Background Hyperglycemia is a prevalent situation in hospitalised patients and it has been associated with higher morbidity and mortality. Poor glycemic control is related to higher costs due to longer hospital stays and higher rates of complications. A large percentage of vascular surgery patients in our hospital have diabetes mellitus with a poor glycemic control.

Purpose To assess the impact of a collaborative, pharmacist-managed insulin titration programme compared to standard medical care on glycemic control in patients with neuropathic diabetic foot ulcerations in vascular surgery unit.

Materials and Methods It was established a new protocol to control glycemic levels in hyperglycemic patients in our hospital. To assess its effectiveness a prospective cohort study to compare pharmaceutical intervention of insulin titration to standard medical care was implanted. 30 patients were recorded and evaluated, 15 subjects were included as control (standard medical care before implementation of insulin protocol) and 15 in the pharmacist-managed group (insulin titration programme). Patients were selected consecutively on admission to the vascular surgery unit, the control group, one month prior to the implementation of the protocol and the rest one month later. In both groups it was registered: age, diabetes mellitus type, blood glucose levels, diet and drug treatment. Student t test was used to evaluate the glycemic values between groups.

Results Both groups were analysed and compared: 67% of subjects from control group were men vs 92% from the intervention group. No significant differences were found in the composition between both groups (p > 0.05) respect of age, diabetes mellitus type and diet. The pharmacist-managed group showed a lower glycemic level compared to standard medical care group (123 mg/dl vs 170 mg/dl respectively; p < 0.044). The hyperglycemic levels were more frequent in control group than intervention group (78% vs 35%). No statistics differences were found with hypoglycemic situations (2% vs 4.5% p = 0.1).

Conclusions At the end of the study period, the intervention group patients had better glycemic control. Pharmacist-provider collaboration can result in significant clinical improvements when compared to standard care glycemic control in diabetic patient in a surgical unit.

No conflict of interest.

Background Rheumatoid arthritis (RA) is an autoimmune disorder, affecting 1% of the population, characterised by pain, joint swelling and progressive destruction of joint tissue. EULAR (European League Against Rheumatism) recommends the use of Tumour Necrosis Factor alpha antagonists (anti-TNFα) if methotrexate or other TNFα inhibitors are contraindicated. A cost-effectiveness analysis of TNFα inhibitors showed that the highest productivity loss of RA is caused by disease-modifying antirheumatic drugs (DMARDs) and not by biologicals. A cost-utility analysis of biologic agents showed that TNFα inhibitors should be included in cost-effective guidelines for treating RA.

Purpose To perform a pharmacoeconomic investigation in the Piedmont region (Italy) to identify the cost of the illness RA. To analyse the payer’s and societal perspectives, investigating direct costs associated with health care use and indirect costs related to productivity loss.

Materials and Methods A multidisciplinary group, rheumatologists, hospital pharmacists and pharmaco-economists, was established to perform a pharmacoeconomic evaluation of the direct and indirect costs of RA, by a systematic literature review. Afterward, we plan a perspective, observational, multicentre, cost-effectiveness analysis of RA biological drugs, involving 100 patients. Each patient will be recorded, every three months for one year, through personal data, disease duration and characterization, systemic manifestations and comorbidities, prescribed biological medicines. A questionnaire will be submitted, in order to assess direct and indirect costs.

Results 40 existing pharmacoeconomic evaluations were critically appraised: the overall mean costs of RA amounted to about €15,000 per year, while the direct annual costs of RA were on average about €4,000. The greatest burden of RA costs was the indirect costs. From a societal perspective the superior clinical outcomes achieved Committee, both observational and experimental. Having a dedicated pharmacist has led to: proper storage of drugs, completing the application form accompanying the samples, storage of electronic and paper documentation of the experimental samples, fitting directly in Pharmacy, randomization of patients enrolled and completing the Drug Accountability.

Results 40 clinical trials have been conducted, 26 of which were conducted in the Oncology OU, 8 in Pulmonary and 8 in Cardiology, 1 in Rheumatology, 2 in Dermatology. As regards the preparation of the antiblastic treatments, the treatment setting provided by the experimental protocols accounted for 5% of all cancer preparations performed in the pharmacy. 83% of the studies (53 studies) were for profit, non-profit research accounted for only 17% of the studies. In 2012 the number of for-profit studies increased compared to 2010; we hope these will be particularly useful to point out any problems of current clinical practice.
with anti-TNFα are worth their higher costs. The most favourable incremental cost-effectiveness ratio was for etanercept compared to methotrexate.

Conclusions The cost-effectiveness of an intervention depends on the maximum the decision makers are willing to pay for an extra unit of health effect. It should be considered that treatments with anti-TNFα, in a societal perspective, decrease the use of health resources and increase productivity.

No conflict of interest.

CPC-107 PHARMACOTHERAPY FOLLOW-UP IN CHRONIC HEPATITIS C PATIENTS TREATED WITH BOCEPREVIR OR TELAPREVIR
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Background The approval for the clinical use of direct-acting antivirals in 2011 (boceprevir [BOC] and telaprevir [TLV]), viral NS protease inhibitors has increased recovery rates by up to 70%. However follow-up of these patients is necessary due to adverse effects (AEs) and the high cost of the treatment.

Purpose To follow up the pharmacotherapy in chronic hepatitis C virus genotype-1.

(VHC-1) patients treated with triple therapy (TT): BOC or TLV, ribavirin and peg-interferon.

To evaluate the efficacy of the treatment and describe the pharmacological handling of severe AEs.

Later, we analysed the compliance of the treatment to the guidelines of Spanish Agency for Drugs. Patient data (age, sex, basal LV at week 4 and week 8, previous treatment response, fibrosis and hae-moglobin levels) were collected from electronic clinical histories and outpatient software.

Results 35 patients were included (22 TLV and 13 BOC), 28 had initial VL > 800000 IU/mL. 34 patients had fibrosis grade ≥ 3.13 patients were treatment-naive, 22 had been treated previously (9 non-responders, 8 relapsers, 5 partial responders). 2 BOC patients obtained fast viral response vs. 4 TLV patients, and 7 BOC patients had undetectable VL at the week 8 cheque-up vs. 16 TLV patients at week 4 cheque-up.

5 patients (4 with BOC) discontinued treatment, one due to severe toxicity and 4 due to lack of efficacy. TT was effective and adhered to the guidelines in 84% patients.

The most frequent AEs were anaemia, anaemia and dermatological reactions (mainly with TLV). 9 patients presented grade 3 anaemia and were treated with erythropoiesis-stimulating agents (EAs) (31% BOC vs. 25% TLV).

Conclusions The safety profiles of BOC and TLV found in our study were similar to those published in clinical trials. Despite not being a comparative study, we observed that more people in the TLV group reached undetectable VL after 4 or 8 weeks (91% TLV vs. 69% BOC). Patients treated with BOC had earlier suspended the TT because of lower effectiveness and higher occurrence of grade 5 anaemia that required EAs.

No conflict of interest.

CPC-108 PHARMACY INTERVENTIONS UNDERTAKEN IN AN INTENSIVE CARE UNIT SPECIALISING IN WOMEN’S HEALTH
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Background Pharmaceutical interventions can prevent drug-related problems and possible prescription errors. They thus