Results A total of 50 patients were studied (mean age 62.7 years, SD 13.2). 60% of patients showed at least one reconciliation error. The average number of drugs involved in reconciliation errors was 1.8 (SD 1.2) per patient. A total of 54 (17%) drugs discrepancies were found. The most common error was omission of a regularly used medicine (74%), followed by discrepancies in the frequency (9%), incorrect drug (9%) and incorrect dose (8%). Antihypertensive drugs represented 37% of all discrepancies. Pharmacists made interventions in 98% of discrepancies. Most pharmacist interventions consisted of the addition of an omitted drug (66%) and dosage adjustment (9.4%). 81% of recommended interventions were accepted by ICU physicians. Most rejected interventions were due to the patient's clinical status (70%).
Conclusions Critically ill patients showed a high incidence of medicines reconciliation errors. Most reconciliation errors consisted of omissions of chronic medicines and involved antihypertensive drugs. 81% of pharmacist interventions were accepted. Medicines reconciliation could reduce medicines errors in critically ill patients and should be incorporated into the daily routine of the pharmacist responsible for the unit.

No conflict of interest.

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, simplification, treatment failure) and the success of variation in term of virological outcome.
Results Switching of antiretroviral treatments occured 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 4396,6€ 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, 55% 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 out of 125 patients (54%) with pre-switch viral load non-suppressed, had a suppression after switch. 172 patients out of 185 patients (93%) with pre switch viral load suppressed, conserved suppression after switch, but 13 patients (7%) had viral rebound. The change of the treatment didn't impact on adherence in 50.32% cases and produced an improvement in adherence in 39.03% of switched patients. Only in 10.65% 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 determinate 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.

CPC-133 TELAPREVIR: ADVERSE EVENTS IN CLINICAL PRACTISE

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Background The addition of telaprevir to peg-interferon and ribavirin represents a new treatment for hepatitis C (HCV) associated with an improvement in treatment response rates but an impairment of the safety profile.

Purpose To evaluate the safety of telaprevir-based treatment in patients with HCV infection in real clinical practise in a specialty hospital.

Materials and Methods Prospective and observational study of patients who started telaprevir between April and September 2012. Data were collected at each treatment visit at the hospital pharmacy through clinical interview and revision of analytical parameters.

Results We enrolled 14 patients treated with telaprevir, 9 mono-infected and 5 co-infected. All patients were between 18 and 70 years old, had HCV genotype-1 infection and had at least stage 3 liver fibrosis (Metavir score).Only two patients had received no previous treatment. In the pre-treated group, 42% of the patients had a previous relapse, 33% had a partial response, and 25% had no response.

43% of patients required ribavirin dose reduction due to anaemia (haemoglobin < 10 g/dl).

23% of patients needed erythropoietin-stimulating agents due to anaemia (haemoglobin < 8.5 g/dl even though the ribavirin dose had been reduced).

8% of patients required a blood transfusion

Telaprevir was stopped in one patient because of rash. No patients discontinued treatment because of anaemia.

Conclusions The safety profile of telaprevir was consistent with the findings in clinical trials. However, most of the adverse events 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.

Abstract CPC-133 Table 1

Anaemia	69%	Grade 2 (8.0 – <10.0 g/dL) Grade 3/4 (<8.0 g/dL)	54% 8%
Thrombocytopenia	69%		
Neutropenia	77%		
Hyperbilirubinaemia	46%		
Increased triglycerides	46%		
Increased ferritin	54%		
Increased GGT	46%		
Photosensitivity	23%		
Fatigue	100%		
Depression	69%		
Reduction appetite	77%		
Nausea	30%		
Diarrhoea	46%		
Vomiting	38%		
Haemorrhoids	77%		
Rash and pruritus	69%		

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%, dyslipidaemia 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 1.1%. According to ABC exposure: mean CVR was 4.02 ± 2.62 (No ABC); 3.77 ± 2.28 (ABC); 4.30 ± 2.0 (ABC+IND). No significant differences were found when we compared mean risks of each group. We did not find differences in CVR according to ET to ABC.

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.