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

[1]D Gomez*, [2]C Serra, [3]G Marina, [4]V Escudero, [4]Jl Revuelta, [4]Y Rioja, [3]G Oarbeascoa, [4]A Herran, [4]M Sanjurjo. *[1]Hospital General Universitario Gregorio Marañon, Hospital Pharmacy, Madrid, Spain*; *[2]Hospital General Universitario Gregorio Marañón, Neurology, Madrid, Spain*; *[3]Hospital General Universitario Gregorio Marañón, Hematology, Madrid, Spain*; *[4]Hospital General Universitario Gregorio Marañón, Hospital Pharmacy, Madrid, Spain*

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?

[1]A Satir*, [1]M Pfiffner, [2]C Meier, [1]A Caduff Good. *[1]University Children's Hospital Zurich, Department of Hospital Pharmacy, Zurich, Switzerland*; *[2]University of Basel, Department of Pharmaceutical Sciences, Basel, Switzerland*

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.

Material and Methods We performed medication reviews on 1000 patients from 0 – 18 years on paediatric general wards before and after the implementation of a CPOE. The CPOE included limited clinical decision support (CDS) such as a drug-drug interaction check and checks for duplicates. Prescribing errors, their type according to the PCNE classification, their severity (adapted NCC MERP index) as well as the interrater reliability (Cohen's Kappa) were analysed.
Results CPOE significantly reduced the rate of errors from 25 errors/100 prescriptions (95% CI: 23 – 27) to 16 errors/100 prescriptions (95% CI 14 – 18). Particularly the prescribing quality was improved by reducing PCNE error 5.2 (e.g. lacking drug form or maximum possible number of doses for reserve medication). Medication reconciliation problems (PCNE error 8), such as drugs prescribed on paper as well as electronically, were significantly increased after introduction of the CPOE. The most common paediatric prescribing errors, the dosing errors (PCNE errors 3), were not statistically significantly altered after introduction of the CPOE. Overall severity of errors was reduced. Interrater reliability showed moderate agreement (K = 0.48).
Conclusion and Relevance The CPOE increases patient safety by reducing the rate and severity of prescribing errors. The reason for the observed increase in medication reconciliation problems might be the hybrid-system with remaining paper-prescriptions for special medication. The lacking effect on dosing errors might be explained by the fact that a web application CDS covering dosing recommendations (PEDeDose) was already in use before implementation of the CPOE. Further investigations should focus on eliminating hybrid systems, interventions on how to increase the usability of the CPOE, and full integration of CDS tools into the CPOE.

REFERENCES AND/OR ACKNOWLEDGEMENTS
1. Gates PJ, *et al*. Prevalence of medication errors among paediatric inpatients: systematic review and meta-analysis. *Drug Saf* 2019;**42**:1329–1342

Conflict of Interest Corporate sponsored research or other substantive relationships:
This study was funded by the grant for the scientific project of national reach 2014 of the Swiss Association of Public Health Administration and Hospital Pharmacists (GSASA).

5PSQ-031 ANALYSIS OF THE USE OF ISAVUCONAZOLE IN CRITICALLY ILL PATIENTS WHEN THE USE OF VORICONAZOLE IS INDICATED

G Martínez Orea*, C Garcia Gonzalez, F Fuentes Hidalgo, FJ Rodriguez Lucena, C Devesa Garcia, N Cano Cuenca. *Hospital Pharmacy, Hospital Vega Baja, Orihuela, Spain*

10.1136/ejhpharm-2023-eahp.440

Background and Importance Isavuconazole and voriconazole are antifungals that have shown similar clinical efficacy in the treatment of invasive aspergillosis. Isavuconazole has certain advantages such as a lower interaction profile and can be used in patients with renal insufficiency; however, its similar efficacy limits its use in situations where voriconazole is contraindicated.
Aim and Objectives The aim of this study is to describe the proportion of isavuconazole prescriptions in which the use of voriconazole would not be contraindicated.
Material and Methods Descriptive, observational and retrospective study in which all patients over 18 years of age who received isavuconazole in 2021 in a hospital were included. Exclusion criteria were: age less than 18 years, pregnancy or duration of treatment less than 24 hours.

The use of intravenous voriconazole is contraindicated in patients with moderate to severe renal insufficiency (ClCr <50mL/min), in severe hepatic insufficiency (Child-Pugh C) and in combination with CYP450 substrates.

The main variable under study was the proportion of isavuconazole prescriptions in which the use of voriconazole would not be contraindicated.

The following variables were also collected: sex, age, number of days of treatment and mycological culture results.

Patients treated with isavuconazole were obtained from a database of the pharmacy service, sociodemographic and clinical variables from the OrionClinic computer program.

A descriptive statistical analysis was performed using measures of central tendency such as mean and median, through the SPSS v.23® program.
Results 37 patients treated with isavuconazole were included. Four patients were excluded. The median age was 63 years (24–82) and 68% were male.

Voriconazole was not contraindicated in 65% of the isavuconazole prescriptions. Thirty-five percent of the patients had renal insufficiency. The mean number of days of treatment was 6 ± 4.9 days.

A mycological culture was performed in 89% of the patients, with 78% of the results being negative.
Conclusion and Relevance A high percentage of patients treated with isavuconazole in our critical care unit did not meet the conditions for which it was included in the pharmacotherapeutic guide of the hospital. These results suggest the need for a specific PROA in critical patients or the multidisciplinary elaboration of a protocol for the use of antifungals.

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

5PSQ-035 MASS UNIFORMITY OF HARD CAPSULES: ROYAL SPANISH PHARMACOPOEIA VS UNITED STATES PHARMACOPOEIA

S Prieto Román*, N Barrueco Fernández, EA Álvaro Alonso, A Such Díaz, C Esteban Alba, L De Agustín SIERRA, B Montero Pastor, L López Guerra, A Santiago Pérez, L Pedraza Nieto, I Escobar Rodríguez. *Infanta Leonor University Hospital, Pharmacy Department, Madrid, Spain*

10.1136/ejhpharm-2023-eahp.441

Background and Importance Quality control (QC) is an important part of the quality assurance of the elaborating process in a Hospital-Pharmacy-Department (HPD).The mass uniformity is the most commonly procedure used for QC of hard-capsules.
Aim and Objectives Analyse comparatively the Royal-Spanish-Pharmacopoeia (RSP) hard-capsule mass uniformity method versus the United-States-Pharmacopoeia (USP).
Material and Methods The following parameters of each method were analysed: sample, average reference weight, percentage and acceptance requirements. Also, the elaborating process necessary to apply each method.

Finally, the elaboration of a batch of 100 hard-capsules of dexamethasone 40mg according to the HPD Standard-Operating-Procedure was taken as a reference. Then the elaborations