Results A total of 16,039 reports were analysed for validation, between March and December 2022. The reports that registered some incidence were 1930 (12%), remaining pending observations and not validated. The reasons for refusal were the following: unfunded indication (58.8%), completion errors – insufficient or incorrect prescription data – (23.6%), absence of computerised validation report (13.5%), absence of clinical report (2.9%) and other causes -unauthorised indication in the technical sheet, hospital diagnostic medication without a specialist report and shortages (1.2%).

Conclusion and Relevance Validation is positioned as a useful tool for the proper use of medicines since it guarantees that they are used according to the indications authorised in the technical sheet. It represents an improvement in the quality of the prescription, because, although most prescriptions conform to their financed indication, some incidents have been detected that were resolved by pharmacists, thus avoiding errors that affect patient safety.

REFERENCES AND/OR ACKNOWLEDGEMENTS

Conflict of Interest No conflict of interest.

5PSQ-020 EVALUATION OF THE EFFICACY AND SAFETY OF EPCORITAMAB-BYSP IN PATIENTS WITH FOLLICULAR B LYMPHOMA: A CASE REPORT

M Martinez*, P Rodriguez, R Moron, J Cabeza, G Rodriguez. *Hospital Universitario San Cecilio, Pharmacy, Granada, Spain*

10.1136/ejhpharm-2024-eahp.354

Background and Importance Follicular B-lymphoma (FL) is an indolent lymphoid neoplasm derived from germinal centre mutated B-cells with a nodular or follicular histological pattern. Approximately 2–3% of patients will transform their neoplasm to diffuse large B-cell lymphoma (DLBCL). Epcoritamab-bysp (EPKINLY®) is a bispecific IgG1 antibody designed to simultaneously bind to CD3 on T-cells and CD20 on B-cells, and induces T-cell-mediated killing of CD20+ cells.

Aim and Objectives The aim of this study is to evaluate the efficacy and safety of epcoritamab-bysp in a patient with LF refractory to previous lines.

Material and Methods Retrospective study of a clinical case in which we follow-up a patient with Relapse/Refractory FL under treatment with epcoritamab-bysp. Administration was done in the lower abdomen or thigh and at a different site each time it was administered. Data were obtained using the digitised clinical history (Diraya) and the electronic chemotherapy or immunotherapy prescription programme (Oncofarm).

Results We present the case of a 57-year-old woman, 48.8 kg and 153 cm. Diagnosed in August 2020 with stage IV FL without B symptoms. FL was refractory to the first two lines of treatment (1L:R-CHOP, 2L:R-ESHAP), as well as to a clinical trial based on CAR-T therapy. In May 2023, expanded use of epcoritamab-bysp in monotherapy with weekly subcutaneous administration in C1 with dose step-up (0.16, 0.8, 48 mg); every 2 weeks C4–9 (48 mg), every 4 weeks from C10 to progression (48 mg) was decided. In all immunotherapy sessions the patient was admitted for 24h due to risk of severe adverse reactions (CRS or ICANS). In the second administration (0.8mg) of epcoritamab-bysp the patient had a CRS:G1, so in the administration of the first target dose (48 mg) 3ªweek of C1, the dose was reduced to 50% (24 mg). Even so, the patient had to be treated with IV tocilizumab (8mg/kg) by CRS: G2 and was admitted for observation for 48h. From C2 onwards, there were no further incidents. Regarding the clinical evolution of the LF PET-CT scan, a partial metabolic response (Deauville:4) was observed with respect to the previous study.

Conclusion and Relevance Despite the need for extended study time to evaluate the clinical benefit and safety in real clinical practice of epcoritamab-bysp in patients with FL or DLBCL, this immunotherapy offers an innovative mechanism of action and an interesting alternative for patients with non-Hodgkin's lymphoma refractory to conventional therapies.

REFERENCES AND/OR ACKNOWLEDGEMENTS

Conflict of Interest No conflict of interest.

5PSQ-021 EVALUATION OF THE PREVALENCE OF MULTI-RESISTANT BACTERIA IN THE INTENSIVE CARE UNIT AFTER SELECTIVE DECONTAMINATION OF THE GASTROINTESTINAL TRACT

[1]M Martinez*, [2]A Alberola, [1]R Moron, [2]A Vazquez, [2]N Chueca, [3]E Yuste, [1]J Cabeza, [1]MT Nieto, [1]X Díaz. *[1]Hospital Universitario San Cecilio, Pharmacy, Granada, Spain; [2]Hospital Universitario San Cecilio, Microbiology, Granada, Spain; [3]Hospital Universitario San Cecilio, Intensivist, Granada, Spain*

10.1136/ejhpharm-2024-eahp.355

Background and Importance One of the measures to reduce the rate of infections by multidrug-resistant bacteria in Intensive Care Unit (ICU) services promoted in the Pneumonia Zero (NZ) programme is oropharyngeal decontamination (DOF) and/or selective digestive decontamination (SDD). Of the different existing protocols, we implemented the administration of non-absorbable topical antimicrobials (colistin, gentamicin and nystatin) in the oropharynx (paste) and gastrointestinal tract (solution). Both were developed as magistral formulas. In the event of MRSA isolation or an increase in the MRSA rate in our hospital, vancomycin would be added.

Aim and Objectives The aim was to assess the effect of such a measure on studies of the prevalence of multidrug-resistant bacteria in critically ill patients, and to see if there is selection for resistance mechanisms.

Material and Methods Ambispective study comprising the pre-DDS (01/01/2022–30/04/2022) and DDS (01/01/2023–30/04/2023) periods conducted in the 22-bed ICU.

From July 2022, ICU patients with isolation of multidrug-resistant bacteria in both clinical or surveillance samples, as well as patients with estimated intubation >72 h or non-intubated patients with risk factors for developing pneumonia are administered DDS/DOF. In addition, nasal, pharyngo-tonsillar and perianal exudate samples are collected for microbiological surveillance cultures on admission and every Tuesday thereafter. Incubate at 37°C for 48h.

Results In the pre-DDS period in the ICU, 626 samples are received for colonisation studies from 132 patients. Excluding repeat isolates in each patient,2 3 multidrug-resistant bacteria were detected. In the DDS period, 537 samples are received from 124 patients, detecting nine multi-resistant bacteria. There is a significant difference (p=0.0138) between the proportion of multi-drug resistant bacteria detected in the surveillance studies after applying ICU decontamination measures.

In the first period, the following bacteria were detected: one MRSA, one Acinetobacter baumannii, eight extended-