

**Background** The average risk of infection after occupational exposure to HIV is 0.3% (0.2–0.5% percutaneous exposure, 0.01–0.5% contact with mucous or non-intact skin) and after sexual exposure 0.01–3%, depending on sexual practise.

An action protocol has been in place at our centre since 2010, based on international recommendations for exposure to HIV that include:

1. Start treatment within 72 hours post-exposure.
2. 1st choice guideline: Tenofovir/Emtricitabine+Lopinavir/Ritonavir regimen or the source treatment if viral load is controlled; 2nd choice Tenofovir/Emtricitabine or Lamivudine/Zidovudine+protease inhibitor(PI), boosted with Ritonavir.
3. Length of treatment: 30 days.
4. Serological analysis at different points until the 6th month.

Before 2010, the hospital followed the international recommendations, with 1st choice Tenofovir/Emtricitabine or Lamivudine/Zidovudine+PI boosted with Ritonavir.

**Purpose** To evaluate the effectiveness and change to the protocol currently in force since 2010 and that of the previous international recommendations, following exposure to HIV.

**Materials and Methods** A retrospective observational study. Sample: 100% of patients with antiretroviral treatment following exposure. Period: January 2000-June 2012. Data Sources: Pharmacotherapy records (Silicon computer programme) and electronic medical records (IANUS application). Variable effectiveness: absence of seroconversion in exposed patient following post-exposure prophylactic treatment (PEPT). Analysis on: day-0, month-1, month-3 and month-6.

**Results** 33 patients. Average age 37.3(23–65), 13 males (39.4%). Patients treated with first choice: 94%, other therapeutic options: 6.0%. 90.9% of patients received treatment for 30 days. 38.2% of patients underwent correct serological monitoring until 6 months, 52.9% until 3 months. 96.9% started treatment within 72 hours of exposure. All baseline serologies were negative and there were no cases of seroconversion. Average cost/patient €747.

**Conclusions** PEPT was able to achieve the therapeutic goal in all study patients. The treatment chosen and the time of beginning after exposure were correct. The follow-up until 6 months was not carried out correctly in a significant percentage of patients. These facts and the high costs, require close pharmacotherapy monitoring of these patients.

No conflict of interest.

#### CPC-044 EFFECTIVENESS AND SAFETY OF BEVACIZUMAB IN METASTATIC BREAST CANCER IN CLINICAL PRACTISE

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**Background** New data released by clinical trials AVADO and RIB-BON have questioned the use of Avastin in metastatic breast cancer (MBC). EMA keeps the indication of first line in combination with paclitaxel or capecitabine when taxanes or anthracyclines are not indicated.

**Purpose** This study explores our single-centre experience to cheque the effectiveness and safety of bevacizumab in MBC in clinical practise.

**Materials and Methods** Retrospective study of 41 MBC patients treated with bevacizumab and chemotherapy in a Spanish teaching hospital from 07/2008 to 06/2012. Toxic effects were graded according to the National Cancer Institute Common Toxicity Criteria (NCI-CTC). Disease status was assessed according to the Response

Evaluation Criteria in Solid Tumors (RECIST). Clinical evaluation included clinical response, time to progression (TTP), and toxicity. Median survival times were estimated from Kaplan–Meier curves. Data analysis was performed using SPSS-17.0.

**Results** Median age was 59 yrs (34–75). 87.8% of patients had ECOG PS 0–1. Bevacizumab was administered with docetaxel (46.3%), paclitaxel (29.3%), taxane-carboplatin (17.1%) or capecitabine (7.3%). It was used as first line in 19 cases (46.3%), second line in 5 and following lines in 17 cases (41.5%). Sites of metastases were: 26 visceral and 4 skeletal. Overall Response was 46.4% (4.9% Complete and 41.5% Partial). 17.1% had progressive disease. Median TTP: 7.8 months (6.5–9.2;95%CI). Median TTP of first-line paclitaxel-bevacizumab was 11 vs. 7.7 months for the rest of the combinations ( $P = 0.501$ ). Safety outcomes were similar among treatments. G1–2 toxicities: bleeding (32%), anaemia (21.8%), mucositis (21.9%), diarrhoea (9.7%), hypertension (20%). 1 patient suffered grade 4 hypertension resulting in discontinuation and 2 patients suffered deep vein thromboembolisms. Other non-specific toxicities: neutropenia (31.2% – G3–4 = 7.3%), neuropathy (19.5%), alopecia (24.4%), nausea/vomiting (9.8%).

**Conclusions** TTP was longer with paclitaxel than with other anti-neoplastic agents but the difference was not statistically significant. Most of patients in the paclitaxel group were censored as they hadn't reached progression yet. Toxicity profile was as expected.

No conflict of interest.

#### CPC-045 EFFICACY AND SAFETY OF BOCEPREVIR AND TELAPREVIR AT WEEK 12 OF TREATMENT

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**Background** Boceprevir and telaprevir are two new drugs approved by the European Medicines Agency for the treatment of hepatitis C genotype 1. They are used in combination with ribavirin and peg-interferon to increase the response to treatment.

**Purpose** To analyse the evolution of the viral load and the adverse effects of boceprevir and telaprevir, at week 12 of treatment.

**Materials and Methods** We undertook a prospective observational study from November 2011 to October 2012 of patients who started treatment with boceprevir and telaprevir. Patients were monitored for 12 weeks after initiation of triple therapy. We also analysed the incidence of adverse effects during treatment. The data collected were: age, sex, grade of fibrosis, type of patient, baseline viral load, and viral load at weeks 4, 8 and 12. The data were consulted in the medical records of patients through the IMDHv.50 programme.

**Results** A total of 31 patients were followed up, eight treated with boceprevir and 23 with telaprevir. The median of age was 60 years. Regarding the type of patient, 10 were treatment naïve, 5 were relapsers, 7 non-responders, 4 presented side effects in previous treatment and 5 were partial non-responders. The median viral load was 2,682,000 IU/ml. At week 12, undetectable viral load was found in 26 (83.8%) patients (6 in the boceprevir group and 20 in the telaprevir group). Five patients (16.1%) had to discontinue treatment, four (12.9%) had >1000 IU/ml at week 12 and one (3%) due to pancreatitis. Adverse events observed during treatment are shown in the table.

**Conclusions** The data show an early decrease in the viral load of patients treated with triple therapy, becoming undetectable by week 12 in most cases. The side effects differed from those described in clinical trials, so more studies and post-marketing pharmacovigilance are needed.