total, throughout their hospital stay, 64% (n=837) of admissions had no change in their CALS (largest group), 36% (n=469) of admissions had an increase and a minority had a decrease in score. For score ≥ 3, ≥ 4 and ≥ 5, increase was observed from admission to discharge of 26%, 16% and 12% respectively. Patients with increase of at least of 1 point of CALS were significantly older ($pval<10^{-4}$) and had increase length of hospital stay ($pval<10^{-15}$). The most common prescribed drugs were analgesics, anti-epileptic and diuretics.

Conclusion and Relevance Following the CRIDECO rule, 30% of patients > 65 years had a risk of anticholinergic burden at admission, and this risk does not decrease during hospitalisations. A threshold of five might be a potential cut-off choice for pharmaceutical interventions in future studies due to its significant increase for a small sample size. This further supports the feasibility and promising benefits of implementing new strategies for physicians with CDSS to improve medication management and to reduce the anticholinergic burden.

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Conflict of Interest No conflict of interest.

4CPS-198 EVALUATION OF PROA TEAM INTERVENTION ACCEPTANCE RATES THROUGH AN AUTOMATED MEASUREMENT SYSTEM

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10.1136/ejhpharm-2024-eahp.302

Background and Importance Programmes to optimise antibiotics use (PROA) are constituted by multidisciplinary teams involving at least one physician, one pharmacist and one microbiologist. Their purpose is to improve clinical outcomes related to antibiotic use, reduce adverse effects and ensure cost-effectiveness treatment through educational clinical interventions.

Aim and Objectives The aim of this study is to evaluate the acceptance of these interventions through an automated system and compare the results with those obtained manually in the previous year.

Material and Methods Descriptive, retrospective and cross-sectional study, conducted between January-September 2023. A software tool was developed to analyse whether PROA interventions were accepted within the following 48 hours.

The system, by means of computer programming, analyses the recorded interventions and assesses whether the prescriptions have been modified. It only focuses on recommendations related to treatment suspension, sequential therapy or antibiotic de-escalation and classifies them as rejected, if prescription continued unaltered, or accepted if changes occurred according with the recommendation. Subsequently, a comparative analysis was conducted between data obtained using this tool and data manually obtained previously from a cross-section study carried out in February 2022. All information was collected from electronic medical records and analysed using the R statistical programme (v.4.2.2). Categorical variables are expressed as frequency and percentage.

Results A total of 859 interventions were analysed with an acceptance rate of 83.5%; 556 involved treatment suspension, 245 antibiotic de-escalation and 58 sequential therapy. Acceptance rates for each were 86%, 80% and 74%, respectively.

Abstract 4CPS-198 Table 1 Acceptance rate of PROA interventions: comparative analysis

Type of intervention	February 2022 N=(154/192)	January-September 2023 N=(717/859)
Treatment suspension%(N)	76% (73/96)	86% (478/556)
Antibiotic de-escalation%(N)	87,2% (68/78)	80% (196/245)
Sequential therapy%(N)	72% (13/18)	74% (43/58)

Conclusion and Relevance The automated system offers a comprehensive view of the acceptance rates of PROA interventions over time, contrasting with the manual approach that only can be afforded for a short period of time. Although it has some limitations because it does not include all intervention types, it allows a quick analysis of the impact of these interventions in clinical practice.

REFERENCES AND/OR ACKNOWLEDGEMENTS

Conflict of Interest No conflict of interest.

4CPS-199 COMPARATIVE EVALUATION OF ENZYME-LINKED IMMUNOSORBENT ASSAY VERSUS A POINT-OF-CARE TECHNIQUE IN THE DETERMINATION OF ADALIMUMAB LEVELS

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10.1136/ejhpharm-2024-eahp.303

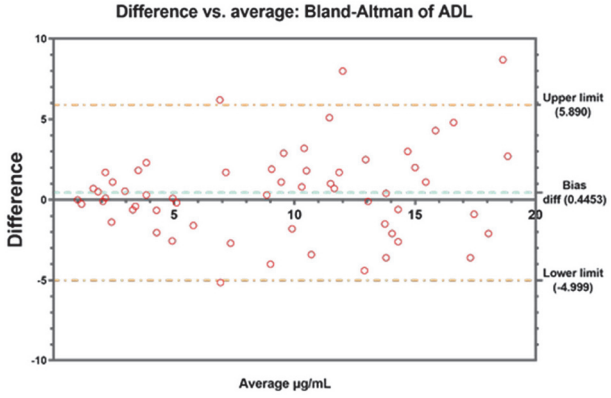
Background and Importance Therapeutic drug monitoring in inflammatory bowel disease (IBD) is a useful tool for optimising biologic therapy. The analysis of adalimumab (ADL) concentrations in blood through enzyme-linked immunosorbent assay (ELISA) requires accumulation of samples to make it a cost-efficient technique, delaying the results for several days. On the other hand, point-of-care (POC) tests facilitate immediate decision making by providing ADL concentration results in less than half an hour. However, it is necessary to demonstrate the equivalence of both methods and their interchangeability.

Aim and Objectives The aim of this study is to compare the reference technique for quantifying ADL levels using ELISA with quantification using POC test.

