generation TKIs) years and must have achieved 2 years of DMR (molecular response (MR) =4 or greater). After discontinuation they have monthly monitoring visits for 6 months (period when most patients lose MMR), afterwards controls are spaced out over time. If patients lose MMR (MR=3) treatment should restart.

Variables age, gender, TKI, start date, response, DMR achieving date, TKI switch before discontinuation and cause, discontinuation and date, withdrawal syndrome (WS), WS treatment, restart date and TKI, last consultation date.

Results Sixty-two CML patients were treated with TKIs and 48.4%(30) discontinued. Median age of patients who discontinued was 57.8 years [interquartile range (IQR): 50.1–67.1], 63.3% were female.

We found 73.3% discontinued with 1st-line TKIs, 26.6% received various TKIs before discontinuation due to: toxicity (60%) and suboptimal response(40%).

For those who discontinued median TKI treatment until discontinuation was 6.2 years [IQR: 4.9–12.1], and median time with DMR was 4.9 years [IQR: 3.3–8.1]. When they discontinued, they were treated with: imatinib (63.3%), nilotinib (23.3%), dasatinib (6.7%), bosutinib (6.7%).

Five patients developed WS: osteomuscular pain (4), panniculitis (1). One patient received corticosteroids and two received analgesics.

63.3% maintained discontinuation, follow-up median of 3.4 years [IQR: 0.9–4.5].

36.7% patients lost MMR, follow-up median until restart was 5.3 months [IQR: 4.2–6.9]. Seven patients restarted with previous TKI, four changed to second generation TKIs. One had a late relapse at 19.4 months. All patients regained MMR after restarting treatment.

Conclusion and Relevance Our results are in line with current literature showing controlled discontinuation is a viable and potentially long-term option. Discontinuation is already part of the standard of care in selected patients since it's cost-effective, representing savings for Healthcare System and improving patient's life quality.

REFERENCES AND/OR ACKNOWLEDGEMENTS

Conflict of Interest No conflict of interest.

4CPS-202 EVALUATION OF THE EXCHANGE OF ANTI-CGRP MONOCLONAL ANTIBODIES FOR THE TREATMENT OF CHRONIC REFRACTORY MIGRAINE

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Background and Importance In clinical practice of chronic migraine treatment, changes between the different anti-CGRP monoclonal antibodies (mABs) on the market are made, but there are still no clinical trials to support the effectiveness of such a switch.

Aim and Objectives To determine the characteristics of the switches made between mABs (fremanezumab, galcanezumab and erenumab) in our hospital, and to evaluate the effectiveness of these changes.

Material and Methods Descriptive observational and retrospective study in a second-level hospital in which patients diagnosed with refractory chronic migraine from June 2020 to September 2023 and who had been on treatment with the three drugs, were included. Inclusion criteria: patients aged >18years, on treatment for at least 3 months with fremanezumab (225 mg/month), galcanezumab (120 mg/month (initial 240 mg) and erenumab (140 mg/month).

Demographic variables (sex, age), efficacy variables: monthly days with headache of at least moderate intensity (HMD) at 0, 3 and 6 months, type of drug used and timing, duration of treatment (DT (months)), and use of concomitant prophylaxis (CP) were collected. Changes with respect to baseline HMD were analysed, establishing as effective a change greater than 30% and 50%.

Results Eighteen patients were included, 71% female (N=13) and a median age of 44.6 (RIQ: 42.6–58.4) years. Patients had a mean and standard deviation (SD) 20.6 (SD 7.8) days of baseline headache. A total of 55 treatments were reviewed: 81% (N=42) received PC together with AcM. The median DT with fremanezumab, galcanezumab and erenumab was 6.7, 10.1 and 7 (SD 4.5, 7 and 5) months respectively. In terms of efficacy, two and three patients (11%/16%) respectively achieved at least a 50% and 30% reduction in headache days at the first change, and none at a second change of treatment, both at 3 and 6 months of treatment (all were on fremanezumab).

Abstract 4CPS-202 Table 1

	1st choice	2nd choice	3rd choice
Erenumab	55%	0%	45%
Galcanezumab	0%	89%	11%
Fremanezumab	45%	11%	44%

Conclusion and Relevance Following the active treatment protocols for chronic migraine with mABs in our centre at any given time, our patient sample shows that only a maximum of 16% of patients could be rescued, taking a 30% decrease in the number of headache days per month as efficacy.

REFERENCES AND/OR ACKNOWLEDGEMENTS

Conflict of Interest No conflict of interest.

4CPS-203 DEVELOPMENT AND VALIDATION OF A DATA COLLECTION TOOL TO EVALUATE PHARMACEUTICAL INTERVENTIONS IN AN INTENSIVE CARE UNIT

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Background and Importance Clinical pharmacy services have been recently introduced in a local intensive care unit (ICU) and consequently, service evaluation is anticipated. There is the need for a tool to capture pharmaceutical interventions in ICU and assess their impact on specific patient outcomes.

