Fifty percent of patients had a GS=9. The percentage of patients with bone, visceral and lymph node metastases was 50%, 33% and 17%, respectively. A cut-off of 30% for PSA decline was established. Median PFS was 10.1 months (95% CI: 5.3–14.8) in patients with PSA decline <30% and 23.9 months (95%CI: 11.7–36.1) in patients with PSA decline ≥30%(p=0.001).

Conclusion and Relevance This real-life study shows that an early decline in PSA value ≥30% after initiating abiraterone treatment may be an indicator of improved treatment response in patients with mCSPC. Larger studies are needed to confirm this hypothesis.

REFERENCES AND/OR ACKNOWLEDGEMENTS

Conflict of Interest No conflict of interest.

4CPS-208 ANALYSIS OF THE IMPLEMENTATION OF A MULTIDISCIPLINARY PHARMACEUTICAL CARE PROJECT FOR GERIATRIC HAEMATO-ONCOLOGY PATIENTS

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Background and Importance The elderly constitute a large percentage of patients with haematologic malignancies. It is estimated that this percentage will grow due to the ageing of the population and the new therapeutic targets that manage to control and chronify the disease. They present cognitive impairment, malnutrition, physical dependence and polymedication, requiring a comprehensive and multidisciplinary approach.

Aim and Objectives To design a pharmaceutical care protocol for geriatric haemato-oncology patients and to evaluate the results.

Material and Methods Prospective observational study conducted from January 2022 to September 2023 in the Pharmaceutical Care Consultation for oncohaematologic patients of a tertiary hospital. The haematologist selected the most fragile patients with the G8 scale and with the highest number of comorbidities evaluated with the CIRS-G scale and sent them to the Pharmacy consultation, where the pharmacist in charge made a previous evaluation of home medication, self-medication, alternative medicine with the aim of detecting drug interactions, therapeutic duplications, inappropriately prescribed drugs using the START-STOPP criteria, assessing the possible deprescription of polymedication, and lack of adherence using the Morisky-Green test. In the event of detecting any errors in medication intake, interactions of interest. or adverse reactions, pharmaceutical interventions were made in the patient's clinical history for consultation by any health professional.

Results With this new protocol, 40 patients were attended, with a median age of 80 years, 68% men and 32% women. Adherence to haemato-oncologic treatment was improved by 90%. Thirty-five pharmaceutical interventions were carried out: 3 related to the dosage and way of taking the treatment, 10 with pharmacological interactions in which it was necessary to substitute a drug in the treatment, five therapeutic duplications, eight with the use of herbal products and multivitamin complexes that interacted with their treatment, four for not attending their medical check-up in 2 years and five had prescribed medication of little therapeutic value and with a high anticholinergic load that was suspended from the treatment.

Conclusion and Relevance The hospital pharmacist has an important role in the pharmaceutical care of geriatric haemato-oncology patients by creating multidisciplinary work protocols offering personalised treatment.

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4CPS-209 COMPARISON OF TWO PHARMACOKINETIC/PHARMACODYNAMIC INDICES IN CRITICALLY ILL PATIENTS TREATED WITH AMIKACIN

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Background and Importance Amikacin is commonly used as an empirical treatment for gram-negative infections in intensive care unit (ICU) patients. The pharmacokinetic/pharmacodynamic (PK/PD) index commonly used is the ratio maximal concentration: minimum inhibitory concentration (Cmax/MIC) and, to a lesser extent, the ratio area under the curve from 0 to 24h:MIC (AUC0– 24/MIC).

Aim and Objectives To evaluate the PK/PD indices Cmax/MIC and AUC0–24/CMI for amikacin in critically ill patients.

Material and Methods Patients admitted to a medical ICU with preserved renal function (CKD-EPI>60 ml/min) treated with empirical amikacin once-daily were included. Therapeutic Drug Monitoring (TDM) was carried out after the first dose (sample timing: Cmax and Cpost-8h, at 30 minutes and 8 hours respectively, after a 30-minute infusion). Targets for PK/PD Cmax/MIC and AUC0–24/MIC were 8–10 and 80, respectively. An empirical MIC of 4 mg/L was established for the calculation. Parametric AUC calculation was performed by empirical Bayesian estimation of pharmacokinetic parameter. Bayesian estimates were performed using PKS® software with a single compartment pharmacokinetic model. Patients were classified according to those who reached the target or not for both indices (Cmax/MIC and AUC0–24/MIC).

Results Results expressed as median and percentile 25–75.

N=48	
Age	63 years
Weight	83 kg
Creatinine	0.6 mg/dL