| Patient | TTA (mins) | LOS (days) | Fever Status | WBC, ANC Manual Diff |
|---|---|---|---|---|
| 1 | 114 | 3 | Febrile (101.5 pre-arrival) 99 in ED | WBC: 0.4 ANC: N/A |
| 1 | 89 | 3 | Febrile (102 pre-arrival) 98.8 in ED | WBC: 0.7 ANC: 0.06 |
| 1 | 76 | 3 | Febrile (100.2 pre-arrival) 98.8 in ED | WBC: 0.5 ANC: N/A |
| 2 | 152 | 7 | Febrile (101.5 pre-arrival) 98.8 in ED | WBC: 0.8 ANC: 0.63 |
| 3 | 250 | 2 | Febrile (103.8 pre-arrival) 98 in ED | WBC: 1.6 ANC: 1.57 |
| 4 | 132 | 2 | Febrile (102.7 pre-arrival) 98.1 in ED | WBC: 2.8 ANC: 2.63 |
| 5 | 133 | 4 | Afebrile (98.1 in ED) | WBC: 0.3 ANC: 0.23 |
| 5 | 243 | 3 | Febrile (103 pre-arrival) 99.1 in ED | WBC: 1.5 ANC: 0.29 |
| 6 | 78 | 9 | Febrile (100.9 in ED) | WBC: 0.1 ANC: 0.49 |
| 7 | 604 | 4 | Afebrile (98.6 in ED) | WBC: 0.6 ANC: 0.08 |
| 8 | 100 | 3 | Febrile (101 pre-arrival) 99.8 in ED | WBC: 2.6 ANC: 1.16 |
| 9 | 114 | 4 | Febrile (104 pre-arrival) 98.4 in ED | WBC: 6.7 ANC: 0.67 |
| 10 | 44 | 1 | Febrile (pre-arrival) 98.8 in ED | WBC: 2.9 ANC: 1.84 |
| 10 | 144 | 3 | Febrile (101 pre-arrival) 99.4 in ED | WBC: 0.1 ANC: N/A |
| 10 | 109 | 3 | Febrile (101.7 in ED) | WBC: 1.9 ANC: 1.65 |
| 11 | 94 | 2 | Febrile (100.7 in ED) | WBC: 1.0 ANC: 0.04 |
| 11 | 206 | 3 | Febrile (101 pre-arrival) 100 in ED | WBC: 0.8 ANC: 0.10 |
| 11 | 44 | 6 | Febrile (101.9 in ED) | WBC: 0.9 ANC: 0.13 |
| 12 | 47 | 3 | Febrile (101 pre-arrival) 99.8 in ED | WBC: 0.1 ANC: N/A |
| 12 | 262 | 3 | Afebrile (98.2 in ED) | WBC: 1.8 ANC: 0.52 |
| 13 | 189 | 2 | Afebrile (97.5 in ED) | WBC: 0.6 ANC: 0.64 |
| 14 | 60 | 3 | Afebrile (97.7 in ED) | WBC: 0.7 ANC: 0.69 |
| 15 | 141 | 2 | Febrile (pre-arrival) 97.9 in ED | WBC: 0.9 ANC: 0.56 |
| 16 | 203 | 3 | Febrile (100.4 pre-arrival) 98.9 in ED | WBC: 0.6 ANC: 0.07 |
| 17 | 89 | 8 | Febrile (104.1 in ED) | WBC: 0.9 ANC: 0.05 |
| 18 | 4141 | 10 | Afebrile (97.1 in ED) | WBC: 1.2 ANC: 0.33 |
| 19 | 4700 | 9 | Afebrile (97.6 in ED) | WBC: 1.9 ANC: 0.88 |
| 20 | 168 | 11 | Afebrile (99.5 in ED) | WBC: 1.7 ANC: 1.00* |
| 21 | 77 | 8 | Afebrile (99.2 in ED) | WBC: 1.5 ANC: 0.50 |

WBC (THO/μL); ANC Manual Diff (THO/μL; range 1.80-7.50); *Automated differential used in lieu of Manual Diff (THO/μL; range 1.80-7.50); N/A: not available

**Conclusions**

Afebrile patients may have longer TTA compared to febrile cases. The IDSA considers afebrile patients displaying symptoms and signs of infection to be high-risk for developing complications and recommends prompt treatment. Providers should be aware that neutropenic patients at risk for sepsis may present as afebrile, and that expedient antibiotic delivery is crucial to avoid complications in these patients.

