

Materials and Methods This included:

- Revision of the existing pharmacy waste control manual and comprehensive list of hazardous drugs. This laminated list with a visual guide to the waste streams was displayed throughout the pharmacy
- The list was used to 'code-tag' and highlight all existing hazardous material in the software system
- New hazardous products were identified following an initial Quality Assurance assessment
- A new permanent self-adhesive purple 'Hazardous – dispose of appropriately' sticker was designed for attachment to each package of relevant items by stores staff on receipt
- A leaflet was designed following discussions with NBT patient panel

Results The new system was agreed/ratified through NBT Medicines Governance Group before implementation. The NBT waste management team adopted this purple waste stream model throughout NBT and amended policies/procedures. Awareness was raised with all staff through existing training sessions to ensure trust-wide uptake and continued compliance.

Conclusions NBT Pharmacy has developed a waste control mechanism to process hazardous waste to ensure compliance with all legal requirements. Following recent external independent audits by the current waste contractors and the Environment Agency, the new model was described as 'very impressive' and stated that that this 'more than satisfied that the department and trust are fully compliant with waste regulations'.

Abstract DGI-070 Table 1**NBT leaflet**

- § The medicine that you have been prescribed has been classified as hazardous waste.
- § This medicine should be disposed of safely as it could be hazardous if it is disposed of in household waste or via the sink or toilet.
- § This medication could also be dangerous if taken or handled by anyone other than the patient.
- § Any unused medicine should be returned to a pharmacy for disposal.
- § This medicine should be taken as directed by your Doctor or Pharmacist and should only be taken by the patient named on the label.
- § Keep all medication out of the reach and sight of children.

Thank you for your co-operation.

NHS Constitution. Information on your rights and responsibilities. Available at www.nhs.uk/aboutnhs/constitution (Last accessed March 2010)

If you or the individual you are caring for need support reading this leaflet please ask a member of staff for advice.

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No conflict of interest.

DGI-071 THE RATIONAL USE OF CETUXIMAB IN METASTATIC COLORECTAL CANCER

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Background Cetuximab label indication includes treatment of epidermal growth factor receptor (EGFR)-expressing, KRAS wild-type metastatic colorectal cancer in several possible ways: combination with irinotecan-based chemotherapy, first-line in combination with FOLFOX and as a single agent after oxaliplatin- and irinotecan-based treatment failure in irinotecan-intolerant patients. In our hospital, a multidisciplinary team drawn from the Oncology and Pharmacy services has established a consensus for the rational use of cetuximab as first or second-line agent in association with other chemotherapeutic agents and as monotherapy in third-line

treatment after the failure of oxaliplatin and irinotecan-based treatment.

Purpose To verify the relevance of cetuximab prescription to the local protocol and check the label indications for cetuximab in our hospital.

Materials and Methods A retrospective study of patients diagnosed with metastatic colorectal cancer between 2006–2012 with available KRAS status. Patients were followed up for a minimum of three months after diagnosis.

Results Twenty-six patients were collected (mean age: 62.2 ± 12.6 years; 53.8% male).

KRAS mutation was negative in 42.3% (11/26) patients and therefore they were eligible for treatment with cetuximab. Five out of those 11 patients underwent cetuximab treatment (5/11; 45.5%): three associated with oxaliplatin in first-line treatment, one associated with irinotecan in second-line treatment and one as monotherapy in second-line treatment. Four out of these 5 prescriptions of cetuximab were in accordance to our local protocol and label (4/5; 80.0%). One prescription was not in accordance with either the local protocol or the cetuximab label; due to this the patient was treated with oral capecitabine as first-line and cetuximab monotherapy as second-line treatment.

Three KRAS-negative patients (3/11; 27.3%) are currently in treatment with irinotecan as second-line therapy.

Three KRAS-negative patients were lost to follow-up after undergoing second-line treatment not known to contain a cetuximab prescription (3/11; 27.3%).

Fifteen patients positive for KRAS mutation (15/26; 57.7%) were not treated with cetuximab.

Conclusions Ninety-five percent of cetuximab prescriptions in our hospital are in accordance with the established local protocol and the cetuximab label (19/20).

No conflict of interest.

DGI-072 THE USE OF LINEZOLID IN NEUROSURGERY: THE EXAMPLE OF A FRENCH TEACHING HOSPITAL

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Background Linezolid (LNZ) is an antibiotic indicated for the treatment of methicillin-resistant Gram-positive infections. Following recent unavailability of fosfomycin in France, local standards for the treatment of nosocomial meningitis and nosocomial brain abscesses (NM-NBA) have temporarily changed. Indeed, in Toulouse's Teaching Hospital, the Anti-infectious Committee has decided to modify its recommendations, changing fosfomycin to LNZ. At the same time, the use of LNZ is strictly controlled in our hospital, in order to preserve antimicrobial activity as long as possible.

Purpose To present an overview of the use of LNZ in a neurosurgery ward, in Toulouse's teaching hospital.

Materials and Methods We analysed the prescriptions for LNZ between 1 January 2011 and 1 August 2012, collecting data on: type of infection, germ and antibiotic sensitivity, treatment duration, total cost of antibiotic treatment.

Results When fosfomycin was still available, LNZ was only prescribed to six patients, none of whom was treated for NM-NBA. When fosfomycin became unavailable, 72 prescriptions were written for LNZ, of which 59 (82%) were for NM-NBA. Of these 59 prescriptions, 54 (92%) were initially empirical; 45 (76%) were reevaluated at day 3 with advice from a senior infectious disease specialist, which resulted in 19 treatment discontinuations (42%). Moreover, 29% (17/59) of identified germs were multi-resistant and