

with anti-TNF α 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-TNF α , in a societal perspective, decrease the use of health resources and increase productivity.

No conflict of interest.

CPC-106 PHARMACOKINETIC DRUG-DRUG INTERACTIONS DUE TO TREATMENT WITH AMIODARONE – A PRACTICAL APPROACH

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Background The drug amiodarone has a complex pharmacokinetic profile and can be a challenge to use due to the high potential for drug-drug interactions.

Purpose To identify and submit proposals for handling drug-drug interactions for patients treated with amiodarone. In addition we would like to highlight the fact that drug interactions can occur even if amiodarone is administered as only a single IV dose, and the effect on further treatment. The purpose was also to prepare proposals for management and follow ups of interactions in the clinic.

Materials and Methods Before the ward round the pharmacist carried out medicines reviews for the 25 patients who were included. They were all treated with amiodarone at admission or during hospitalisation. Input was given on the clinically significant interactions identified. For patients treated with warfarin in addition to IV amiodarone the INR values were observed through the entire hospital stay for any signs of a drug-drug interaction.

Results The pharmacist had 54 inputs referring to interactions with amiodarone, of which 41 were taken into account. The inputs led to dose reductions, changes of drugs and monitoring of blood values. Case reports showed that interactions do occur after IV amiodarone treatment and these lead to uncertain and variable drug efficacy over time.

Conclusions Based on results from the study and a literature search, general advice for handling interactions due to amiodarone and further treatment were prepared. The recommendations were endorsed by the consultant Cardiologist.

Abstract CPC-106 Table 1

Advice for avoiding Drug-Related Problems DRPs due to treatment with amiodarone

- Warfarin Reduce/give half-dose warfarin at start-up. Monitor the INR values (1)
 Digitoxin Give half dose digitoxin/digoxin and monitor digitoxin/digoxin determined by procedure (2)
 Simvastatin No doses above 20 mg or switch to another statin. (3)
 Atorvastatin Note the dose! No clear recommendations, but maximum 40 mg
 Metoprolol Bradycardia? The dose may be adjusted (4)

General advice

When admitted from other hospitals

Note in the drug curve if recently treated with amiodarone!

Discharge summaries

Explain why the GP should follow up the blood values; INR, digitoxin/digoxin and possibly CK.

- Edvin SB *et al*, An evaluation of early pharmacodynamic response after simultaneous initiation of warfarin and amiodarone.
- Laer S *et al*, Digitoxin intoxication during concomitant use of amiodarone.
- Marot A *et al*, Concomitant use of simvastatin and amiodarone resulting in severe rhabdomyolysis: a case report and literature review
- Fukumoto *et al*, Effect of amiodarone on the serum concentration/dose ratio of metoprolol in patients with cardiac arrhythmias

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 anti-virals in 2011 (boceprevir [BOC] and telaprevir [TLV], viral NS3 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.

Materials and Methods Prospective study (from 01/01 to 30/9/2012) was carried out in the Pharmacy Department. VHC-1 patients who started TT were included. All of them had at least one viral load (VL) determination (BOC at week 8 and TLV at week 4).

A hospital pharmacist interviewed the patient at the first day treatment and provided oral and written information about how to take the drugs and their potential 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 haemoglobin 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 asthenia, anaemia and dermatological reactions (mainly with TLV). 9 patients presented grade 3 anaemia and were treated with erythropoiesis-stimulating agents (EAs) (31% BOC vs. 23% 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 3 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