CPC-130 SWITCHING FROM ADEFOVIR TO TENOFOVIR IN HEPATITIS B-INFECTED PATIENTS

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Background Adefovir disoproxil (ADF) was the second nucleoside analogue to be approved for Hepatitis B Virus (HBV) treatment. Later studies showed that tenofovir had better and more cost-effective clinical outcomes for HBV treatment.

Purpose To analyse the treatment changes in patients with chronic infection on ADF treatment. To define treatment changes and their clinical causes and effects in our population.

Materials and Methods A retrospective observational study was performed in a tertiary hospital including all patients treated with ADF between January 2005 and September 2012. Data collected: demographics (sex, age) previous treatment, ADF treatment duration, reasons for changing from ADF, new drug prescribed, HBV DNA viral load at the moment of change and 6 months later.

Results Fifty-nine patients started treatment with ADF during the study period; men (81.4%), mean age: 42 years. Previous treatment: 45 treatment-naïve, 2 Peginterferon-a2-a and 12 lamivudine. Fourteen patients were lost to follow-up. Of the 45 patients included mean duration of treatment with ADF was 44.96 months (range: 3–92). 40 patients changed treatment with ADF: 27 patients switched to TDF with undetectable HBV DNA viral load (two of them returned to ADF due to intolerance); 15 patients switched due to detectable HBV DNA-viral load: 10 patients to TDF and 5 to ETV. 5 patients remain on ADF.

Conclusions Nearly every patient treated with ADF has changed treatment at some point and are no longer treated with this drug.

Most patients switched from ADV to TDF without any clinical reason; this may be related to better clinical outcomes and cost-effectiveness.

No conflict of interest.

CPC-131 SWITCHING STRATEGY. THE PHARMACIST’S POINT OF VIEW ON COST, ADHERENCE AND VIROLOGICAL OUTCOME

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Background HIV infection is a complex medical problem that requires careful monitoring of adherence to treatment, efficacy, development of resistances and toxicities. The estimated life expectancy of patients is increasing, this makes it necessary to find efficient ways to optimise switching therapy away from HAART in order to reduce costs and increase its efficacy. At Amedeo di Savoia Hospital of Turin, the regional centre in Piedmont for HIV infection diagnosis and treatment, hospital pharmacists work in a multidisciplinary team with infectiologists, nurses, psychologists and dieticians. The team follows every aspect of the clinical pathway, leading to an improvement in the clinical management of HIV patients.

Purpose

To monitor HAART for all patients on therapy

To identify patients with a switch of therapy

To create a multidisciplinary database including adherence, economic and clinical data before and after the switch

To monitor the distribution of available resources in relation with virological outcome and adherence response of patients

To achieve a rational use of resources

Materials and Methods Collecting data from Oliamm Software and File F using a specific software application, we analysed cost and adherence by the pharmacy refill method (days supplies between refill dates/duration of dispensed therapy x 100) for each switch of treatment between March 2010 and March 2012. From clinical reports we also evaluated the reasons for switching (toxicity, modification, treatment failure) and the success of variation in term of virological outcome.

Results Switching of antiretroviral treatments occurred in 250 patients (male 177, female 73, median age 48 years), out of about 1,835 HIV-positive people in treatment, considering overall 310 switches (about 8% at the patient’s request). In 151 cases the switch led to a financial saving and in 159 cases to an increase in cost, leading overall to an excess of cost of €496,66 each month (an additional €17.59 for each patient for each month). The reasons for the variation were: treatment failure in 30%, simplification of the treatment in 20%, toxicity in 44% and other causes in 6%. Focus on simplification evidenced: 13% decrease in pill burden, 17% on STR, 5% on LDR, 10% on QD therapy. We also analysed the causes of toxicities. From our study we observed an increased number of patients with suppressed viral load (from 60% to 77%) as evidence of efficacy. 67% of patients already suppressed pre-switch. We also analysed the cost distribution, observing a better use of resources to obtain a viral load under 20 cp/ml and a financial saving for treatment didn’t impact on adherence in 50.32% cases and produced an improvement in adherence in 39.03% of switched patients. Only in 10.69% did a decrease of adherence improve. We have also analysed the cost distribution, observing a better use of resources to obtain a viral load under 20 cp/ml and a financial saving for treatment of patients already suppressed pre-switch.

Conclusions In our study an analysis of switching treatment has demonstrated a correct distribution of budget and an improvement in adherence. It has also demonstrated the importance of working in team for better management of the therapeutic path.

No conflict of interest.

CPC-132 SYNDROME OF INAPPROPRIATE ANTIDIURETIC HORMONE SECRETION AS ADVERSE DRUG REACTION IN HOSPITALISED PATIENTS TREATED WITH TOLVAPTAN

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Background Some drugs can cause Syndrome of Inappropriate Antidiuretic Hormone Secretion (SIADH). Tolvaptan is a new drug...
to treat SIADH. There is a lack of studies about the prevalence of SIADH as an Adverse Drug Reaction (ADR).