## NEUTR-11
## BILIARY-RELATED EVENTS (BRES) IN PANCREATIC CANCER (PC) PATIENTS (PTS)

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**Introduction**

Malignant bile duct obstruction occur in 65-75% of PC Pts, contributing to treatment interruption and increasing mortality. We aim to evaluate BREs in the PC population.

**Methods**

Retrospective evaluation of BREs in patients treated with FOLFIRINOX or Gemcitabine based treatments,in adjuvant and locally advanced settings at our Institution; from January 2016 to July 2020.SPSS was used for data analysis.

**Results**

Total of 32 Pts included.Median(md) age was 71years[y;(39-81)]; majority of Pts male(n=17,53%),with performance status(PS) ECOG 1(n=17,53%) and stage III(n=21,66%);17 Pts(53%) submitted to biliary intervention at diagnosis due to obstruction; After chemotherapy 11 pts(34%)had ≥ 1 hospital admissions due to BREs during chemotherapy;9Pts(82%)had a previous biliary intervention at diagnosis.Md lenght of hospital stay was 13.5days[d;(4-41)],majority submitted to broad spectrum antibiotics;6Pts(55%) could not resume treatment after discharge due to a decline in PS or death(n=2; 0.18%). Md follow-up time of 21months(m;[21.6-30.3],21 deaths seen(66%).The md overall survival (OS) of the population was 15m(8.7-21.3).A shorter OS related to BREs during chemotherapy(20vs11m, p=0.018) and hospital admissions(24vs9m, p=0.004).Biliary stent prior to starting chemotherapy associated to a shorter OS (p=0.846).

**Conclusions**

BREs lead to multiple hospital admissions, increasing mortality in PC Pts.Prophylactics strategies, such as antibiotics have been proposed in previous trials.Prospective studies are warranted.

## NEUTR-12
## CLINICAL MANIFESTATIONS OF ORAL KAPOSI SARCOMA IN HIV-INFECTED PATIENTS: A RETROSPECTIVE STUDY

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**Introduction**

Acquired immune deficiency syndrome (AIDS) caused by human immunodeficiency virus (HIV) infection leads to reduced immune function. The resultant accompanying opportunistic infections and tumors are considered as AIDS-defining illnesses (ADIs). We investigated the incidence and characteristics of oral Kaposi sarcoma (OKS), which is one of the ADIs, in HIV-infected patients.

**Methods**

We conducted a retrospective study using medical records of HIV-infected patients with OKS who visited our institute between January 2011 and December 2021. We examined the clinical and laboratory findings of OKS, treatment, and prognosis.

**Results**

Of 614 newly diagnosed HIV-infected patients, we included 8 OKS patients (1.3%) with a median age of 41 (range, 37–46) years. All patients were men. OKS tended to occur most frequently in the gingiva (n=6) and hard/soft palate (n=6) followed by the tongue (n=3) and buccal mucosa (n=2). OKS presented as a well-defined, extroverted painless mass with deep red coloration. Notably, six out of eight patients (75%) had OKS as the first ADI. The median CD4 and HIV-RNA levels were 78 (range, 8–254) count/μL and 203,500 (range, 35,000–2,150,000) copy/mL, respectively. Chemotherapy with doxorubicin with or without ART resulted in complete response and all patients survived without recurrence.

**Conclusions**

Despite low incidence of OKS, it may be diagnosed as the first ADI, suggesting the importance of intraoral screening in HIV-infected patients.