Aim and Objectives To develop and validate a tool to describe and classify drug-related problems (DRPs) and pharmaceutical interventions (PIs) in ICU and evaluate the clinical relevance of the PI in preventing a potential Adverse Drug Event (pADE).

Material and Methods A classification system based on Pharmaceutical Care Network Europe (PCNE) V9.1 was identified

to capture and resolve DRPs identified in ICU. The PCNE V9.1 classification provides extensive categories of DRPs. Evaluation of impact of PIs in preventing a pADE is conducted using an established score[1]. The pADE score reflects the likelihood of an ADE occurring in the absence of a PI. The developed data collection tool was validated by an expert panel made up of three clinical pharmacists practising in ICU and a consultant intensivist. The expert panel assessed the tool for face and content validity and practicality in ICU setting. Subsequently, the tool was piloted in ICU for 10 days.

Results The data collection tool consists of seven sections namely patient demographics with details about pertinent laboratory results, description of DRP and PI, classification of DRP and PI, outcome of PI, and categorisation of medications involved. The final section of the tool relates to evaluation of PI in relation to prevention of a pADE and contains five categories, zero to high, which correspond to the probability of a pADE occurring if the pharmacist had not intervened. Examples from literature are presented for each pADE category to assist with the evaluation of PIs. Following validation and pilot testing, four sections were amended to better adapt the tool to ICU setting.

Conclusion and Relevance The development of such a data collection tool is important to standardise the classification of DRPs and interventions recommended by pharmacists in ICU. The tool contributes to data demonstrating value of pharmacist interventions on patient outcomes.

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Conflict of Interest No conflict of interest.

4CPS-204 MONITORING OF LINEZOLID IN HAEMODIALYSIS: A CLINICAL CASE

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Background and Importance The Antimicrobial Therapy Guidelines recommend the conventional dosage of linezolid (600 mg every 12 hours) for patients on haemodialysis (HD). Linezolid dialyzes 40% by HD.

Aim and Objectives Monitoring plasma concentrations of linezolid in a patient on HD.

Material and Methods A 63-year-old man with a history of bypass with saphenous vein and stage-4 of chronic kidney disease on an HD programme, was admitted to the intensive care unit (ICU) for septic shock due to an ischiorectal abscess.

Enterococcus faecium sensitive to linezolid (MIC 2) was isolated from the abscess culture and linezolid treatment (600 mg every 12 hours) was started. During his stay at the ICU, he underwent daily continuous haemodiafiltration.

After that, he was transferred to the ward where he underwent three conventional high flow HD sessions per week.

Upon arrival at the ward, we were asked to monitor linezolid levels due to probable toxicity associated with a decrease in platelets (196,000/mcl at that moment vs. 441,000/mcl prior to linezolid).

Results After 12 days of linezolid treatment, a trough level of 12.6 mcg/ml was obtained (range 2 – 7 mcg/ml). We recommended to discontinue the linezolid treatment and to measure the trough level again the next day before and after HD. The levels found were 6.71 and 1.26 mcg/ml respectively (HD elimination rate of 81.22%). Thus, we advised to restart with a dosage of 600 mg every 24 hours that same night.

During the following days, we recommended to continue with the same dosage guided by pre- and post-HD levels. The platelet count increased progressively after establishing levels within the therapeutic range.

Abstract 4CPS-204 Table 1

Linezolid days	Pre-HD level (mcg/ml)	Post-HD level (mcg/ml)	HD elimination rate (%)
13	1.26	6.71	81.22
15	1.39	5.95	76.64
23	2.06	7.14	71.15
25	2.04	8.32	75.48

Conclusion and Relevance This clinical case demonstrates that there may be patients undergoing HD who have toxic levels of linezolid with the standard dosage. In these cases, there is a need to monitor and adjust the dose.

We have also observed that the HD elimination in this patient differs from the value reported by the Antimicrobial Therapy Guidelines probably due to the different type of HD membrane.

REFERENCES AND/OR ACKNOWLEDGEMENTS

Conflict of Interest No conflict of interest.

4CPS-205 RESULTS OF ANTIBIOTIC PROPHYLAXIS IN ACUTE BRONCHO ASPIRATION PNEUMONITIS

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Background and Importance The use of antibiotics in acute bronchial aspiration is common, although there is little evidence that it provides benefits, and it exposes patients to increased microbiological resistance and the appearance of side effects from the use of antibiotics.

Aim and Objectives Compare mortality, change of ventilation modality, ICU admission and hospital stay of patients with aspiration who receive prophylactic antibiotic therapy, with patients who do not receive antibiotics.

Material and Methods Retrospective descriptive observational study of patients with acute bronchial aspiration (January 2022 to March/2023). Demographic and clinical data were collected from the patient's medical history; and medication-related information from the electronic prescription software available in the hospital.

Results 267 patients (50.6% women). Average 81.62 years. Services: Emergencies (75.7%), Internal (12.4%). Charlson index 6.10 (SD 2.73). Risk of bronchial aspiration in 71 patients (26.6%). 231 (86.5%) antibiotic, 36 (13.5%)