(38.3%) a mechanical-thyroid pattern. Two patients had up to 7 pathologies of the same pattern. 4 patients (8.5%) had over 10 comorbidities. 57.4% of the patients suffered from arterial hypertension, 53.2% dyslipemia, 31.9% diabetes and 23.4% benign prostatic hypertrophy.

Conclusion and Relevance In conclusion, non-HIV-related comorbidities are increasingly important in older HIV-infected people. It is important to detect and prevent modifiable age-related risks of non-HIV comorbidities. It is necessary to develop a multidisciplinary approach to ensure high-quality clinical care in these patients. Understanding the range of comorbidity patterns facilitates precision in developing forthcoming health interventions in complex elderly PLHIV.

REFERENCES AND/OR ACKNOWLEDGEMENTS

Conflict of Interest No conflict of interest.

4CPS-105 MEDICINES OPTIMISATION FOR PATIENTS IN A NURSING HOME

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Background and Importance Inappropriate prescribing is associated with increased morbidity and mortality, especially in the elderly. It is necessary to find tools to improve the care of these patients.

Aim and Objectives The objective was to evaluate the results of a medication review program in nursing home (NH) patients, analysing the acceptance of pharmacotherapeutic recommendations and identifying the most frequent interventions and the pharmacological groups involved.

Material and Methods Prospective-multidisciplinary intervention study carried out between 03/07/23 and 25/09/23 using a treatment review program for institutionalised patients in NH.

All institutionalised patients were included. Patients who died were excluded. Sex, age, NG-tube, creatinine, blood pressure, main diagnoses, and drugs prescribed were collected. Using the software Checkthemeds®,the pharmacist reviewed treatments, preparing a report that included the problems detected and suggestions: Start drug, stop drug, substitution, dose change, or monitoring. Therefore, the NH doctor could assess the need for treatments modifications.

Number of initial and final drugs, interventions performed and accepted, and type of interventions were analysed.

The descriptive analysis was performed using Microsoft Excel® (percentages, means, standard deviations).

Results A total of 46 patients (28 women), mean age 85.95 years [7.96], were reviewed. Two were excluded due to death. A total of 526 drugs were analysed. Each patient was prescribed an average of 11.95 [4.45]. In 5 patients no recommendation was made. Eighty-nine recommendations were made, 46 (51.7%) were accepted, being the recommendations: 2 new medicines suggestions, none accepted; 75 medication discontinuations, 40 accepted; 5 therapeutic substitutions, 3 accepted; 6 dose modifications, 2 accepted and 1 monitoring, 1 accepted. The final number of drugs was 11.02 [4.21]. Drugs involved were mainly Central Nervous System depressants (34 recommendations); Proton Pump Inhibitors (20); and antianemic preparations (12). The main cause of non-acceptance was the reluctance of relatives to modify antipsychotic therapies.

Conclusion and Relevance The medication review program for NH residents, through the collaboration of a hospital pharmacist and a primary-care physician, optimises the pharmacotherapy of institutionalised patients. The interventions of the multidisciplinary team provide great value in deprescribing, reducing the number of drugs used, and are a valuable tool to improve the safety and effectiveness of treatments.

REFERENCES AND/OR ACKNOWLEDGEMENTS

Conflict of Interest No conflict of interest.

4CPS-106 AUC-SURVIVAL REANALYSIS OF TROPICS-02 TRIAL WITH SACITUZUMAB GOVITECANFOR METASTATIC LUMINAL BREAST CANCER

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Background and Importance Sacituzumab govitecan (SG) was recently approved by European Medicines Agency for heavily treated metastatic breast cancer (mBC) patients positive hormone receptor (HR+) and human epidermal growth factor receptor-2(HER2) negative supported by TROPiCS-02 trial which compare standard chemotherapy (ChT). Pivotal study results in overall survival (OS) was HR=0,78 IC95% (0,65–0,95). OS difference in median survival times was: 3,3 months. Although medians are commonly used in oncology to measure the magnitude of the benefit between different drugs, this is not accurate because only measures the difference in one point of the curves. A visual inspection of Kaplan-Meier's survival functions of TROPiCS-02 suggested that the difference of medians could overestimate the OS benefit, as the curves separate in the central area.

Aim and Objectives The aim of study was to reanalyse the OS benefit of SG from pivotal clinical trial by calculating the difference in mean survival time by area-under curves (AUC)-based methods.

Material and Methods We use WebPoltDigitizer 4.6 to extract survival data at 100 points in each Kaplan-Meier's OS curves. Mean survival times were estimated by AUC with Seruga's method (Ann Oncol 2012). with or without a correction from Fenix's method (Eur J Clin Pharm 2015). The later prevents underestimation by subtracting the areas corresponding to the proportion of the population whose survival is greater than the maximum observation time.

Results The AUC-estimated difference for SG vs. standard ChT were 2,30 by Seruga's AUC method and 2,35 months with the correction from Fenix et al. It was 1 month less than the difference of medians showed the pivotal study.

Conclusion and Relevance European Society Medical Oncology rated this drug-indication with a score of 3 (not substantial benefit) in their Magnitude of Clinical Benefit Scale (0 to 5). Moreover, the difference of medians overestimated the benefit in the pivotal trial, as it was just shown by AUC-methods. These results suggest a modest benefit for SG in mBC HR+/HER2-. Indeed AUC-methods could be a good option when difference of medians are doubtful to estimate the benefit; its use should be extended.

