Conclusion

- Switching of BT in our hospital is common. The most frequent reasons were the loss or lack of response and the presence of adverse effects.
- In most of the cases, there was a change in the pharmacological target, although in recent published studies the proportion of TNF cyclers and MOA switchers is similar.[1]
- Despite the switching of BT, the rate of response was high.
- Switching BT meant an increase to our budget.

REFERENCES AND/OR ACKNOWLEDGEMENTS

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No conflict of interest.

5PSQ-077 COST-EFFECTIVENESS OF BIOSIMILAR ETANERCEPT IN CLINICAL PRACTICE USE

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Background Etanercept is a tumour necrosis factor (TNF) inhibitor indicated for active rheumatoid arthritis (RA) as monotherapy or in combination with methotrexate. Biosimilar drugs currently commercialised are Benepali and Erelzi.

Purpose To evaluate biosimilar etanercept effectiveness in patients with RA and calculate the saving due to use them versus the original drug.

Material and methods Retrospective observational study in a cohort of patients with RA treated with a biosimilar etanercept from January 2017 to August 2018. Data collected: drug, age, sex, dose, schedule, concomitant disease-modifying antirheumatic drugs (DMARD), previous biological drugs, treatment length, baseline and final disease activity score (DAS28). Data sources: electronic medical records and outpatients' electronic prescription. Costs considered were hospital average prices.

Results Thirty-two patients were included; but only 16 had DAS28 documented. 81.3% were female, median age 61 (IQR 50.75–66.75) years and median treatment duration 186 (IQR 107.25–263.75) days. All patients were treated with a concomitant DMARD. Baseline and final DAS28 means differences were statistically significant (p=0.002). 56.3% of patients were naive, whose DAS28 difference was statistically significant (p=0.006). Twenty-five per cent of patients received etanercept as a third line of treatment, with a DAS28 difference statistically not significant (p=0.496).

Eight (50%) patients received Benepali, 75% were female, median age 61 (IQR 54.00–66.25) years and median treatment duration 253.50 (IQR 212.50–418.50) days. Baseline and final DAS28 means differences were statistically significant (p=0.014).

Eight (50%) patients received Erelzi. 87.5% female, median age of 60.50 (IQR 46.00–69.00) years and median treatment duration of 143.50 (IQR 92.50–180.00) days. DAS28 difference was statistically not significant (p=0.068).

The use of biosimilar in these patients would suppose a saving of 27.47% versus the original drug (34.93% Benepali, 20% Erelzi).

Conclusion Effectiveness results were similar to the original drug. Both biosimilar drugs show a decrease in DAS28, although Erelzi was statistically not significant possibly because of its lower treatment length in this study. DAS28 difference was statistically significant in naive patients, however, in those who received more than two lines, there was not a decrease in this value.

The use of biosimilar drugs instead of original drugs entails an important saving.

These results require confirmation in long-term treatments.

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5PSQ-078 MORPHINE OVERDOSE FROM ERROR INFUSION RATE WITH INTRAVENOUS PUMP: FEEDBACK EXPERIENCE AND ACTION PLAN

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Background Syringe pumps (SP) are a vital tool for administering medicine, especially in palliative care. However, an infusion rate error can be fatal for patients. It is part of the 'never events' list (programming error of administration device).

Purpose An infusion rate error (7 mg/h administered versus 0.7 mg/h prescribed) on a SP of morphine in a palliative care patient was reported by the care team. The experience feedback committee (EFC) decided to clarify the error's circumstances in order to establish an action plan to prevent this error from ever happening again.

Material and methods The adverse event was analysed according to the Association of Litigation and Risk Management (ALARM) method.

The patient's medical file was investigated and six interviews with health professionals were conducted. We report successive steps of systemic analysis according to the ALARM process. Results of this analysis were presented at an EFC staff meeting and an action plan was established.

Results The immediate cause found was the infusion rate programming error of the SP. Five root causes were identified: SP installation; absence of using bolus function by nurses; lack of training for nurses; interruptions of tasks; and the delay between two infusion rate monitoring of the SP. An action plan has been drafted with seven main actions among which are: creation of simplifying instructions concerning SP's functions with the help of the biomedical unity and pharmaceutical laboratories, harmonisation of infusion rate monitoring in medicinal protocols and nurses training for intravenous devices used. For each of them a leader has been assigned and a deadline fixed.

Conclusion The infusion rate programming error of the SP is a 'never event' which requires the studying of causes and to establish preventive actions. The analysis of this adverse event and its presentation to the EFC led to the setting up of an action plan within our hospital. Such analysis helped to identify care management problems and their systemic causes. Thus it led to corrective measures in order to prevent such