prescribed for every refractory moderate to severe patient with IBD treated at the centre between January 2014 and November 2017. For each patient dispensed treatments, switches and reason for switches were analysed.

Results Eight-hundred and fourteen patients with IBD treated with biologics were included: Adalimumab (42.7%), Infliximab (27.4% originator; 14.4% biosimilar), Golimumab (6.8%) and Vedolizumab (8.7%). Five per cent of overall in-treatment patients changed treatment. Switch rates were: 8.5% from Infliximab originator to Vedolizumab, 3.6% from Golimumab to Adalimumab, 1.8% from Golimumab to Infliximab biosimilar, 12.8% from Infliximab biosimilar to Vedolizumab, 2.8% from Vedolizumab to Infliximab biosimilar, 4.5% from Infliximab originator to Infliximab biosimilar and 1.7% from Infliximab biosimilar to originator. Reasons for switching were inefficacy (61%) or treatment cost reduction (39%).

Conclusion Analysis showed a high variability in biological therapy prescription trends at the centre, which could be related to patients' characteristics. Even in the absence of clear comparison data between different treatments, clinical choices included all biological treatments approved in Italy, which were almost always effective and were associated with a low overall switch rate.

REFERENCES AND/OR ACKNOWLEDGEMENTS

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1ISG-034 A CRITICAL LOOK AT ERRONEOUS INCENTIVES AND LACKING LEGAL FRAMEWORK AS DRIVERS OF MEDICINES SHORTAGES AND OBJECTORS TO PROBLEM-SOLVING APPROACHES

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Background Medicines shortages deteriorate. No prompt solution is foreseen. Interest vary between stakeholder values and patient outcomes. More analyses will not contribute substantively to relief. Distinct contributions to the solution of problems are urgently needed.

Purpose This work aims to report on the causes and solutions of medicines' shortages.

Material and methods Twenty-three lead stakeholders were interviewed. Erroneous incentives and/or system shortcomings and potential to improve shortages prevalence were evaluated. Applied methodologies comprise qualitative research, system dynamics-aided simulation and best hospital pharmacy practices.

Results One-hundred and thirteen relevant causes of medicines' shortages and 126 approaches to improvement were issued in mind-maps.

Governments' actions are limited to epidemiology and responsibility for public health. The State monopoly serves to fix reference pricing. However, free trade is not touched while macro-economy runs satisfyingly. Commodity exchange of starting materials might be a break-out option. Dogmata such as Public Health as cost booster need revision. In fact, added values arising from healed patients being reintegrated into work processes should be validated.

Manufacturers do not opt for business without free trade and guidance-independent decision making. Unmet gain perspective and break-even induce deregistration for economic reasons. Upcoming personalised medicine requests precision medicine, whereas large-scale production is transferred to low-income countries, although quality, reliability and capacity are undoubtedly inferior. The construction of new production plants have to anticipate two upcoming decades. Precious APIs and products could be sustained by transfer to intermediate scale manufacturers.

(Pre-) wholesalers carry burdens of capital bound for stock-keeping. Replenishing is not compensated. GPS-aided medicines spotting from source to consumer might help to overview and warrant steady flow.

In the past, hospital pharmacy manufacturing has been reduced for economic reasons. Vulnerabilities in the supply chain and of patient outcome were not considered. The revised truly inspiring Swiss Act on Medicinal Products requests more independence and ability of hospital pharmacies to produce formula hospitalis and magistralis.

Conclusion Some stakeholders still have the best (i.e. unrestricted gains) and the worst alternatives (i.e. loss of reputation, unmet break-even points, new legislation with shifting tasks and responsibilities to the State) to voluntarily negotiated agreements. Therefore, negotiations led by a referee board and a true private/public partnership might markedly improve the availability of medicines.

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1ISG-035 URETERAL MAGNETIC CATHETER: AN EASY AND ECONOMICAL WAY TO REMOVE THE DEVICE

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Background During the urology device tender, a new ureteral catheter (UC) was proposed: the UROTECH's MAGNETIC BLACK-STAR kit, which is three times more expensive than the traditional UC (non-magnetic rigid polyurethane double loop UC). Its bladder side magnet allows its removal thanks to a magnetic recovery device. As this new technique is faster and requires no endoscope or re-sterilisable equipment, the additional cost of purchase would be offset during the withdrawal, and the discomfort would be reduced for the patient, according to the manufacturer.

Purpose We wanted to estimate the overall cost differences for our hospital between the BLACK-STAR UC and a traditional UC, and compare our results with an estimation made by the manufacturer to another hospital.

Material and methods The estimation is based on the time spent by the nurse and surgeon, and the exhaustive listing of the devices used during the removal procedure of the two UC, in men and women. The estimated costs of using re-sterilisable medical devices include depreciation and sterilisation. For the flexible endoscope, this was evaluated in 2015 in our hospital by also integrating the maintenance cost. As the placement technique is identical for both UC, the cost of the equipment used was not evaluated.