The main recommendation was the maintenance of the regimen and the intensification of the dose. The gastroenterologist acted following the suggestion of the pharmacist in more than 80% of the cases.

Conclusion Results obtained show a high percentage of patients with inadequate anti-TNF serum levels and support the use of anti-TNF pharmacokinetic monitoring as a useful tool in clinical decision-making.

REFERENCES AND/OR ACKNOWLEDGEMENTS

To my workmates, thank you.

No conflict of interest.

4CPS-158 CLINICAL BENEFIT OF INFlixIMAB MONITORING IN INFLAMMATORY BOWEL DISEASE

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Background The adjustment of infliximab (IFX) doses is commonly based on subjective data or invasive methods. However, pharmacokinetic monitoring of IFX plasma levels is a currently available tool that has proved to be useful in the optimisation of clinical results.¹

Purpose To analyse the clinical course of acute-phase reactants in patients with inflammatory bowel disease (IBD) treated with IFX, and to evaluate if there is a clinical benefit resulting from applying the pharmacokinetic recommendations in the management of these patients.

Material and methods Retrospective, cross-sectional study carried out in a general hospital. All the determinations of IFX performed during 2017 in patients with IBD were analysed. After analytical determination, the pharmacy service performed a pharmacokinetic study (Bayesian statistics) and recommended a new dosage to the digestive specialist. Identification data of the patients and analytical results (fecal calprotectin and C-reactive protein (CRP)) measured before the monitoring (pre) and 3 months later (post) were collected. In addition, it was evaluated if the digestive specialist followed the pharmacokinetic recommendation (acceptance/rejection).

Results During the study period, the IFX serum levels of 21 patients with IBD were determined. The mean level of fecal calprotectin measured before the extraction of IFX blood levels was 1,257.2 mg/kg and this was reduced to 503.2 mg/kg at 3 months after monitoring ($p=0.053$). As for CRP, a decrease was also observed, with a CRP value of 7.1 mg/L before monitoring and a CRP value of 3.8 mg/L after 3 months ($p=0.035$). These data were analysed again, stratifying according to the degree of acceptance of the pharmacist's recommendations for clinical decision-making (table 1).

Abstract 4CPS-158 Table 1 Acute-phase reactants (pre- and post-monitoring) segmented by the acceptance of the pharmacist's intervention

	Fecal calprotectin (mg/Kg)	CRP (mg/L)
	Xpre-Xpost monitoring (P-value)	Xpre-Xpost monitoring (P-value)
ACCEPTED	1.163-475 (0.044*)	7.4-3.8 (0.021*)
REJECTED	1.295-727 (0.655)	4.6-3.8 (0.715)

X=average; P-value (Wilcoxon test)

Conclusion Both PCR and calprotectin were reduced after 3 months of IFX monitoring. The clinical improvement observed was greater in the group of patients in whom the dose drug was adjusted following the recommendation of the pharmacist. These results support the role of therapeutic IFX monitoring in the optimisation of IBD treatment, according to the evidence published by other authors.

REFERENCE AND/OR ACKNOWLEDGEMENTS

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No conflict of interest.

4CPS-159 PERIOPERATIVE MANAGEMENT OF ANTIRHEUMATIC MEDICATION IN REAL PRACTICE: IS MISMANAGEMENT RELATED TO POST-SURGICAL COMPLICATIONS?

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Background A perioperative management of antirheumatic drug therapy guidelines was published by the American College of Rheumatology in 2017. The optimal perioperative management of immunosuppressant therapy may present an opportunity to mitigate post-surgery infection risk versus disease flare risk if the medication is withheld.

Purpose To evaluate the accuracy between the real practice in perioperative management of patients with rheumatic diseases and the guideline recommendations, and to assess post-surgery complications and identify associated risk factors.

Material and methods Retrospective, observational study. Adult patients with rheumatoid arthritis (RA), spondyloarthritis (SpA) and psoriatic arthritis (PsA) in treatment with biologic agents while undergoing surgery between January 2017 and August 2018 were included.

Data collected:

- Diagnosis, antirheumatic treatment (biologic agent, disease-modifying antirheumatic drugs (DMARDs) and glucocorticoids) and doses.
- Continuation/interruption of DMARDs and biologic agent, time of reintroducing them and glucocorticoid adjustment dose during surgery.
- Post-surgery complications: infections and disease flares.

Descriptive statistics and binary logistic regression were performed with SPSS 20.0.

Results Forty-seven patients were included: 63.8% RA, 19.1% SpA and 17.1% PsA. Anti-TNF α agents were used in 76.5% patients, from which 14% of patients required an intensified dose. DMARDs were combined with biologic therapy in 63.8%, while glucocorticoids were used in 44.7%.

During perioperative time and according to guidelines, a total of 93.3% continued with DMARDs and 95.2% with glucocorticoids when the daily dose of prednisone or equivalent was <20 mg. Nevertheless, 14.8% interrupted the biologic agent, from which 42.8% of the surgeries were scheduled at the end of the biological therapy cycle and no patient was properly reintroduced to a biologic agent after 14 days from surgery.