5PSQ-117 EVALUATION OF CARDIOTOXICITY BY OSIMERTINIB IN CLINICAL PRACTICE

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Background and Importance Osimertinib is a tyrosine kinase inhibitor (TKI) indicated for the treatment of epidermal growth factor receptor mutated non-small-cell lung cancer (NSCLC). Despite a better safety profile than other TKIs for the same indication, osimertinib could produce some potentially fatal cardiotoxicity. However, the available evidence on cardiotoxicity in clinical practice is very limited.
Aim and Objectives To analyse the incidence of cardiotoxicity associated with osimertinib in the real clinical practice.
Material and Methods We conducted an observational cross-sectional study in a third-level hospital in Spain. We included all adult patients diagnosed with NSCLC treated with osimertinib between February 2018 and May 2021. We collected socio-demographic data and treatment characteristics, as well as cardiological history, all events of cardiac toxicity during treatment and other comorbidities. Descriptive statistical analysis was performed.
Results 33 patients were included, with a median age of 72.5 (interquartile range [IQR]= 62.2–81.0) years, and 63.6% were women. The indication for osimertinib was metastatic lung adenocarcinoma (32 patients, 96.7%) and epidermoid non-small-cell lung cancer (1 patient, 0.3%). It was used as the first-line of treatment in 39.4% of the patients and as the second-line or successive in 60.6% of them.

At the start of treatment, 57.6% of the patients had cardiovascular comorbidities. The most frequent comorbidites were arterial hypertension (48.5%), dyslipidemia (36.4%), and diabetes mellitus (12.1%), and one patient was diagnosed with congestive heart failure.

The median time on osimertinib treatment was 11.0 (IQR= 4.6–17) months. Of the 33 patients, 21.2% of patients had previous cardiac examinations before starting osimertinib treatment. During the treatment, 4 (12,1%) patients developed cardiac adverse reactions: 2 (6.1%) suffered a decrease in the Left Ventricular Ejection Fraction (LVEF), 1 (3.0%) experienced atypical chest pain, and 1 (3.0%) developed an increase in the D-dimer and hyperfibrinogenaemia. One of the patients with LVEF decreased required hospitalisation and invasive management. The rest of the cardiotoxicities were managed with dose reduction and conservative measures.
Conclusion and Relevance More than 10% of osimertinib-treated patients had cardiotoxicity. Of these, 25% required hospitalisation. Oncologists should always assess cardiac function at the start of osimertinib and during the follow-up.

REFERENCES AND/OR ACKNOWLEDGEMENTS

Conflict of Interest No conflict of interest.

5PSQ-121 CYTOKINE RELEASE SYNDROME RELATED TO THE TREATMENT WITH TECLISTAMAB: A CASE REPORT

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Background and Importance Teclistamab is a bispecific antibody (BsAb) targeting the CD3 receptor complex on T cells and BCMA on B cells. This treatment is the process of approval for patients with relapsed or refractory multiple myeloma (RRMM). It is only available in some countries through an Expanded-Access Program. The posology consists of two set up-doses of 60 and 300 μg/Kg separated 2–4 days, and treatment doses of 1500 μg/Kg administered weekly. Hospitalisation is required for at least 48 hours from the start of administration of the two set-up doses and the first treatment dose.

It has been observed that the administration of BsAb such as Teclistamab might cause the cytokine release syndrome (CRS). CRS is a potentially life-threatening, systemic inflammatory response.

Given the BsAb market is growing rapidly, it is important to train the healthcare professionals to good handling these adverse reactions.
Aim and Objectives To describe the CRS produced by Teclistamab in one patient with RRMM and the management of this adverse reaction.
Material and Methods A case report identified in a tertiary hospital in 2022. Clinical data were collected through the electronic medical record.
Results A 76-year-old man with hypertension history and diagnosed with RRMM, was admitted to hospital to be treated with Teclistamab. Just 24 hours after the first set-up dose, the patient experienced CRS-related symptoms such as chills and a hypertensive crisis (300/140 mmHg). He was treated with a dose of Tocilizumab 600 mg, corticosteroids, antipyretics and oral antihypertensives, without clinical improvement. The patient was transferred to the Intensive Care Unit (ICU) for the management of his hypertension. At the ICU, he received two more doses of Tocilizumab 600 mg every 8 hours. The hypertension was controlled with oral antihypertensive drugs and the patient was discharged from the ICU the following day.

The subsequent doses of Teclistamab were well tolerated and the patient did not experience any other adverse reaction.
Conclusion and Relevance Although CRS is predictable in patients who receive BsAb and it is well controlled with Tocilizumab, it is important to monitor the patients within the 24–48 hours after the first administration of Teclistamab. This monitoring is particularly crucial for those patients with history of arterial pressure alterations.

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5PSQ-126 EFFECTIVENESS AND SAFETY OF OMALIZUMAB, MEPOLIZUMAB AND BENRALIZUMAB IN PATIENTS WITH SEVERE UNCONTROLLED ASTHMA

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Background and Importance Despite following adequate treatment, a high percentage of patients with asthma is not controlled; therefore, alternative treatments that are effective and safe are necessary, especially in patients with severe uncontrolled asthma. Among the new treatments for asthma,