Results Seventy-four patients, 64% men, mean age 58.6 years. All of them were high/very high CDV risk (stable or unstable coronary artery disease, ischaemic stroke, transient ischaemic attack or peripheral arterial disease). Eighty per cent presented baseline LDL-C levels higher than 150 mg/dL. Forty (54%) patients reached the targeted range for LDL-C. Thirty-four (46%) patients reached LDL-C levels >70. All of them started with 75 mg every 14 days. Only nine patients (27%) have increased the dose of praluent to 150 mg/14 days in the week 12.

Conclusion Dosage adjustments according to LDL-C levels should be followed closely to achieve better outcomes. The dose should be increased to 150 mg every 2 weeks at week 12 if LDL-C is greater or equal to 70 mg/dL at week 8. An adequate organisation and coordination between the different implicated medical services would be desirable, as the dates for monitoring LDL-C and the optimal monitoring interval are already established.

REFERENCES AND/OR ACKNOWLEDGEMENTS

Alirocumab: EPAR – Summary for the public. EMA
No conflict of interest.

4CPS-032 SKIN PROTECTION AND PREVENTION OF CUTANEOUS MYCOSIS

C Léger*, E Delandre, A Durand, A Chaupin-Prieur, L Caumette. *Centre Hospitalier des Vallées de L'Arège, Pharmacie, Saint-Jean de Verges, France*

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Background Skin protectors Dexeryl (D) and Bepanthen (B) contain petroleum derivatives (PD) such as petroleum jelly and paraffin. These substances may favour cutaneous mycosis by triggering an epidermidis pH imbalance and development of fungal infection.¹ This observation led our department to limit the use of D and B in favour of calcium hydroxyde liners (L) and care oil (O). In 2016, we initiated a change in practice by providing recommendations, analysis and follow-up of cutaneous topical prescriptions.

Purpose The purpose of this study was to determine if there is a correlation between the prescription of PD and the consumption of a topical antifungal, Econazole (E).

Material and methods Four-year retrospective analysis of consumption in a geriatrics ward:

- Skin protector with PD: D, B.
- Natural skin protector with: L, O.
- Topical antifungal: E.

Comparison of consumption over two periods (period 1: 2014–2015; period 2: 2016–2017) with the Mann–Whitney log rank test.

Results Average of mensual consumption, expressed in tubes (T):

- Period 1: B=117.5T (56; 177), D=52.4T (36; 103), E=79.4T (44; 121), L=2.5T (0; 24), O=171.5T (0; 337).
- Period 2: B=4.8T (0; 18), D=0.3T (0; 3), E=47.2T (22; 128), L=139.3T (59; 220), O=242T (153; 338).

The consumption of B, D, E and L were significantly different between these two periods ($p < 0.001$)

Conclusion A change in routine practice led to decreased consumption of B and D in favour of L. This correlated with a

significantly decreased c consumption of E. These results are in agreement with those of a case control study that shows that the use of PD promoted an increase in the incidence of systemic candidiasis.¹ From now on, B use is limited only to diaper dermatitis resistant to natural skin protectors in order to limit the risk of epidermitis deterioration. A prospective clinical follow-up is ongoing, with physicians from our department, to complete the data.

REFERENCE AND/OR ACKNOWLEDGEMENTS

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No conflict of interest.

4CPS-033 THE USE OF ORAL APREMILAST FOR THE TREATMENT OF PLAQUE PSORIASIS

¹MC Sánchez Argai, ²B Cancela Díez*, ²S Sadyrbaeva Dolgova, ³R Álvarez Sánchez, ¹MR Cantudo Cuenca. ¹San Agustín Hospital, Hospital Pharmacy, Linares Jaén, Spain; ²Virgen de Las Nieves University Hospital, Hospital Pharmacy, Granada, Spain; ³Campus de la Salud Hospital, Hospital Pharmacy, Granada, Spain

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Background The current treatment for psoriasis depends on the severity of the disease, in mild disease topical therapies alone, and with increasing disease severity in combination with phototherapy and/or traditional systemic therapy (methotrexate, cyclosporine, acitretin) or biologics agents.

Apremilast is a selective inhibitor of phosphodiesterase 4, able to down-regulate the inflammatory associated with psoriasis. An oral option for treating chronic moderate/severe plaque psoriasis (PP) in adults whose disease has not responded to other therapies or are contraindicated/not tolerated.

Purpose To report the hospital cases of moderate/severe PP treated with apremilast, describing patients' profile and analysing the efficacy and safety of apremilast.

Material and methods A retrospective case series. We reviewed the clinical history of the patients with moderate/severe PP treated with apremilast until August 2018.

To assess the severity of the disease: Psoriasis Area and Severity Index (PASI) or % of body surface area (BSA). Moderate disease: PASI ≥ 10 or 5%–10% of BSA; severe disease: PASI > 20 or BSA $> 10\%$. Adequate response to treatment: 90%, 75% or 50% reduction (improvement) from baseline in PASI score (PASI90, PASI75 or PASI50) at 16 weeks.

We investigated previous treatments from the beginning of the disease, analysed the efficacy of apremilast collecting the PASI or BSA scores at the beginning, after 16 and 32 weeks, and collected the adverse events during the treatment.

Results Eighteen patients, 83% men, mean age 52 (± 12) years. Three patients suffered PP and psoriatic arthritis. Previous treatment: 83% (15) topical therapies and 17% (three) phototherapy. Sixty-seven per cent (12) had received prior systemic therapy with conventional agents and 17% (three) biologic agents. At the start of apremilast: five patients suffered severe disease, nine moderate disease and one without data. Three patients were unmeasurable because of the recent start of apremilast. Sixty per cent (nine) of patients achieved PASI75/PASI90 from baseline at week 16, thirty-three per cent (five) PASI50% and 7% (one) without improvement. Maintenance improvement at week 32 (21% without data): 64%. During treatment six gastrointestinal adverse events, one atrial fibrillation and two cholesterol increased.