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

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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

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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.

Conclusion Almost all patients had received prior systemic therapy with conventional agents and/or biologics. The use of premilast has some advantages including oral administration, being well tolerated and with a safer profile. It will likely be of value to these patients and those who may not be candidates for biologics.

REFERENCES AND/OR ACKNOWLEDGEMENTS

No conflict of interest.

4CPS-034 USE OF USTEKINUMAB IN REFRACTORY PATIENTS OF PSORIASIS

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Background Ustekinumab is indicated for moderate to severe psoriasis (msPs) in patients who have had an inadequate response to systemic treatments.
Purpose To assess the effectiveness and safety of ustekinumab in our hospital patients with msPs refractory to tumour necrosis factor inhibitors (anti-TNFα).
Material and methods Descriptive retrospective study from January 2010 to September 2018 was developed. Patients with msPs had previously been treated with ≥2 anti-TNFα and received ustekinumab were selected. Farmatools application and digital clinical history were used to record variables: age, gender, previous treatment, therapy duration, treatment regimen and Psoriasis Area and Severity Index (PASI). Patients with weight ≤100 kg received subcutaneous ustekinumab 45 mg at week 0, 4 and 16, followed by 45 mg every 12 weeks, and patients with weight >100 kg received ustekinumab 90 mg. Effectiveness endpoint was PASI90 (≥90% reduction from baseline in PASI) and PASI75 (≥75% reduction from baseline in PASI) at 24, 48 and 96 weeks. Adverse reactions (AR) were collected to analyse safety.
Results In the study period, 36 patients with mean age 47.2 (24–78) years were included: 22 (61.1%) men and 14 (38.9%) women. Previous anti-TNFα treatments were: 28 (77.7%) patients with etanercept+adalimumab, four (11.1%) infliximab+etanercept+adalimumab, two (5.6%) infliximab+adalimumab, one (2.8%) infliximab+etanercept and one (2.8%) efalizumab+infliximab. Mean therapy duration was 30.7 (6–85) months. Thirty-four (94.4%) patients received ustekinumab 45 mg and two (5.6%) ustekinumab 90 mg. At baseline: 29 (80.5%) patients had PASI ≥12, two (5.6%) PASI=6, two (5.6%) PASI=4 and three (8.3%) PASI=2. At week 24 and 48: 24 (66.7%) patients achieved PASI90 and seven (19.4%) PASI75. At week 96, 35 patients were assessed (one withdrew from treatment for pregnancy): 20 (57.1%) patients achieved PASI90 and seven (20%) PASI75. No AR were reported.
Conclusion Ustekinumab was an effective treatment in more than half of our study patients with msPs refractory to ≥2 anti-TNFα, showing a response maintained for long periods of time (96 weeks). No patients recorded AR, so ustekinumab was safe in our hospital patients. Studies with a larger sample size and duration are necessary to assess the effectiveness and security of ustekinumab. The main limitation of our research was the limited number of patients.

REFERENCES AND/OR ACKNOWLEDGEMENTS

None.
No conflict of interest.

4CPS-035 PERSISTENCE AND SAFETY OF APREMILAST IN PSORIASIS

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Background Psoriasis is a disease that requires long-term treatment. Apremilast is indicated in the treatment of psoriasis in patients who have not responded or have contraindicated or cannot tolerate other treatment systemics. This drug has a lower accumulated specific organ toxicity, so it seems that it is the first oral systemic drug with which long-term treatments can be planned.
Purpose To estimate the persistence and safety of treatment with apremilast in patients diagnosed with psoriasis.
Material and methods Retrospective observational study of all patients with psoriasis who were treated with apremilast (January 2016 to September 2018). Demographic variables (age, sex) and variables related to the drug were collected (treatment start and discontinuation date, adverse reactions, causes of suspension and previous treatment). Persistence was defined as time (months) from the start of treatment until its discontinuation due to toxicity or inefficiency. Persistence was calculated with Kaplan–Meier survival curves (log rank test).
Results Forty-two patients (54.8% women) were included. Mean age was 46.5 years (SD=13,2). Previous therapies: topical (100%), methotrexate (38.1%), acycretin (30.9%), ciclosporin (23.8%) and etanercept (7.2%). Average of previous treatments/patient: 2 (1–3). Mean persistence was 19.4 months (95% CI 14.9 to 23.9). At the end of the study period, 69% (n=29) of patients continued with apremilast and 31% (n=13) were discontinued. The causes of suspension were inefficacy in 62% (n=8) and toxicity in 38% (n=5). The severe adverse reactions that required the suspension of treatment were: diarrhoea (one), migraine (one), low back pain (one) and psychiatric disorder (two). Two patients required dose reduction (30 mg/24 hour). The estimated median time of treatment until discontinuation due to toxicity is 3 months compared to 4 months for patients who leave treatment due to inefficiency. There are no statistically significant differences between the survival curves of the causes of abandonment of treatment with apremilast (p=0.532). After 15 months of treatment the probability of discontinuing treatment for any of the causes is maintained over time.
Conclusion The role of the pharmacist is essential in detecting the symptoms and signs of toxicity and ineffectiveness in the first year of treatment. Even so it would be of interest to extend the study time to analyse the long-term persistence.

REFERENCES AND/OR ACKNOWLEDGEMENTS

No conflict of interest.