(DDIs) but would be interesting to know which ones are real and have clinical outcomes.

**Aim and objectives** The main objective of the study was to determine the prevalence of real DDIs between immunosuppressants and other drugs in transplant patients. Secondary objectives were to evaluate clinical impact, categorise the type of DDIs, identify drugs involved and propose alternative therapeutic strategies.

**Material and methods** A prospective, observational 1 year study (February 2018 to February 2019) was conducted at a third level hospital, including all new transplanted patients. DDIs were detected by a computer application. To determine real clinical DDIs, patient medical records were reviewed, looking for data on monitoring blood concentrations of immunosuppressive drugs and adverse drug events (ADEs) caused by DDIs. DDIs were classified in C, D or X according to the Lexi interact score (C=monitor therapy, D=consider therapy modification, X=avoid combination). The clinical importance of the real DDIs was expressed in terms of patient outcomes: percentage of patients with ADEs due to real DDIs. Data were analysed using SPSS V.17.0 (Chicago, Illinois, USA).

**Results** A total of 309 transplant patients were included with a mean age of 52±14 years (13–79) and 69.9% were men. The prevalence of real DDIs was 21.68%. The number of real DDIs between immunosuppressants and other drugs was 71. The largest type of real DDIs was category D (52 (73.23%)).

Immunosuppressive drugs administered with antifungal azoles and tacrolimus with nifedipine had a great clinical impact due to the fluctuation in trough immunosuppressant blood concentrations (C₀) of the immunosuppressants.

The most common clinical outcomes were nephrotoxicity (12%), hyperkalaemia (10%) and hypertension (5%). Suggestions to avoid D and X for real DDIs included: immunosuppressant dose change, consider therapy modification and using paracetamol instead of non-steroidal anti-inflammatory drugs. A statistically significant linear correlation was detected between number of prescribed drugs and real and clinically important DDIs.

**Conclusion and relevance** There are many potential interactions described in the literature but only a small percentage have been proved to be real DDIs, based on patient outcomes, which were detected by determining the variations in C₀ of immunosuppressants and ADEs caused by DDIs. Few patients suffered ADEs due to the close pharmacokinetic monitoring of immunosuppressants. The results allow us to identify the pharmacological groups that caused real DDIs.

**REFERENCES AND/OR ACKNOWLEDGEMENTS**

No conflict of interest.
4CP-120  TEN YEAR ANALYSIS OF THE USE OF INFLIXIMAB IN ULCERATIVE COLITIS

G González De La Fuente*, F Gutierrez Nicolas, J González García, B Del Rosario García, I Cantarelli, J Ramos Rodríguez, GJ Nazco Casariego. Hospital Universitario De Canarias, Pharmacy, La Laguna, Spain

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Background and importance Analysis of data obtained in the ‘real world’ setting is acquiring great importance in the healthcare environment. It is important to know the results obtained with different treatments outside the ideal environment offered by clinical trials.

Aim and objectives To describe and analyse the results obtained with infliximab (IFX) over a 10 year period in patients diagnosed with ulcerative colitis (UC).

Material and methods This was a retrospective descriptive study conducted in a third level hospital that included all patients diagnosed with UC who started IFX treatment between January 2005 and December 2014. Follow-up was up to 31 July 2015. The following clinical data were recorded: age, sex, time in treatment, previous biological lines, definitive or temporary suspensions of treatment and reason, dose modifications and values for C reactive protein (CRP) before starting and at the end of treatment. Dosage modifications were recorded as those that implied a treatment pattern not described in the technical data sheet. Treatment interruptions were considered to be those of a duration ≥ 6 months. Data were recorded using the OncoWin computer application and the electronic medical record stored in SAP.

Results A total of 32 patients were included in the study (59.4% men, mean age 37.7 years (12–72)). Mean follow-up time was 52.5 months (8–109); 93.8% of patients received IFX as firstline therapy. Mean baseline CRP was 19.92 mg/L (0.70–84.94), and 7.82 (0.10–30.90) at the end of treatment. A total of 71% of patients discontinued treatment definitively: 6.3% for infusion reactions, 31.2% for inefficacy, 25.0% for remission of the disease and 9.4% for other reasons. In addition, 28.7% of patients received only the three IFX induction doses, of which 78% were not able to control the disease. Only 9.4% of patients temporarily interrupted treatment, with an average interruption time of 28.7 months (7–41); 12.5% of patients required dose modifications to control the disease.

Conclusion and relevance With the present work we wanted to show the long term results of IFX in UC in clinical practice. IFX can be an effective tool to control disease symptoms in the long term. Its use, administering only three induction doses, does not seem to be useful, with about 80% inefficiveness rate.

REFERENCES AND/OR ACKNOWLEDGEMENTS
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