

gene polymorphisms) in daily clinical practice that allows the early detection of patients treated with 6-MP with a higher risk of myelosuppression.

REFERENCES AND/OR ACKNOWLEDGEMENTS

Conflict of interest No conflict of interest

4CPS-298 EFFICACY AND SAFETY PROFILE OF ANTI-EGFR TYROSINE KINASE INHIBITOR THERAPY IN PATIENTS WITH METASTATIC NON-SMALL CELL LUNG CANCER

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10.1136/ejpharm-2021-eahpconf.130

Background and importance Tyrosine kinase inhibitors (TKI) are oral drugs that have demonstrated efficacy against metastatic non-small cell lung cancer (mNSCLC) with mutation of EGFR.

Aim and objectives To evaluate the efficacy and safety associated with TKI drugs in mNSCLC patients with the EGFR mutation.

Material and methods This was a retrospective single centre study over 5 years and 7 months (January 2015 to July 2020) that included all patients with mNSCLC treated with the anti-EGFR TKI erlotinib (ERL), gefitinib (GEF), afatinib (AFA) and osimertinib (OSI). Variables corresponding to age, sex and mean duration of treatment were collected.

The efficacy of the different treatments was determined, calculating progression free survival (PFS) applying the Kaplan-Meier statistic, with SPSS V.15. Progression was analysed according to the radiological criteria response evaluation criteria in solid tumours (RECIST V.1.1). The occurrence of grade III/IV adverse effects (AEs) leading to a dose reduction/suspension of treatment was determined. The severity of these AEs was classified according to the common terminology criteria for adverse effects (CTCAE V.6.0).

Results 76 patients (51.3% women (n=39), mean age 70.3 years) were included in the study (47–90). 19.7% (n=15) received OSI, 32.9% ERL (n=25), 32.9% GEF (n=25) and 14.5% AFA (n=11). Mean duration of treatment was 11.2 months (0.2–63.3). Median PFS for each of the treatments was: OSI versus ERL (13.9 vs 5.3 months, p=0.66); OSI versus GEF (13.9 vs 10.5 months, p=0.63); OSI versus AFA (13.9 vs 3.9 months, p=0.56); GEF versus AFA (p=0.74); ERL versus GEF (p=0.94); and ERL versus AFA (p=0.84).

34.2% of patients (n=26) had to reduce their dose/suspend treatment due to the appearance of AEs grade III/IV: OSI (13.3%, n=2), ERL (48%, n=12), GEF (24%, n=6) and AFA (63.6%, n=7). The most common AEs were: for OSI: thrombopenia (100%, n=2); for ERL: skin toxicity (n=4, 33.3%), gastrointestinal (GI) (n=5, 41.6%), haematological (n=3, 25%), renal (n=2, 16.6%), other (n=1, 8.3%); for AFA: skin toxicity (n=6, 85.7%), GI (n=1, 14.3%); and for GEF: skin toxicity (n=4, 66.7%), GI (n=1, 16.7%), other (n=1, 16.7%).

Conclusion and relevance The study showed that there were no differences in PFS values between the different TKI anti-EGFR treatments for mNSCLC. In terms of safety, the best tolerated was osimertinib, with AEs appearing in only 13% of patients.

REFERENCES AND/OR ACKNOWLEDGEMENTS

Conflict of interest No conflict of interest

4CPS-299 PATIENTS' MISCONCEPTIONS FOLLOWING INITIATION OF ANTINEOPLASTIC TREATMENT FOR COLORECTAL CANCER

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10.1136/ejpharm-2021-eahpconf.131

Background and importance The importance of empowering patients to be active participants in their care gained policy attention in the last years. To promote this, patients' access to evidence based information is of paramount importance. Identification and addressing misconceptions about disease management are critical components to improve knowledge and communication between healthcare professionals and patients.

Aim and objectives To identify patients' misconceptions about antineoplastic treatment following initiation of treatment for colorectal cancer (CRC).

Material and methods Prospective indepth semi-structured interviews were conducted with 16 newly diagnosed patients with CRC during their first cycle of treatment with XELOX or FOLFOX. Ethical approval was acquired. Interviews held between October 2018 and September 2019 were audio recorded and transcribed verbatim. Data were analysed using an interpretative phenomenological approach and key themes were identified.

Results These results are part of a larger study about patients' experiences following initiation of antineoplastic medicines. A subtheme identified was patient understanding of antineoplastic medicines. All patients were acquainted with the term 'chemotherapy' and described that hearing this word induced "fear of the unknown" (P014). Misconceptions identified in relation to the prescribed antineoplastic treatment were related to the method of administration "It looks simple here, as a drip, no?!" (P015), mode of action "What does it contain radiation?" (P014) and adverse effects "(..)really afraid I will lose my hair..especially from the beard!" (P007) and safety "I've started ginger pills and vitamin C to prevent me from catching a cold. Being herbal treatment, there's no need to tell the doctor" (P016).

Conclusion and relevance This study highlighted that patients had misconceptions about antineoplastic treatment that persisted after attending a nurse led information session and following initiation of treatment. This exposed the need to have an individualised tailored information approach which deliberately targets specific misconceptions. This gap may be addressed by the inclusion of clinical pharmacists as medicines experts within the multidisciplinary oncology team.

REFERENCES AND/OR ACKNOWLEDGEMENTS

Conflict of interest Corporate sponsored research or other substantive relationships: The research work disclosed in this publication was funded by the Tertiary Education Scholarships Scheme.