Material and methods We conducted a search of clinical trials of these drugs, phase III, double-blind, controlled with methotrexate or placebo, efficacy evaluated at 12 weeks or next, adults diagnosed with PP and uncontrolled disease with topical treatments and/or phototherapy. The 75% reduction in the Psoriasis Area and Severity index was used as the main variable (PASI75). An indirect comparison (IC) of cyclosporin versus fumarates and dimethylfumarate versus methotrexate was performed using the Bucher method, using the Indirect Treatment Comparisons calculator from the Canadian Agency for Health Technology Assessment. For cyclosporine with more than one published study, a previous meta-analysis was performed (Der Simonian–Laird method), using the Joaquin Primo calculator. Considering that the failure can be recovered with an effective second line, it was taken as delta value, for PASI75 the value in previous published studies of IC of biological in PP, 15%. The results were analysed graphically and the relative position of the 95% CI and the equivalence margin were observed. To establish the positioning, the ATE Guide was followed.

Results Included four clinical trials, two of ciclosporin, one of dimethylfumarate and one of fumarates. The acitretin studies were excluded because they did not meet the inclusion criteria. The difference in PASI75 expressed as RAR (IC95%) of methotrexate versus dimethylfumarate, and ciclosporin versus fumarates, was: 2.2% (-22,2;26,6) y 17 (-14,83;48,83). Applying the ATE Guide, methotrexate and dimethylfumarate can be declared ATE, being the probability of clinically relevant difference <50% (most of the 95% CI is in the equivalence range) and the failure does not involve serious/irreversible damage. Cyclosporine and fumarates could not be considered ATE (the RAR exceeded the delta with more than 50% probability so that the difference was clinically relevant).

Conclusion Dimethylfumarate and methotrexate could be considered ATE. Ciclosporin and fumarates could not be considered ATE. For a definitive statement of ATE, the criteria of safety and adequacy should be considered.

REFERENCES AND/OR ACKNOWLEDGEMENTS

No conflict of interest.

2SPD-003 MONITORING THE USE OF LINEZOLID IN A THIRD-LEVEL HOSPITAL

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Background The consequences of misuse of antibiotics can be very serious for patients and affect health systems and the community as a whole.

Purpose To analyse the evolution of linezolid (LNZ) consumption from 2009 to 2017 in general in the hospital and in critical care services (Anaesthesia-Resuscitation (A-R) and Intensive Care Unit (ICU)), and see if the introduction of the LNZ generic produced an increase in its use.

Material and methods Observational and retrospective study in a tertiary level hospital. The Farmatools program was used to obtain annual consumption from 2009 to 2017, both included, of the three available LNZ presentations (tablets, vials and oral suspension). The same information was obtained from the A-R and ICU services. The defined daily doses (DDD)/100 stays for the 9 years of the study were calculated on an annual basis. The differences in the LNZ consumption of each year with respect to the previous year were analysed in a general way for the hospital and for the A-R and ICU services. The introduction of the LNZ generic in the hospital was in 2016.

Results The table shows: (A)% variation of global LNZ consumption by years; (B) DDD/100 stays for years of LNZ; and% variation of consumption in A-R (C) and ICU (D) services. It is observed that as of 2015 there was a considerable increase in the consumption of LNZ. After analysing its use in critical patients, we observed that A-R increased consumption in 2017 (14.5%). In ICU there was a very significant increase (54.35%) during the year of availability of the generic and it was maintained during 2017. The introduction of the generic and the associated price decrease could relax the monitoring of the prescription of this antibiotic.

Conclusion The increase in LNZ consumption appeared one year before the availability of the generic. In the critical units, the consumption was affected differently, increasing in A-R less and one year later than in ICU, in which it increased very significantly and coinciding with the access to the generic. The introduction of the LNZ generic contributed, along with other factors, to explaining the increase in consumption of it in our hospital.

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No conflict of interest.

2SPD-004 DRUG CONSUMPTION DATA FOR GUIDING ANTIBIOTIC USE RATIONALISATION IN A SURGICAL DEPARTMENT

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Background An antibiotic stewardship programme was set up recently in the University Hospital.

As a first step we intended to assess antibiotic use and identify problematic areas.

Purpose The aim of the present study is to map antibiotic use in a tertiary care surgical unit.

Material and methods Data was collected on systemic antibiotics delivered from the central pharmacy to the department between 2010 and 2017. Antibiotics were classified according to the Anatomical Therapeutic Chemical index. Consumption was analysed by the WHO Defined Daily Dose (DDD) method, considering the new DDDs assigned and valid from January 2019. Consumption data in DDD was standardised for 100 patient-days. Quality was assessed by the DU90 method.

Results The antibiotic use of the surgical department was more than 20,000 DDDs each year with no particular trend in use, and in different years it was responsible for 14.5% and 16.8% of total systemic antibiotic use of the university.

The total antibiotic use in DDD/100 patient-days has decreased by 10% (from 80.7 to 72.0 DDD/100 patient-days), but mainly because of the increase in patient-days.