REFERENCES AND/OR ACKNOWLEDGEMENTS

1. Seruga B, Pond GR, Hertz PC. Comparison of absolute benefits of anticancer therapies determined by snapshot and area methods. *Ann Oncol.* 2012;**23** (11):2977–82.

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4CPS-107 ADHERENCE TO DAILY ORAL TREATMENT IN MULTIPLE SCLEROSIS

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Background and Importance Several studies conclude that correct adherence of patients with multiple sclerosis (MS) is related to higher efficacy and lower risk of relapses, disease progression, hospitalisations, emergency department visits, and ultimately lower health care costs. Therefore, it is a priority to detect non-adherence in order to optimise therapy.
Aim and Objectives To assess adherence to daily oral treatment in people with MS. To perform a detailed descriptive analysis of non-adherent treatments, identifying reasons, previous treatments received and current status.
Material and Methods Using the Hospital's outpatient module, a record was obtained of the corresponding dispensing dates between December 2017 and September 2023. This information was used to calculate adherence for treatments exceeding 6 months, which was complemented with the electronic medical record and patient interviews. A medication possession rate (MPR) of less than 90% was considered non-adherence. Interruptions due to medical reasons were taken into account.
Results A total of 114 patients were included and 144 treatments were analysed, corresponding to 66 treatments with dimethyl fumarate (9 non-adherent, 13.6%), 63 with teriflunomide (3 non-adherent, 4.8%), 13 with fingolimod (2 non-adherent, 15.4%) and 2 treatments with ponesimod without adherence problems.

There was non-adherence in 14 treatments corresponding to 12 patients, with a median MPR of 84.4% (interquartile range 78.0 – 85.5%). Of these, 7 patients remained on the same treatment despite non-adherence, with no worsening of lesions detected by magnetic resonance imaging. 4 patients switched to another treatment and 1 patient discontinued treatment without switching to another treatment. Of the 12 patients, 7 had previously received other treatments, with glatiramer being the most common, along with interferon and teriflunomide.

Reasons for non-adherence in 14 treatments were adverse effects (4), missed doses (4) and in 6 patients we could not clearly identify the cause.
Conclusion and Relevance We found good adherence in almost all patients. In non-adherent patients the rate of medication possession remains high and did not translate in most cases into clinical worsening.

Adherence assessment and subsequent detection of non-adherent patients in MS is a key strategy for pharmaceutical interventions aimed at achieving better health outcomes and efficiency.

REFERENCES AND/OR ACKNOWLEDGEMENTS

Conflict of Interest No conflict of interest.

4CPS-108 CLINICAL IMPACT OF PHARMACOKINETIC MONITORING OF INFLIXIMAB AND ADALIMUMAB IN INFLAMMATORY BOWEL DISEASE

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Background and Importance Failure of biologic therapy (anti-tumour necrosis factor (TNF) drugs) is a common problem. Pharmacokinetic monitoring can contribute to early identification of therapeutic failure and thus optimise treatment by keeping drug concentrations within the therapeutic interval (TI) where the probability of efficacy is higher and the likelihood of toxicity and development of immunogenicity is minimal.
Aim and Objectives To assess the acceptability of pharmacokinetic recommendations for adalimumab (ADA) and infliximab (IFX) in clinical practice in patients with inflammatory bowel disease (IBD).
Material and Methods Retrospective observational study (June 2023 – September 2023) in patients with IBD treated with anti-TNF drugs. All patients who were requested for ADA or IFX plasma levels were included.
Variables sex, age, type of pathology (Crohn's disease (CD) or Ulcerative Colitis (UC)), anti-TNF regimen, concomitant immunomodulators, type of recommendation (maintenance of regimen, optimisation, intensification) and acceptance of recommendations. The therapeutic interval (TI) was 3–10 mcg/ml (IFX) and 5–12 mcg/ml (ADA).
Data source electronic health record (Mambrino XXI®) and MwPharm++ pharmacokinetic monitoring software.
Results Seventy-two patients (65% male) were included, with a median age of 47 (16–77) years. Of these, 75% had CD and 25% had UC. 53 patients were on ADA and 19 on IFX. Seventy-eight pharmacokinetic monitoring tests were performed. 60% were within the TI, 21% were subtherapeutic and 19% were supratherapeutic. In 3 patients, the concentration was higher than the TI and was not in accordance with the previous ones, so a new control was requested. After this, it was confirmed that they were within the TI and maintenance of the regimen was recommended.
The pharmacokinetic recommendations conducted were maintenance of regimen (73%), intensification (17%) and optimisation (10%). 94% of recommendations were accepted. The recommendations that were not accepted (6%) were due to clinical worsening of the patient and a change of therapeutic target was made.
Conclusion and Relevance Based on the results of our study, the degree of acceptance of pharmacokinetic recommendations was high (94%). Pharmacokinetic monitoring is an important element of support in clinical decision making. Through this practice, the hospital pharmacist contributes to the optimisation of these treatments, helping to ensure that the appropriate adjustment is made for a better response.

REFERENCES AND/OR ACKNOWLEDGEMENTS

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