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.

REFERENCES AND/OR ACKNOWLEDGEMENTS

Conflict of Interest No conflict of interest

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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10.1136/ejhpharm-2023-eahp.438

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.

REFERENCES AND/OR ACKNOWLEDGEMENTS

Conflict of Interest No conflict of interest

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

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10.1136/ejhpharm-2023-eahp.439

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.