Results 199 substitution proposals were sent to the physicians (51.8% accepted, 48.2% not accepted. Of these, in 17.1% of cases the patient brought the medicine from home and in 7% treatment was discontinued).

The most common clinical justification accepted (8 cases) was leg oedema caused by amlodipine (maintenance of manidipine). The second one was anaerobic infection where levofloxacin is not active (maintenance of moxifloxacin).

The global DNI price within two months of study was €1,148.78. The cost saving with the acceptance of 51.8% of substitutions was €472.63 in two months. If 100% of substitutions had been accepted, the therapeutic equivalent prescription would have saved €586.75.

In 17% of cases therapeutic equivalents were prescribed at discharge.

Conclusions The suggested substitution was accepted in more than half of cases.

The adjustment of medical prescriptions to the hospital's pharmacotherapeutic guide prevailed over the economic saving, which was not significant.

The prescription of therapeutic equivalents at discharge was not as expected.

No conflict of interest.

OHP-015 CLINICAL RESEARCH IN FRANCE AND QUEBEC

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Background Pharmacy practise is evolving in most countries. Hospital pharmacists are pivotal in the organisation and the support of clinical trials. We looked at the current state of pharmacy practise in clinical research.

Purpose To identify differences in clinical research organisation and pharmacy practise between France and Quebec (Canada).

Materials and Methods This is a descriptive study. A literature review was performed in order to describe the organisation of clinical research and the role of pharmacists in clinical research for both countries. Differences were identified by a panel consisting of one French pharmacy intern, one French hospital pharmacist, one Quebec research assistant and two Quebec hospital pharmacists.

Results Fourteen differences relating to research organisation were identified. France and Canada have different normative frameworks, regulatory authorities, authorization processes, delays and shutdown processes. While it is encouraged, clinical trial registration is not mandatory in Canada. Data needs to be archived for 15 years in France vs. 25 years in Canada. Institutional review boards (IRB) have different names, location, composition, nomination processes, mandate duration and informed consent processes for minors. Seven key differences in pharmacy practise were identified. There are different authorization processes for drug compounding and manufacturing. Pharmacy fees are based on a national reference in France, but not in Canada. Software for the computerization of pharmacy services for clinical trials is common in France. In addition to drug trials, French pharmacists also manage sterile medical devices and medicinal products derived from human blood. Canadian pharmacists offer decentralised pharmaceutical care to hospitalised patients. Canadian pharmacists can be principal investigators if a doctor is the qualified investigator.

Conclusions Clinical research organisation is similar on many aspects, but 21 main differences were identified. Comparisons between countries help identify best practise and may contribute to practise improvement.

No conflict of interest.

OHP-016 CONSUMPTION OF OPIOID ANALGESICS IN HOSPITAL PHARMACY AND CONSULTATIVE CARE FOR PATIENTS

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Background In recent years the incidence of different types of pain is increasing. We have found the same in the St. Anne's hospital in the Czech Republic. Patients are now able to ask about the correct usage of opioid drugs in pharmacy consultation centre, which opened in 2011.

Purpose To find out the consumption of opioid analgesics from 2008 to 2011. This is an analysis of prescriptions by doctors from the pain treatment centre. We also collected data from patient records in the pharmacy consultation centre and we wanted to know how many patients come to consult us.

Materials and Methods Data were obtained from the pharmacy computer software. We made a retrospective evaluation, calculated the defined daily dosage (DDD) and compared consumption of opioid analgesics during 2008–2011 for ATC class N02A and other subclasses. We analysed the consultation records.

Results Consumption of weak opioids decreased over that time, while consumption of strong opioids increased, which had to be prescribed. Opiates were prescribed more often to women. The highest consumption was of buprenorphine, than fentanyl and oxycodone, from weak opioids it was tramadol. Consumption of fentanyl increased from 35 735 DDD (2010) to 39 924 DDD (2011), while buprenorphine consumption decreased from 45 059 DDD (2010) to 38 675 DDD (2011). The amount of morphine used last year was twice that of previous years. The total number of patients who visited the pharmacy consulting centre was 41, six patients were from the pain treatment centre. Average age was 61.3. Patients wanted to control interactions, secondly combat adverse effects of opioids and requested information about neuropathic pain. Average consultation length was 22.5 minutes.

Conclusions The consumption of strong opioids is gradually increasing, doctors follow guidelines and they aren't afraid of prescribing strong opioids. In future it would be appropriate to extend the distribution of informatory materials by the consultation centre – not only about the opioid analgesics.

No conflict of interest.

OHP-017 COST COMPARISON OF INTRAVITREAL ANTIANGIOGENIC DRUGS IN THE TREATMENT OF AGE-RELATED MACULAR DEGENERATION

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Background The primary treatment of Age-related Macular Degeneration (AMD) is based on inhibition of Vascular Epithelial Growth Factor (VEGF) with antiangiogenic drugs, which delay disease progression and improve the patient's vision.

Choosing between bevacizumab and ranibizumab is still up for debate. Bevacizumab has not been approved for AMD, while ranibizumab has a safer profile and is legally approved for this condition, although it is more expensive.

Purpose To evaluate the cost of intravitreal ranibizumab in AMD and to compare with the hypothetical cost of treatment with intravitreal bevacizumab in off-label conditions for the same group of patients.

