4CPS-184 THERAPIES IN ENDOMETRIAL CANCER WITH DNA MISMATCH REPAIR DEFICIENT OR MICROSATELLITE INSTABILITY: A SYSTEMATIC REVIEW

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Background and Importance Standard therapy for advanced endometrial cancer (EC) pre-treated with platinum-based chemotherapy (PCT) showed limited efficacy. DNA mismatch repair deficient/microsatellite instability-high (dMMR/MSI-H) neoplasms are associated with increased PD-1 and PD-L1 expression. Thus, immunotherapy could play an important role in EC with dMMR/MSI-H.
Aim and Objectives To conduct a systematic review of scientific evidence on treatments for EC with dMMR/MSI-H in patients who previously received PCT.
Material and Methods A literature search in PubMed® database was performed to August 2023. Filter 'clinical trials' was applied with the following search strategy: [microsatellites instability OR Mismatch Repair Deficient] AND endometrial cancer. Preferred Reporting Items for Systematic reviews and Meta-Analyses (PRISMA) methodology was used in bibliographic review. Inclusion criteria: clinical trials (CTs) involving patients with dMMR, or MSI-H diagnosed with advanced and/or metastatic EC who had previously received PCT. Efficacy endpoints assessed were overall survival (OS), progression-free survival (PFS) and objective response rate (ORR). Data collected: publication date, study design, stage, median patient follow-up, sample size, therapies, comparator arm and efficacy data.
Results A total of 30 search results were identified. Thirteen CTs met the inclusion criteria. These studies were published between May 2019 and February 2023. Study design: nine non-randomised phase II, two non-randomised phase I, one randomised phase III and one randomised phase Ib/II. Patients with advanced EC were included in 23.1% of CTs, with metastatic disease in 23.1% and both in 53.8%. Median follow-up ranged from six to 42.6 months. Sample size comprised 11 to 130 patients. Therapies analysed were: pembrolizumab, pembrolizumab plus lenvatinib, durvalumab, durvalumab plus tremelimumab, dostarlimab, nivolumab and avelumab. A total of 11 studies had no comparator arm. Pembrolizumab achieved the highest numerical efficacy [OS= 40.0 months (95% CI 25.3-Not Reached); PFS= 23.5 months (95% CI 10.7-NR); ORR= 58% (95% CI 37–78)]. Dostarlimab [OS= NR; PFS= 12.2 months (95% CI not available); ORR= 43.5% (95% CI 34.5–53.4)] and durvalumab [OS= NR; PFS= 8.3 months (95% CI 2.4-NR); ORR= 47% (95% CI 32–63)] presented the next best numerical efficacy. No CTs compared pembrolizumab with dostarlimab or durvalumab.
Conclusion and Relevance The greatest numerical efficacy data were achieved by pembrolizumab, followed by dostarlimab and durvalumab. Nevertheless, CTs with adequate comparisons are needed for reliable data interpretation.

REFERENCES AND/OR ACKNOWLEDGEMENTS

Conflict of Interest No conflict of interest.

4CPS-185 ANALYSIS OF THE USE OF MEDICATION NOT INCLUDED IN THE PHARMACOTHERAPEUTIC GUIDE OF A TERTIARY HOSPITAL

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Background and Importance Interdisciplinary collaboration, particularly involving pharmacists in medication reconciliation, can prevent errors. Medication discrepancies at care transitions are common and linked to adverse events that's why addressing communication barriers before errors happen is crucial.
Aim and Objectives This study aims to analyse the prescription of medication not included in the hospital's pharmacotherapeutic guide (MNIG) and the pharmaceutical interventions (PI) performed.

Additionally, this research evaluates the effectiveness of a quality indicator aimed at reducing MNIG prescriptions in the cardiology service through PI.
Material and Methods A prospective study was conducted from 20 April to 31 August 2023, utilising the Farmatools® program to assess the following variables:

- The percentage of MNIG prescriptions, categorised by therapeutic group (TG) based on ATC codes.
- The cause of MNIG prescriptions, including reconciliation and new treatment.

-Number of substitutions in the therapeutic exchange program (TEP) resulting from PI, including the percentage of MNIG replaced by therapeutic equivalents (TE), discontinued, not substitutable, and included in the hospital guideline.
Results 322 MNIG were prescribed: 13% G04C, 12% B01A, 11% A10BD, 10% C10B, and the remaining 54%, miscellaneous drugs.

As for the cause of prescription: 95% is conciliation and 5% is prescription of a new treatment.

Of the MNIG prescribed, 53.4% had TE in the TEP, 18% were substituted, and the rest were provided by the patient. A total of 26.4% were not substitutable, and 11.18% were included in the hospital pharmacotherapeutic guide (HPG) and 9% were recommended to be suspended on admission, as indicated by the TEP.

The prescription of MNIG is variable during the months studied, with a median of 4%, maximum of 7.5% and minimum of 2%, with concerning the total number of prescriptions, without a linear trend.
Conclusion and Relevance The multidisciplinary team responsible for the patient should be involved in the reduction of MNIG to avoid medication errors, through the use of HPG and TEP.

Regarding the analysis of the indicator, we consider it important to perform PI to raise awareness among physicians of the correct use of NID, although we cannot confirm that the punctual decreases in prescriptions are due to the PI performed. In addition, the pharmacy service should review the HPG and TEP to include the necessary drugs and to disseminate the PET among health professionals.

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