Purpose To assess the budget impact of introducing FCM in the current practise for treating postoperative anaemia in orthopaedic surgery.

Materials and Methods A budget impact model (BIM) was built from a hospital perspective. Study population consisted of patients who underwent total hip or knee replacement in 2011. Costs are estimated by micro-costing for treatment costs and questionnaire for nursing costs. A reference case is based on the present patient case-mix. Simulations consider different substitutions: simulation A 100% ISC for FCM, simulation B 100% ISC and 50% oral iron for FCM and simulation C 100% ISC and 100% oral iron for FCM. One-way sensitivity analysis is applied to simulations.

Results Population: 314 patients (210 women) underwent 327 operations (205 total hip replacements), mean age was 71.6 years. Costs per treatment: oral iron €0,57, ISC €60,48, FCM €82,46 and transfusion €431.13 (no patient received erythropoietin treatment during hospitalisation). Average costs per patient: reference case €161,63, simulation A €169,83, simulation B €195,93 and simulation C €219,85. Total costs per year: reference case €44 124,20, simulation A €46 864,85 (+5%), simulation B €55 488,94 (+21%) and simulation C €60 018,12 (+51%). Discussion: BIM is very sensitive to variations in transfusion rate, moderately sensitive to variations in treatment costs and insensitive to variations in nursing costs. Economically, simulation A is feasible for many patients, simulation B is feasible, but simulation C is not.

Conclusions FCM will be added to the hospital formulary. A further study is needed to define substitution modalities in the real-life situation. BIM has contributed to this decision-making process. No conflict of interest.

OHP-079 TUMOR NECROSIS FACTOR BLOCKERS IN RHEUMATOLOGY: CONVENTIONAL VERSUS OFF-LABEL DRUG DOSAGE
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Purpose To describe and evaluate the use of chemotherapy in cancer patients in their last days of life.

Materials and Methods Retrospective observational study that included all cancer patients who died in our hospital in 2011. Information sources used were: a) Mambriano for the age, date of death of the patient and clinical charts; b) Oncocare to record the type of cancer, the last cycle of intravenous (IV) chemotherapy received, the historic administration, lines of treatment and the percentage of the last dose received; c) AFPC-Athos to review data from the patient’s hospital stay and outpatient oral cytostatics dispensing. We collected for each patient their demographics, pharmacotherapy, the temporal interval between the last chemotherapy administration and death of the patient and the number of days in hospital one month before death.

Results A total of 94 patients (30% female) died in 2011 in our hospital. Of these, 10 patients didn’t receive chemotherapy, 10 received IV chemotherapy combined with oral, 4 received oral chemotherapy alone and 70 IV chemotherapy alone. Tumours with the highest number of deaths were non-small cell lung cancer (21), head and neck cancer (11) and colorectal cancer (10). The most common last chemotherapy regimens were combinations of carboplatin (16) (especially with pemetrexed and paclitaxel), gemcitabine (11) (mostly alone), combinations of cisplatin (9), paclitaxel (9) ( alone or combined with carboplatin) and monoclonal antibodies (9) (mostly combined with bevacizumab); the most frequent oral chemotherapy drugs were erlotinib (4) and temozolomide (3). Of the 80 patients who received IV chemotherapy, 27.5% (22) received chemotherapy in the last 14 days of life, another 27.5% (22) received chemotherapy between 15 and 30 days before death, 21.25% (17) between 31 and 60 days, 13.75% (11) between 61 and 90 days and 10% (8) more than 90 days before death. In addition, 14% (12)