Materials and Methods This descriptive observational study was carried out in a General Hospital, over a period of 24 months between January 2010 and December 2011. All patients diagnosed with AMD who received at least one dose of intravitreal ranibizumab were included.
Results 77 patients were included in the study, with a total of 82 eyes treated. This involved the administration of 259 injections of intravitreal ranibizumab. Each dose cost €549.75. In total, the consumption of intravitreal ranibizumab to treat the AMD during the period of study carried an expense of €142,385.25.

Considering that the unit cost of intravitreal bevacizumab is €4.08, the administration of this drug instead of ranibizumab would have cost €1,056.72.
Conclusions Ranibizumab is 135 times more expensive than bevacizumab.

In this group of patients, the use of bevacizumab would have reduced costs by approximately €141,000.

No conflict of interest.

OHP-018 COST-MINIMIZATION STUDY ASSOCIATED WITH TWO STRATEGIES OF INTRAVENOUS CHEMOTHERAPY: PERIPHERALLY INSERTED CENTRAL CATHETERS VERSUS SUBCUTANEOUS CENTRAL VENOUS ACCESS PORTS

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Background Subcutaneous central venous access ports (CVPs) and peripherally inserted central catheters (PICCs) are two widely used devices for the administration of chemotherapy. Many studies focus on their complications but no cost study could be found in the literature.
Purpose To determine which technique allows cost minimization in the administration of chemotherapy.
Materials and Methods We constructed a Markov chain (TreeAge Software) from literature data in which probabilities were adjusted to the duration of one cycle (21 days).

Time horizon was 5 cycles. Population was oncohaematology.

Four states were identified for patients: absence of complications; mechanical complications, infectious complications and obstructive thrombotic complications.

Three consequences were isolated: the maintenance, removal or reinstallation of the catheter.

Costs were estimated from care protocols of a French University Hospital, from treatment recommendations and the French 'Common Classification of Medical Acts'.
Results Adjusted complication rate (%): (Table)

Cost of these strategies:

PICC (with fixture) = €542
PICC (without fixture) = €486
CVP = €550

The financial gain on the purchase of PICCs doesn't recoup the costs associated with maintenance and management of their complications.

Limits: the study is based on a literature review with a low number of subjects (PICCs) and foreign data (CVPs).The foreign data cannot necessarily be applied to French practise (PICC thrombosis rate in France < international rate).

Moreover unlike the CVP group, the majority of PICC complications are mechanical and therefore depend on the hospital maintenance practises.
Conclusions Costs incurred by the two strategies are equivalent; however we economise on PICCs when the care protocol doesn't change the fixture every time.

Abstract OHP-018 Table 1 Adjusted complication rate (%)

Complications	Infectious	Mechanical	Obstructive/ thrombosis	Absence of complications
CVP	0.41	0.16	0.31	99.1
PICC	0.76	9.28	0.76	82.3

No conflict of interest.

OHP-019 DAY-1 CALL IN AN ONCOLOGY DAY UNIT: WHAT IMPROVEMENTS?

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Background The preparation in advance of anticancer drugs can decrease the waiting time of patients in oncology day units.
Purpose To establish a system of phoning patients before their session (D-1 call) to cheque their availability. A year after its deployment, we evaluated the impact of this plan.
Materials and Methods The oncologist and a nurse call patients one day before their appointment. The prescriptions are validated when the patient's condition permits it in the light of the patient's biological assessment, done in an outside medical analysis laboratory, and an interview using a standardised questionnaire. After pharmaceutical validation, anticancer drugs are prepared in the afternoon for the next day. Indicators of routine monitoring were defined.
Results A median of 13 patients with 23 planned day-hospital appointments were called the day before their appointment. An oncologist validated the treatment of 45% of the patients on D-1 and 95% of the cancer treatments were delivered on D1 before 9:00 am. The total time the patients spent in the unit was reduced from 273 minutes to 242 minutes after our plan was adopted. The average time between the end of the medical consultation and the start of the treatment went down from 79 minutes before the D-1 call to 52 minutes. In addition, 2/3 of patients received the treatment only 30 minutes after seeing their doctor. Finally, fewer than 2% of anticipated preparations were not administered.
Conclusions The D-1 call requires significant effort, but it enables us to improve the organisation of care in the oncology day unit and the preparation of the anticancer drugs by the pharmacy's production unit. The workload is more even throughout the day and is not stressful for the staff. All of this contributes to making the system safer. We are hoping to extend the D-1 call to the oncology week unit and evaluate patient satisfaction.

No conflict of interest.

OHP-020 DE-ESCALATION STRATEGY OF EMPIRICAL ANTIBIOTIC TREATMENT WITH CARBAPENEMS

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Background Therapeutic de-escalation enables us to improve the effectiveness of empirical antimicrobial therapy and avoids the development of resistance.
Purpose To analyse the preliminary results of a pilot project of pharmacy interventions to achieve de-escalation of treatment with carbapenems, within a programme of optimisation of antibiotics use.
Materials and Methods Prospective study of pharmacy interventions aimed at de-escalation in patients starting treatment with carbapenems, over three months (from March to June 2012) in a