Results Were included 13 patients, with a mean age of 67 ± 13.5 (39–86). The location of tumour was 6 in oral cavity and 7 in oropharynx. The causes of admission was surgery (69.3%) and complications of neoplastic pathology base (39.7%); bleeding: 40%, dysphagia: 20% bronchoaspiration: 20%, oral mycosis: 20%.

According to the nutritional status before admission, were found 4 patients (30.7%) with mild malnutrition, 2 (15.3%) with moderately malnutrition, 1 (7.7%) with severe malnutrition and 6 patients with not available data. At discharge: 5 patients (38.5%) with mild malnutrition, 7 patients with not available data and one patient died during the period.

During the admission period, all the patients received oral feeding, 6 patients received enteral nutrition (EN) by gastrostomy tube. At discharge, 61.5% of patients received oral diet and the 7.7% of them needed energy supplementation. The remaining 30.8% needed to continue with EN.

Conclusions The risk of malnutrition in patients with head and neck cancer is high.

Individualized nutritional support in these patients is necessary to prevent weight loss.

In the absence of parameters to perform an adequate nutritional assessment, we need greater involvement by hospital physicians with the clinical nutrition unit.

No conflict of interest.

CPC-095 OFF-LABEL USE OF ANAKINRA IN A PATIENT WITH FAMILIAL MEDITERRANEAN FEVER: A CASE REPORT

doi:10.1136/ejhpharm-2013-000276.552

[1]F Valiente, [1]I Sánchez, [2]A Martínez-Blázquez, [1]MA Rodríguez, [1]J Ramos. *[1]Hospital de la Vega Lorenzo Guirao, Pharmacy, Murcia, Spain; [2]Hospital de la Vega Lorenzo Guirao, Internal Medicine, Murcia, Spain*

Background Familial Mediterranean Fever (FMF) is an autosomal recessive autoinflammatory disease characterised by periodic episodes of fever, peritonitis, arthritis and may be complicated by secondary amyloidosis. FMF affects groups of people from around the Mediterranean Sea. Colchicine is the standard treatment in the prevention of both acute attacks and secondary amyloidosis but there are some resistant patients. Anakinra, an interleukin-1 (IL-1) receptor antagonist indicated for the treatment of the signs and symptoms of rheumatoid arthritis in combination with methotrexate, is also known to affect the severity and the frequency of FMF attacks.

Purpose To describe the progress of a patient with FMF treated with anakinra as IL-1 blocker, and evaluate the efficacy and safety of this treatment

Materials and Methods We describe the case of a 53-year-old colchicine-resistant woman suffering from FMF, who was treated with anakinra between April and September 2012 as second-line treatment, after several episodes of recurrent fever and abdominal pain. In order to evaluate the treatment the patient's clinical history and analytical data (C-reactive protein) were reviewed.

Results Anakinra was started with a daily subcutaneous dose (100 mg) associated with oral corticosteroids (methylprednisolone 8 mg). After the first cycle of treatment, the patient was fine, with no recurrent episodes of fever or abdominal pain. C-reactive protein (CRP) fell from 0.8 to <0.1 mg/dl. There were no injection site reactions. The only noteworthy adverse effect was neutropenia (1.4 × 109/L).Corticosteroids and anakinra doses were reduced to zero and 100 mg every other day respectively.

Conclusions In this case of FMF, anakinra successfully suppressed the number of attacks and the symptoms, without significant adverse reactions and with improvement in quality of life. Controlled trials are necessary to confirm the safety and efficacy of interleukin-1 antagonists in FMF patients.

No conflict of interest.

CPC-096 OPTIMIZATION OF THE TREATMENT OF RHEUMATOID ARTHRITIS WITH BIOLOGICAL TREATMENT

doi:10.1136/ejhpharm-2013-000276.553

D Ferràndez Martí, A Camacho Calvente, C Campabadal Prat, RM Parés Marimon, R Sala Robinat, J Serrais Benavente, A Perelló Juncà. *Hospital Igualada, Pharmacy, Barcelona, Spain*

Background The introduction of biological treatment (BT) in the treatment of rheumatoid arthritis (RA) has led to better control of this disease, but on the other hand to a great increase in pharmacy costs.

Purpose To review BT regimens in patients with RA in order to optimise treatment; to try to increase the dosing interval in patients who are responding well and evaluate the savings made.

Materials and Methods Interventional prospective study aiming at optimising the treatment of RA with BT by expanding interval in patients with a good response: adalimumab 40 mg/every 14–21 days and etanercept 50 mg/every 10–14 days. The review of treatments was made jointly between the pharmacy and rheumatology, adjusting the dose and calculating the cost avoided.

Results Patients chosen to extend the dosing interval had a mean DAS28 value of 2.183 (DAS28 < 2.4 is considered to mean disease remission). By extending the dosing interval €108,049.47 was saved in a year.

Conclusions The review and optimization of BT dosage regimens in RA patients in remission allowed us to control the disease and save money.

Abstract CPC-096 Table 1

Rheumatoid arthritis

Patients with BT	Extended interval
Adalimumab: 62 patients	10 patients (16.1%)
Etanercept: 53 patients	5 patients (9.5%)

Etanercept (cost per unit: 236,805€)

Posology	Cost/patient/year	Incremental cost	Number of patients with extended interval	Annual savings
Etanercept 50 mg/7 days (standard)	€12,313.86			
Etanercept 50 mg/10 days	€8,524.98	– €3,788.88	2	€7,577.76
Etanercept 50 mg/14 days	€6,156.93	– €6,140.35	3	€18,470.79

Adalimumab (cost per unit: 514,145€)

Posology	Cost/patient/year	Incremental cost	Number of patients with extended interval	Annual savings
Adalimumab 40 mg/14 days (standard)	€13,567.77			
Adalimumab 40 mg/21 days	€8,946.13	– €4,621.64	6	€27,729.84
STOP upon prolonged remission of the disease	€13,567.77	– €13,567.77	4	€54,271.08

No conflict of interest.

CPC-097 OPTIMIZING CLINICAL PHARMACY: DETERMINING CRITERIA TO TARGET "HIGH RISK" PRESCRIPTIONS

doi:10.1136/ejhpharm-2013-000276.554

M Philippe, B Leroy, S Coursier, M Bourdelin, H Bontemps. *L'hôpital Nord Ouest, Villefranche sur Saône, France*

Background Because pharmacists do not yet systematically analyse prescriptions closely due to lack of time and resources, tools to optimise pharmaceutical validation must be developed.

Eur J Hosp Pharm: first published as 10.1136/ejhpharm-2013-000276.553 on 12 March 2013. Downloaded from http://ejhp.bmj.com/ on October 7, 2024 by guest. Protected by copyright.