

biological therapy (treatment-naïve). Data were collected from the pharmacy outpatient dispensing programme and the clinical history.

**Results** 46 treatment-naïve patients started treatment, mean age 43 (17–83), 58.7% men. They were treated with: adalimumab (20 patients), infliximab (17) and ustekinumab (9); none with etanercept.

Abstract CPC-148 Table 1

	Adalimumab	Infliximab	Ustekinumab
Lost to follow-up	5% (1/20)	23.5% (4/17)	22% (2/9)
Continuing treatment	40% (8/20)	29.4% (5/17)	67% (6/9)
Withdrawal/ Discontinuation by doctor	5% (1/20)	5.9% (1/17)	11% (1/9)
Discontinuation due to good response	20% (4/20)	–	–
Change of treatment	30% (6/20)	41.2% (7/17)	–

The causes of the discontinuation/change of treatment were:

Abstract CPC-148 Table 2

	Adalimumab	Infliximab	Ustekinumab
Lack of efficacy	27.2% (3/11)	25% (2/8)	–
Adverse reactions	18.2% (2/11)	37.5% (3/8)	–
Lack of response + adverse reactions	18.2% (2/11)	12.5% (1/8)	–
Lack of adherence	–	25% (2/8)	–
Good response	36.4% (4/11)	–	–
Other reasons	–	–	100% (1/1)

Adverse reactions that caused withdrawal or change were:

Abstract CPC-148 Table 3

Adalimumab	Autoimmune hepatitis 25% (1/4) Asthenia and mood changes 25% (1/4) Psoriatic arthritis 25% (1/4) Pharyngitis and candidiasis 25% (1/4)
Infliximab	Acute infusion reactions 75% (3/4) Psoriatic arthropathy 25% (1/4)

**Conclusions** The first biological in treatment-naïve patients was 1st) adalimumab, 2nd) infliximab and 3rd) ustekinumab. Ustekinumab was the biological drug that achieved the best retention rate. Several patients discontinued their treatment with adalimumab because of good response, since it can be used in intermittent treatment schemes. Change in treatment was more frequent with infliximab, mainly because of infusion reactions. Ustekinumab was the only biological that didn't cause adverse reactions that caused withdrawal or change.

No conflict of interest.

#### CPC-149 TRIMEBUTINE: A CASE OF ABUSE AND POSSIBLE DEPENDENCE

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**Background** Trimebutine has an agonist effect on digestive tract and brain mu, kappa, and delta opiate receptors.

**Purpose** To describe a case report of an abuse and a possible dependence on trimebutine.

**Materials and Methods** Medical record review and literature search about trimebutine dependence.

**Results** A 46-year-old woman with a history of Chronic Intestinal Pseudo-Obstruction (CIPO) was prescribed amikacin and trimebutine in the hospital since 2011. Her gastroenterologist initially prescribed trimebutine at 100 mg intravenously three times a day,

with a possibility of 100 mg shots if necessary without a maximum dose. At the same time she obtained another prescription by her general practitioner (50 mg IV if needed). Finally 735 ampoules were delivered in seven weeks (15 a day). This overconsumption alarmed the pharmaceutical team and a literature review was made. Dependence is described in a French register: six cases of intravenous abuse or dependence were reported between 1993 and 2009. At high doses trimebutine is cardiotoxic (bradycardia, rhythm disorders) and neurotoxic (convulsions). We alerted the prescribers and reported this abuse to our pharmacovigilance centre. A questionnaire to evaluate the level of dependence was sent to the general practitioner.

Once the general practitioner had been informed, the gastroenterologist alone managed her CIPO treatment and a new prescription was established with a trimebutine posology more consistent with the marketing authorization.

**Conclusions** Provision from a hospital enabled us to detect the overuse of this drug. Dependence is difficult to prove and drug abuse screening test in the assessment of DSM IV should be used to establish it.

No conflict of interest.

#### CPC-150 TUBERCULOSIS AND SYSTEMIC DISEASES

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**Background** The immunosuppression of systemic diseases makes the management of patients with tuberculosis more complicated.

**Purpose** To monitor the clinical evolution of tuberculosis in patients suffering from systemic diseases.

**Materials and Methods** A retrospective study, from 1998 to 2012, in the internal medicine service in Rabta hospital, Tunisia, of 9 patients (8 women and a man, median age: 54 years) suffering from connective tissues disease, treated by corticosteroids linked in one or several treatments to immunosuppressants, who subsequently developed tuberculosis.

**Results** The median time to diagnosis was 116 days (7d – 1 year). The location of the tuberculosis was pulmonary (n = 2), ganglionic (n = 3), urogenital (n = 2), tubercular spondylodiscitis (n = 1), more than one location (n = 1). The diagnosis of tuberculosis was confirmed by bacteriology (n = 4) four cases, histologically (n = 5) and by a test treatment (n = 1). Systemic illnesses were: systemic lupus erythematosus (n = 5), Gougerot-Sjögren syndrome (secondary or primary) (n = 3), sarcoidosis (n = 1), systemic scleroderma linked to pernicious anaemia (n = 1), rheumatoid arthritis (patient 2 linked to lupus) (n = 1) and multiple auto-immune syndrome (n = 1). The diagnosis of systematic illness was made before that of tuberculosis in 8 patients and concomitantly in only one. Under treatment by four drugs then by two drugs, the evolution of tuberculosis was favourable in five of nine patients. One of the patients developed an allergy to isoniazid and resistance to the anti-tubercular treatment. Five of our patients recovered from their illness.

**Conclusions** This study confirms the often extra-pulmonary character of tuberculosis in patients with systemic disease as well as the difficulty of diagnosis and problems multiplied by this association.

No conflict of interest.

#### CPC-151 TYPE OF CANCER AND RISK FACTORS IN HIV PATIENTS ON ANTIRETROVIRAL TREATMENT

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