**Purpose** To classify by the Naranjo Algorithm (NA) and to determine the prevalence of SIADH in hospitalised patients caused by ADR and treated with tolvaptan.

**Materials and Methods** Two-year descriptive, retrospective, longitudinal, historical cohort study of 33 patients (15 men, 18 women). We sought patients and their clinical characteristics (age, sex, pretreatment in the week prior to tolvaptan with drugs that could cause SIADH as ADR) using pharmacotherapy management software SINFHOS, Silicon, IANUS and BOT Plus. To determine the probability of ADR, we used the NA. Probability levels based on total score are: definite (>9), probable (5–8), possible (1–4), doubtful (0).

**Results** 12 of the 33 (6 men, 6 women) patients were treated in the week prior to tolvaptan with drugs that could cause SIADH as ADR. 16 treatments with 10 drugs that could cause SIADH as ADR (1.3 drugs per patient) were found in the week prior to tolvaptan. The 16 treatments detected were classified as possible (12 times), probable (once) and doubtful (three times); average score was 2.6. SIADH could have been caused by a drug in 10 patients and was classified as possible (4 men, 5 women, 7 older than 65, 2 younger), and probable (1 man over 65). Prevalence was 30%, 40% in men and 34% in women, 28% in people older than 65 and 40% in younger people.

**Conclusions** Our results suggest that some drugs may contribute to the development of SIADH, and there seems to be a greater risk in male patients under 65. Further research is required to evaluate the prevalence and the relative risk of suffering from SIADH as ADR.

No conflict of interest.

**Abstract CPC-133 Table 1**

<table>
<thead>
<tr>
<th>Anaemia</th>
<th>69%</th>
<th>Grade 2 (8.0 – &lt;10.0 g/dL)</th>
<th>54%</th>
<th>Grade 3/4 (&lt;8.0 g/dL)</th>
<th>8%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thrombocytopenia</td>
<td>89%</td>
<td>Neutropenia</td>
<td>77%</td>
<td>Hyperbilirubinemia</td>
<td>46%</td>
</tr>
<tr>
<td>Increased triglycerides</td>
<td>46%</td>
<td>Increased ferritin</td>
<td>54%</td>
<td>Increased GGT</td>
<td>46%</td>
</tr>
<tr>
<td>Photosensitivity</td>
<td>23%</td>
<td>Fatigue</td>
<td>100%</td>
<td>Depression</td>
<td>69%</td>
</tr>
<tr>
<td>Rash</td>
<td>23%</td>
<td>Nausea</td>
<td>77%</td>
<td>Reduction appetite</td>
<td>77%</td>
</tr>
<tr>
<td>Thrombocytopenia</td>
<td>69%</td>
<td>Diarrhoea</td>
<td>46%</td>
<td>Diaphoresis</td>
<td>38%</td>
</tr>
<tr>
<td>Haemorrhoids</td>
<td>77%</td>
<td>Vomiting</td>
<td>38%</td>
<td>Rash and pruritus</td>
<td>69%</td>
</tr>
</tbody>
</table>

were reported more frequently in patients in real clinical practise compared with previous results in clinical trials.

These serious and frequent adverse events may be an opportunity for pharmacists to get involved to improve the safety of this treatment.

No conflict of interest.

**CPC-134** THE EFFECT OF ABACAVIR ON CARDIOVASCULAR RISK OF A SPANISH HIV-INFECTED COHORT

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**Background** There is evidence that antiretroviral therapy (ART) increases cardiovascular risk (CVR). There is controversy over the effect of abacavir (ABC) on CVR. The use of abacavir has been associated with a higher incidence of myocardial infarction in several cohort studies, but data from clinical trials are not conclusive.

**Purpose** To determinate the effect of exposure to ABC and exposure time (ET) to ABC in CVR of a HIV-infected cohort on ART from the northwest of Spain.

**Materials and Methods** Cross-sectional study including HIV patients on ART who were treated at our hospital between March-May 2012. We recorded demographics, ART history and CVR risk factors. CVR was estimated using the Framingham function calibrated for Spanish population (REGICOR). CVR categories were: low (<5%); intermediate (5–9%); high (10–14%); very-high (>15%). Three ABC exposure groups were defined: a) no abacavir exposure (No ABC); b) exposure to abacavir but not to indinavir (ABC); c) exposure to abacavir and indinavir (ABC + IND).

**Results** 89 HIV patients were included in the study (83.1% males, mean age 47.4 ± 7.8 years). Smoking prevalence was 51.7%, hypertension 39.3%, dyslipidemia 24.7%, low HDL cholesterol 67.4%, diabetes 4.5%. Mean global CVR was 4.01%±2.50. Proportion of patients with low CVR was 70.8%; intermediate 25.8%; high 2.2%; very high (15%–1%). Three ABC exposure groups were defined: a) no abacavir exposure (No ABC); b) exposure to abacavir but not to indinavir (ABC); c) exposure to abacavir and indinavir (ABC + IND).

**Conclusions** Apparently, ABC exposure does not increase CVR in our HIV-infected population. More prospective controlled studies are needed to evaluate any association between ABC and increased CVR.

No conflict of interest.