increase of 0.1% from baseline in the usual care group (P = 0.019). The intervention group compared with the usual care group had small but statistically significant improvements in the secondary measures of fasting blood glucose, systolic and diastolic blood pressure, total cholesterol, LDL, serum triglycerides, self-reported medication adherence and self-care activities. Between-group differences in changes in the secondary measures of HDL and body mass index were not significant.

Conclusions The enhanced patient clinical outcomes as a result of pharmacist-led pharmaceutical care in an outpatient diabetes clinic in the present study demonstrate the value of an enhanced clinical pharmacy service in improving diabetes care and achieving the desired therapeutic outcomes for patients with type 2 diabetes.

No conflict of interest.

CPC-120 RANITIDINE-INDUCED SYSTEMIC HYPERSENSITIVITY REACTION: A CASE REPORT

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Background Ranitidine is a histamine-2-receptor antagonist (antiH2) widely used with an excellent safety record. It's a drug included in the premedication for several chemotherapy regimens.

Purpose To report a case of hypersensitivity to ranitidine.

Materials and Methods Case report, literature review.

Results A 68-year-old man was being followed at hospital for management of metastatic lung carcinoma. A third-line treatment with weekly paclitaxel had been decided. The usual premedication includes intravenous ondansetron, ranitidine, dexchlorpheniramine and methylprednisolone. The patient's anamnesis hadn't reported any allergic events.

During the first course, the patient presented pruritus 5 minutes after ondansetron and ranitidine injections. Hypotension and warmth occurred despite the administration of dexchlorpheniramine. 120 mg of methylprednisolone resolved the hypersensitivity completely before the patient received paclitaxel, without further event.

During the next course, ondansetron was replaced by metoclopramide. During the ranitidine infusion the patient presented sweats, hypotension and bronchospasm. Ranitidine infusion was stopped and methylprednisolone overcame the reaction. The patient's condition allowed paclitaxel administration although he refused dexchlorpheniramine.

The need for antiH2 and the most appropriate premedication for the next courses were discussed by the clinician and pharmacist. Hypersensitivity reactions are reported in ranitidine's SPC with an estimated rare frequency and also in the literature review. A case also reported a cross-reaction between antiH2 and other antihistamines [1], while another author excluded it [2].

As no allergic investigation has been performed, all antihistamines have been removed as a precaution. For subsequent courses the premedication included metoclopramide 10 mg and methylprednisolone 80 mg. No other incidents have been reported. This search didn't formally establish the need for antiH2 in paclitaxel premedication.

Conclusion: This case has been reported to the pharmacovigilance centre and reminds clinicians that even commonly used and generally well-tolerated substances can cause serious side effects.

References

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No conflict of interest.

CPC-121 REPORT AFTER ONE YEAR USING OF FINGOLIMOD, THE FIRST ORAL TREATMENT FOR MULTIPLE SCLEROSIS: ANALYSIS OF PATIENTS IN A NEUROLOGY UNIT

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Background Multiple sclerosis (MS) is in Europe the most common neurological disease starting between the ages of 20 and 40 years. It affects approximately 2.5 million people worldwide and is the first cause of non-traumatic disability for young people. Management of this disease has for a long time been limited to treatment of relapses. However, in recent years, significant progresses have been made in the treatment with the appearance of, among others, fingolimod for relapsing-remitting MS in March 2011 in the European Union.

Purpose To observe the impact of fingolimod in the care of patients, and make an assessment of practise in the neurology unit (Professor Pelletier, La Timone hospital, Marseille) one year after fingolimod was approved for use.

Materials and Methods We noted treatment interruptions and their causes, and analysed benefits and side effects reported by patients treated with fingolimod for more than three months. Data collection was based on meetings or telephone interviews with patients and on information taken from medical records.

Results 143 patients started treatment with fingolimod between March 2011 and October 2012, 51 in the last three months. Our analysis was performed on 92 patients, and included 19 meetings and 20 telephone interviews. Four definitive treatment interruptions were identified: three for disease progression (relapses) and one hepatic cytolysis. We also noted two temporary discontinuations for tuberculosis contagion and hives. Preliminary results show that the clinical and biological tolerance was satisfactory in most cases. Furthermore, absence of relapse or improvements in motor status and tiredness were noted by the majority.

Conclusions Fingolimod has changed the management of patients with MS, and many of them have reported an improvement in their quality of life and feel side effects to be acceptable. The imminent arrival of other oral agents should result in clarification of the role of each in the strategy, and might be the subject of comparative studies.

No conflict of interest.

CPC-122 RISK FACTORS IN THE INCIDENCE OF CHEMOTHERAPY-INDUCED EMESIS

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Background Chemotherapy-induced nausea and vomiting (CINV) are the most common side effects after the administration of anticancer drugs. CINV appears in a variable percentage of patients, depending on the cytostatic agent and patients' risk factors.

Purpose The aim of this study was to evaluate the effect of the risk factors on the incidence of emesis after the administration of the first cycle of chemotherapy.

Materials and Methods A literature search was conducted for articles addressing the risk factors in CINV. Younger age, female sex, history of motion sickness or pregnancy-induced vomiting, radiotherapy and anxiety/depression were included. A history of alcohol intake was considered a protective factor and it was graded as none, mild (1–5 drinks/month), moderate (6–14) or high (>14) consumption. The impact on complete response (CR) of those risk factors for