Material and Methods From our own biobank with serum samples of 200 IBD patients treated with biologics, those with adalimumab levels were selected. Later, a total of 60 patients were randomly selected: 19 for ADL sub-therapeutic range (<5 µg/ml), 21 for ADL therapeutic range (5–12 µg/ml) and 20 for ADL supra-therapeutic range (>12 µg/ml). Quantitative sandwich ELISA assay was performed with Promonitor ADL kit and POC test was performed with Quantum Blue assay. Correlation was evaluated with Spearman's correlation

coefficient (rs). Concordance between the three different therapeutic groups was assessed through weighted Cohen's kappa (κ) and differences in classification for each group was determined using McNemar test.

Results No statistically significant differences in ADL trough levels were observed between ELISA and POC (p= 0.3101). Median values were 10 µg/mL (IQR: 3.87–13.25) for the Promonitor assay and 8.85 µg/ml (IQR: 3.67–13.62) for Quantum Blue assay. A good correlation of ADL trough levels between the two assays (rs = 0.88) and a substantial agreement in stratifying in the different groups of therapeutic ranges (K= 0.751 ± 0.063) were observed. McNemar's test revealed no significant differences among different ranges classification (p-value=1). Bland-Altman's analysis (figure 1) was done to complete the comparison between the methods, revealing a bias difference of 0.4453.



Abstract 4CPS-199 Figure 1

Conclusion and Relevance The Quantum Blue POC test represents an alternative to ELISA in determining ADL concentrations, allowing results to be obtained in less time, which facilitates therapeutic decision-making in patients with IBD.

REFERENCES AND/OR ACKNOWLEDGEMENTS

Conflict of Interest No conflict of interest.

4CPS-200 TRIPLE THERAPY FOR METASTATIC HORMONE-SENSITIVE PROSTATE CANCER PATIENTS BASED ON A PHARMACOLOGICAL TREATMENT ALGORITHM

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10.1136/ejhpharm-2024-eahp.304

Background and Importance Standard treatment for metastatic hormone-sensitive prostate cancer (mHSPC) supplements androgen deprivation therapy (ADT) with docetaxel, second-generation hormonal therapy, or radiotherapy. However, the PEACE-1 study demonstrates that adding abiraterone plus prednisone to ADT and docetaxel improves survival with a moderate increase in toxicity, currently off label.

Aim and Objectives To evaluate eligibility for abiraterone plus ADT and docetaxel in de novo metastatic hormone-sensitive prostate cancer (mHSPC) based on a pharmacological treatment algorithm.

Material and Methods Observational, prospective, multidisciplinary study including all mHSPC patients scheduled for first-line treatment (July 2022/December 2022). The choice of triplet therapy was based on compliance with a pharmacological treatment algorithm, including: age <75 years, geriatric assessment using the Geriatric 8 (G8) scale >14, no fragility impression by the oncologist, ECOG 0–1, absence of comorbidities such as liver disease, coagulation problems, and/or active heart disease in the last 6 months; High Risk (at least two of the following characteristics): Gleason 8–10, ≥ 3 bone metastases and/or ≥ 1 visceral metastasis; High Volume (CHAARTED trial); and Prognostic Grade Group (ISSUP 2014-OMS 2016) 4–5. Other variables: PSA, comorbidities, polypharmacy, treatment. Progression-free survival (PFS) and treatment duration. Adverse reactions (AR).

Results Twenty-nine patients were included, 75.9% were de novo mHSPC, 44.8% had high volume, of which 69.2% met all algorithm criteria. Patients treated with the triplet had a median age of 65 years, 100% had G8>14, 66.6% had ECOG 1, 77.7% had multiple bone metastases, mean PSA at the start was 136.32ng/ml, 77.7% had Gleason 9, 88.8% had ISSUP 5, only one patient had >3 comorbidities, and three patients were on polypharmacy. The median treatment duration was 5.97 months, and PFS has not been reached yet, with only one patient progressing during docetaxel treatment, while the rest completed the proposed six cycles. 77.7% of patients experienced some AR, none of which were G3–4. The most common AR was skin-related (44.4%), followed by edema (33.3%), insomnia (22.2%), digestive toxicity (11.1%), neurotoxicity (11.1%), and elevated transaminases (11.1%).

Conclusion and Relevance Choosing triplet therapy based on a studied algorithm helps identify patients who can benefit more from treatment, focusing on those at higher risk and with worse prognosis, leading to favourable outcomes in efficacy and safety.

REFERENCES AND/OR ACKNOWLEDGEMENTS

Conflict of Interest No conflict of interest.

4CPS-201 CLINICAL EXPERIENCE OF TYROSINE-KINASE INHIBITORS DISCONTINUATION IN CHRONIC MYELOID LEUKAEMIA

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10.1136/ejhpharm-2024-eahp.305

Background and Importance Tyrosine-kinase inhibitors (TKIs) have shown to be effective in chronic myeloid leukaemia (CML) treatment. Recent clinical trials show selected patients with deep molecular response (DMR) can safely discontinue treatment.

Aim and Objectives Describing clinical experience of discontinuing treatment with TKIs in CML patients.

Material and Methods A retrospective observational study analysed TKIs discontinuation and maintenance of major molecular response (MMR) after discontinuation in all CML patients treated at our centre from the moment they started TKIs until September 2023.

Discontinuation protocol stipulates patients must have been treated for five first generation TKIs) or three (second