials, related to T-cell hyperactivation, namely cytokine release syndrome (CRS) and Immune effector cell-Associated Neurotoxicity Syndrome (ICANS). Hospital Pharmacists should continue generating knowledge about these adverse effects (AEs) in real-life population.

Aim and Objectives Describing the toxicity profile of CAR-T cells therapies in a cohort of real-life patients and looking for possible risk factors related to current and previous treatments.

Material and Methods All patients infused with anti-CD19 CAR-T therapies in our centre between 01/01/2019 and 21/07/2022, out of clinical trials, were retrospectively analysed. We collected different descriptive variables of the patient, their pathology, CRS and ICANS type AEs, and treatments against them. For the statistics, proportion comparison tests and multivariate logistic regression were performed.

Results 88 patients were included (mean age 54.5 years, 44.3% women), 92.0% treated for B lymphomas and 8.0% for acute lymphoblastic leukemias. 56.8% received axicabtagene ciloleucel and 43.2% tisagenlecleucel, with 2.46 (1–6) previous lines received on average. About AEs, 79 (89.8%) patients suffered CRS (38.0% of them grades 2 to 4) and 31 (35.2%) ICANS (58.1% grades 2 to 4). The proportion of CRS was significantly higher (diff=55.5%, p>0.001), but, on the other hand, when the AE had occurred, the probability of it being grade 2–4 was significantly higher for ICANS than for CRS (diff=20.1%, p<0.05).

Concerning treatments employed, 77.1% of patients received tocilizumab, 61.4% corticosteroids (18.2% bolus doses), 27.3% siltuximab, and 19.2% anakinra. 53 (60.2%) patients required 2 or more treatments. Performing logistic regression, we found no significant risk factors for CRS, while having received tocilizumab, using axicabtagene ciloleucel, and suffering previous CRS grades 2–4 were associated with increased risk of ICANS (OR=6.72, 4.46, and 4.45 respectively, p<0.05).

Conclusion and Relevance Our real-life study supported the conclusions of other authors. After infusing a CAR-T, it was more likely to suffer CRS than ICANS, but, if it occurred, ICANS was more likely to be more severe. Suffering ICANS seems to be associated with previous tocilizumab use, axicabtagene ciloleucel, and previous moderate-severe CRS.

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5PSQ-018 PRESCRIBING ERRORS IN CHILDREN: WHAT IS THE IMPACT OF A COMPUTERISED PHYSICIAN ORDER ENTRY?

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Background and Importance Prescribing errors represent a safety risk for hospitalised patients, especially in paediatric s.[1] Computerised physician order entry (CPOE) might reduce prescribing errors, although its effect has not yet been thoroughly studied on paediatric general wards.

Aim and Objectives This study investigated the impact of a CPOE on prescribing errors in children on general wards at a University Children's Hospital.