Mainly parenteral agents were used and this trend creeped up gradually (2010: 56.3%, 2017: 68.0%). Ten antibacterial agents were responsible for the DU90% segment in 2010 and nine in 2017. Metronidazole and cefuroxime (routinely administered for 2 days as surgical antibiotic prophylaxis in the study period) headed the top list in each year and they were responsible for 50% or more of total antibiotic use during the whole study period. Cefazolin use was very low despite the fact that it was the recommended first-line agent in combination with metronidazole for colorectal surgeries. Narrow spectra beta-lactamase-sensitive penicillin use was also marginal (below 1 DDD/100 patients-days).

Conclusion Our study showed a decrease in standardised antibiotic exposure but quality indicators revealed some suboptimal pattern (homogenous antibiotic use, lack of narrow spectra penicillin use, low use of recommended agents (e.g. cefazolin)). Stewardship intervention – aiming to further decrease antibiotic quantity – should first target the surgical antibiotic prophylaxis, while specific intervention should be implemented to optimise the pattern of antibiotic use.

REFERENCES AND/OR ACKNOWLEDGEMENTS

EAHP Position Paper on Antimicrobial Resistance (AMR).

No conflict of interest.

2SPD-005 ECONOMICAL ANALYSIS OF TENOFOVIR ALAFENAMIDE VERSUS TENOFOVIR-DISOPROXIL FUMARATE

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Background Due to the recent commercialisation of the presentations of Tenofovir Alafenamide (TAF) for HIV, there is a need to analyse the costs involved in its introduction into the public health system and its potential impact.

Purpose The objective of the study is to assess the cost of using TAF instead of tenofovir-disoproxil fumarate (TDF) in a public health hospital.

Material and methods A retrospective and descriptive study of all the patients who used TDF in their HIV treatment regimens from January 2018 to October 2018 was done. Data of the different treatment regimens for HIV containing TDF and adherence to treatment were collected. The TDF treatments regimens were replaced by their commercial equivalent with TAF and the hospital acquisition prices were compared. The cost for each patient was calculated according to TDF or TAF presentation and extrapolated to one year of treatment. The sources of information were the outpatient database and management of the hospital pharmacy service.

Results During the study period, 204 patients used TDF in their treatment regimen for HIV: 151 patients used TDF +emtricitabine + elvitegravir, 16 patients used TDF +emtricitabine + darunavir/cobicistat and 37 used TDF +emtricitabine + another third drug. The adherence to the treatment was 95%. The patient cost and its annual potential cost are summarised in the following table 1:

Abstract 2SPD-005 Table 1

	N° patients	Patient cost	Annual cost	Difference
TDF+emtricitabine +elvitegravir	151	€ 560,22	€ 1,015,118.64	
TAF+emtricitabine +elvitegravir	151	€ 726	€ 1,315,512	€ 300,393.36
TDF+emtricitabine +darunavir/cobicistat	16	€ 380,65	€ 73,084.8	
TAF+emtricitabine +darunavir/cobicistat	16	€ 918	€ 1 76 256	€ 103,171.2
TDF+emtricitabine+3° fármaco (not study)	37	€ 31.2	€ 13,852.8	
TAF+emtricitabine+3° fármaco (not study)	37	€ 314.3	€ 139.549.2	€ 125,696.4

Conclusion Almost 75% of patients with TDF used a treatment regimen with emtricitabine +elvitegravir. Adherence to the treatment was excellent. The consideration to switch TDF to TAF must take into account its associated cost due to the high impact that would imply.

REFERENCES AND/OR ACKNOWLEDGEMENTS

No conflict of interest.

2SPD-006 ECONOMIC IMPACT OF INFLIXIMAB BIOSIMILAR REFERENCING IN THE HOSPITAL

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Background Since biosimilar infliximab's arrival on the market in 2015, health authorities promote their prescription. The question arises of the medico-economic interest of the switch from an originator to its biosimilar in patients already treated. The NOR-Switch study gives us an answer in showing the non-inferiority of biosimilar CT-P13 against the originator in terms of effectiveness and tolerance. Since biosimilar (Inflectra) referencing in our hospital in 2015, all treatment initiations are done with the biosimilar and a switch is proposed to patients already treated with the originator (Remicade).

Purpose To evaluate the economic impact of introducing the biosimilar infliximab in our hospital.

Material and methods We made an evaluation between June 2015 (biosimilar arrival) and 2018 to measure the impact of this referencing. We used a prospective database since 2014 concerning all infliximab injections ((Remicade+Inflectra), patient, indication, number of vial per injection, cost).

Results Patients are treated in rheumatology (83%) and gastrology (17%): rheumatoid arthritis, Ankylosing spondylitis, Crohn's disease and haemorrhagic rectocolitis.

Since 2014, vial consumption (annual and by injection) of infliximab has risen (+8% per year, from 1641 vials to 2117).

The partition between biosimilar and originator has evolved since 2015: the biosimilar proportion has increased from 8% (160 vials) to 55% (1056). In addition to treatment initiation,