consultation (63.0%), prescriptions with inadequate validity until the subsequent consultation (21.0%), prescription errors (8.6%), patient non-attendance at the preceding consultation (4.9%), absence of a patient consultation within the last year (1.2%), and rescheduling of the previous consultation (1.2%).

Within our sampled cohort, the median consultation waiting time amounted to 36 minutes, with an extreme delay reaching up to 3 hours.

Conclusion and Relevance As evidenced by this investigation, the absence of an active prescription at the dispensation juncture exerts an adverse influence on the day-to-day operations of the Hospital Outpatient Pharmacy. It is our assertion that enhanced training and more robust communication with the implicated clinical services could prove invaluable in proactively addressing this predicament.

REFERENCES AND/OR ACKNOWLEDGEMENTS

Conflict of Interest No conflict of interest.

5PSQ-119 REVIEW OF REAL-WORLD MANAGEMENT OF NATALIZUMAB TREATMENT IN MULTIPLE SCLEROSIS: A DOUBLE-EDGED WEAPON

A Gil Garcia, A Rojas Albarrán*, M Gragera Gomez, MD Zambrano Croche, H Velazquez Vazquez, A Navarro Ruiz, L Torres Zaragoza. *University Hospital Complex of Badajoz, Hospital Pharmacy, Badajoz, Spain*

10.1136/ejhpharm-2024-eahp.453

Background and Importance We know that natalizumab is an effective treatment in patients with relapsing-remitting multiple sclerosis with high activity. More doubts arise regarding its safety which will lead to having to closely monitor the patient.

Aim and Objectives To evaluate the safety of treatment with natalizumab for relapsing-remitting multiple sclerosis (RRMS), specifically John Cunningham virus (JCV) infection that can cause Progressive Multifocal Leukoencephalopathy (PML). Also evaluate effectiveness by counting outbreaks during treatment and time in treatment.

Material and Methods Retrospective observational study since the approval of the drug. All patients with RRMS under treatment with natalizumab were included and the variables sex, age, previous and subsequent treatments, positive JCV serology at any time, duration of treatment, relapses and number of them, and reason for discontinuing treatment were collected. Data was extracted from FarmaTools® software database and the electronic medical.

Results A total of 75 patients were analysed, 47 (63%) of them women. Mean age at the time of initiation of treatment of 41 years (28–69), median number of previous lines of 1 (0–5), being used as first line in 15 patients (20%), second line in 42 patients (56%). The patients analysed were on treatment for an average of 2.6 years, the reasons for suspension being: Positive JCV serology 39 (52%), adverse effects 11 (15%), outbreaks six (8%), progressive worsening five (7%), unknown cause three (4%) and 2 (3%) discontinued due to pregnancy. Nine (12%) are still receiving treatment. Sixteen patients (21%) had an outbreak during the time on treatment.

Conclusion and Relevance A large proportion of the patients analysed manage to reach the 2-year treatment period, after which the risk of JCV infection increases. At that point, the majority of patients discontinue treatment. The drug is well tolerated, with little suspension of treatment due to adverse effects, and is usually chronic fatigue (also associated with the disease). Effective drug, with only 16 patients having an outbreak during treatment. With these data, we can conclude that in our patients it has been an effective treatment, used once the patient has high activity to stop it. Regarding safety, JCV would be the main drawback, requiring close monitoring for possible infection.

REFERENCES AND/OR ACKNOWLEDGEMENTS

Conflict of Interest No conflict of interest.

5PSQ-120 PEMBROLIZUMAB IMMUNE-MEDIATED TOXICITY

R Conde*, C Soares, P Barbeita, T Cunha, P Rocha. *Centro Hospitalar Universitário De Santo António, Serviços Farmacêuticos, Porto, Portugal*

10.1136/ejhpharm-2024-eahp.454

Background and Importance Checkpoint inhibitors (ICI) are increasingly used in various cancers. While they offer clinical benefits, they also introduce drug management challenges due to their adverse effects (AE). A notable concern is the potential for severe immune-mediated toxicities, which can pose significant risks to patients. The presented case is unique as it underscores the severe repercussions of immune-mediated toxicity from pembrolizumab.

Aim and Objectives This reports a case of a 70s male with clear cell renal cell carcinoma (ccRCC) who developed severe immune-mediated toxicity following treatment with pembrolizumab. The patient had a history of some comorbidities. The initial presentation was incidental detection of ccRCC post-trauma. His subsequent treatment, adverse reactions, and outcomes form the crux of this case.

Material and Methods The patient was in his 70s, caucasian male, 1.64 m, 58 kg, non-smoker, and non-alcoholic. His medical history included type 2 diabetes, hypertension, nephrolithiasis, benign prostatic hyperplasia, pacemaker implant due to bradycardia. Daily medication: metformin, amlodipine, perindopril/indapamide, acetylsalicylic acid, dutasteride, afluzosin, lactulose, sodium picosulfate. First line treatment with intravenous pembrolizumab 400 mg (6/6 weeks) and axitinib 5 mg twice daily.

Results Days after the first cycle of treatment, the patient presented to the emergency service (ES) with swallowing difficulties, imbalance, and muscle pain. A probable diagnosis of G3 polymyositis with suspected pembrolizumab-induced myopathy was made. Despite suspending the oncology treatment and initiating high-dose corticosteroid therapy, the patient's condition deteriorated. He developed myocarditis leading to severe global dysfunction of left ventricular systolic function. Subsequent treatments including human immunoglobulin and abatacept were unsuccessful, and the patient unfortunately succumbed to cardiorespiratory arrest two weeks later.

Conclusion and Relevance This case report brings attention to the severe immune-mediated toxicity, emphasising the challenges in its management. While acute AE can often be managed with symptom-based approaches and high-dose corticosteroids,[1] this case demonstrates that these measures may sometimes be insufficient. Creating structured protocols and conducting in-depth research is imperative. Medical professionals should remain vigilant to such adverse effects. This case underlines the importance of risk assessment and continuous monitoring of patients on immunotherapies.