

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, pre-treatment 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

#### **Abstract CPC-133 Table 1**

Anaemia	69%	Grade 2 (8.0 – <10.0 g/dL)	54%
		Grade 3/4 (<8.0 g/dL)	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%		

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 determine 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.