biological agent, dose and adherence were examined. To calculate the adherence we used a record of prescriptions dispensed over a period of six months. We used the formula: % adherence = no. of units dispensed/no. of units theoretically needed × 100.

**Results** The sample included 62 patients, 45 males and 17 females with mean age of 50 years (range 12–81). 53.2% were using etanercept, 43.6% adalimumab and 3.2% infliximab. The adherence was high in the infliximab group (94%) and very similar in the other groups (etanercept 83.7%, adalimumab 87.4%). In the adalimumab cohort 11% had a reduced dose, in the etanercept group 9% had a reduced and 30% an increased dose. In all these groups the calculated adherence was quite similar.

**Conclusions** As described in the literature, adherence to biologics was significantly higher compared with the adherence observed with other treatments for psoriasis. Infliximab had the highest rate, maybe because it is administered in hospital. There was no difference between adalimumab and etanercept. It is known that there is progressive loss of patient adherence to treatment, for this reason it is important to focus the attention on this concept.

No conflict of interest.

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**OHP-036** EVALUATING SINGLE-INCISION SLINGS IN FEMALE STRESS URINARY INCONTINENCE: THE USEFULNESS OF THE CONSORT STATEMENT CRITERIA

doi:10.1136/ejhpharm-2013-000276.409

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**Background** Unlike drugs, medical devices (MDs) are not submitted for health authority marketing authorization based on in-depth clinical evaluation: critical review on an evidence-based medicine approach is essential for practitioners. The Consolidated Standards of Reporting Trials (CONSORT) statement is an international consensus expert guideline aimed at improving the reporting quality of clinical trials reports.

**Purpose** To evaluate the usefulness and applicability of the CONSORT for journal articles reporting randomised controlled trials (RCTs) evaluating an implantable MD.

**Materials and Methods** Original articles published before 2012 reporting RCTs assessing single-incision slings (SISs) in the treatment of female stress urinary incontinence were searched for in PubMed and Embase databases. Reporting quality was assessed by two hospital pharmacists and two urological surgeons according to three CONSORT checklists: abstract (17 items), standard (37 items) and extension for non-pharmacological trials (20 items); the results were discussed to reach a consensus.

**Results** Among 135 articles retrieved, eight articles met the inclusion criteria and were assessed. Abstract scores ranged from 4.7 to 14.1 out of 20. Standard scores was greater than 10.0 out of 20 for most articles; the extension scores did not exceed 5.0 out of 10. Half the reported trials were not identified as randomised in the title. Three articles did not mention any confidence interval or standard deviation for outcomes. The interventions were incompletely described; only four articles reported the configuration of the devices. Four articles reported whether blinding was achieved but lack of blinding was never discussed as a potential source of bias. Few articles reported the operators and centres’ characteristics and their impact on statistical analysis.

**Conclusions** The reporting quality of SISs RCTs should be improved because readers require complete, clear and transparent information to assess the relevance and applicability of results. Our study supports further use of the CONSORT criteria to enhance and assess the reporting quality of surgical trials.

No conflict of interest.
**Results** 109 patients (43% men; 57% women) met inclusion criteria. Mean age was 54 ± 13.5 years and mean BMI 26.5 ± 4.8 kg/m². 58.7% had Rheumatoid Arthritis, 19.3% Ankylosing Spondylitis, 1.8% Juvenile Idiopathic Arthritis, 16.5% Psoriatic Arthritis and 3.7% Psoriasis. 82% self-administered the pen, and 71% the syringe. The median pain with the syringe was 3 [interquartile range (IQR): 2–6] and with the pen was 4 [IQR: 2–5] (P = 0.008). 65% reported the same pain with both devices. 35% reported differences in pain and most of them (71%) had much pain (>5) with the pen and little pain (<5) with the syringe.

There was a statistically significant association of pain with gender: women had more pain with the pen (P = 0.05), but less with the syringe (p > 0.05). There was no association with BMI, age or diagnosis. Acceptance of the pen and self-administration were higher even though pain was greater, so it is necessary to maintain both devices to assure adherence. No conflict of interest.

**Conclusions**

The mean value obtained in the questionnaire was 0.71 ± 0.19.

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**Background**

Pharmacists are essential for the safe use of medicines, and have a very important role in providing comprehensive drug management. Their crucial responsibilities in medicines management and promoting quality control necessitate developing a computerised tool to improve their communication with other medical team members.

**Purpose**

To develop a pharmacist interface, as a part of the computerised medical file ‘Chameleon’, to display all the information required by pharmacists for preparing and documenting their intervention.

**Materials and Methods**

Step 1: mapping the processes required for implementation of the system.

Step 2: preparing a dedicated tool with two components:

1. A pharmacist interface: a screen designed to show all related data required for a clinical pharmacist to form his opinion regarding the medicinal treatment. The pharmacist intervention is documented in an assigned field ‘pharmacist follow up’, which is also displayed beside the ‘physician follow up’ field in the physician interface to save switching screens.

2. The pharmacy services as an advisory ward: the pharmacists’ team is defined as an advisory ward that can be invited by the physicians. Requests for advice are displayed in a pharmacist work list.

**Results**

The pharmacist interface was integrated into the ‘Chameleon’ and is used regularly. It is a convenient tool that displays all the information required for a professional pharmacist’s opinion, and improves medical team communication by allowing this opinion to be viewed by other staff members. There is an ongoing process of assimilation and dissemination of the computerised availability of pharmacy advisory services. There are two topics in development: (a) physician feedback and reference regarding the pharmacist advice, and (b) the ability to monitor all revised cases.

**Conclusions**

The computerised tool satisfies the pharmacist work process and improves communication with the medical staff. The final tool will generate statistics about its contribution to medical personnel and improve the quality of pharmacy services in this medical care hospital.

No conflict of interest.