4CPS-122 POTENTIAL OPTIMISATION OF TREATMENT WITH USTEKINUMAB IN CROHN'S DISEASE

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Background and importance According to the EMA product information, in Crohn's disease (CD), ustekinumab is dosed first by intravenous administration. Patients should then continue with 90 mg ustekinumab subcutaneous every 8 (q8W) or 12 (q12W) weeks depending on the response to treatment.

Aim and objectives To review the use of ustekinumab in patients with CD in a third level hospital and identify those with sustained remission that are susceptible to optimisation, evaluating the associated economic impact.

Material and methods This was a descriptive cross sectional study. Patients from the digestive medicine service under active treatment with ustekinumab in September 2019 and who were treated in the hospital outpatient pharmacy were included. Variables collected from the clinical history were: demographic (sex and age), pharmacotherapeutic (previous biological treatment, treatment time with ustekinumab, dosage) and clinical (response to treatment according to the prescriber). The response to treatment was classified based on the presence or absence of a sustained response (>4 months of symptomatic stability with the same dosage schedule). Additionally, the economic impact associated with optimisation of the administration interval in patients with a sustained response was determined.

Results Thirty patients with CD under active treatment with subcutaneous ustekinumab were included: 90% were men, with a mean age (range) of 48 years (18–75). The average time in treatment with ustekinumab was 11 months. The majority of patients had received at least one prior biological treatment (an integrin $\alpha 4\beta 7$ inhibitor drug (n=8), a tumour necrosis factor antagonist agent (anti-TNF) (n=15) and two anti-TNF (n=3)) and in two cases ustekinumab was the first biological therapy.

At the time of the study, the maintenance dose in the majority of cases was 90 mg q8W (n=23), followed by q4W (n=5) and q12W (n=2) administration. Nine patients (30%) were identified in whom clinical stability was observed in the last 4 months and, therefore, could be candidates for an extension of the dosage interval (from q4W to q8W (n=1) and from q8W to q12W (n=9)). A potential saving of 75 000€ (13%) was estimated in the event that the recommendation to optimise treatment was followed in 100% of patients with a sustained response.

Conclusion and relevance The most common drug regimen for ustekinumab in CD was 90 mg q8W. However, 17% of patients required intensification of the dosage. A significant number of patients showed clinical stability and could be candidates for treatment optimisation with close follow-up by the multidisciplinary team. Optimisation could mean significant economic savings.

REFERENCES AND/OR ACKNOWLEDGEMENTS

To my workmates.

No conflict of interest.

44CPS-123 EVALUATION OF ADHERENCE TO ORAL DISEASE MODIFYING THERAPIES IN PATIENTS WITH RELAPSING-REMITTING MULTIPLE SCLEROSIS

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Background and importance Adherence to treatment is a key factor in the control of symptoms of multiple sclerosis and the risk of relapses with adherence exceeding 80–85% is lower. Oral treatments can improve adherence.

Aim and objectives To evaluate adherence to oral disease modifying therapies (oral-DMT) in multiple sclerosis and to determine factors that can influence this adherence.

Material and methods This was a retrospective study of adherence to oral-DMT for multiple sclerosis, from 10 February 2017 to 10 March 2019, in a general university hospital with a reference population of 361 526 inhabitants. All patients who had been dispensed oral-DMT in the indicated period (with at least 6 months of treatment) were selected. Dates and amount dispensed to calculate the percentage of adherence and persistence of treatment, as well as demographic (sex, age) and therapeutic (previous treatments, treatment stopped, subsequent treatments) data were recorded. The data were analysed statistically with the SPSS programme V.24.

Results Eighty-seven patients, 56 (64.4%) women, with a mean age of 46 years (SD 13.3) were included: 45 (51.7%) were treated with fingolimod, 22 (25.3%) with teriflunomide and 20 (23%) with dimethylfumarate. The majority (68, 78.2%) had been treated previously with injectable DMT, 36 (52.9%) with one drug, 15 (22.1%) with two drugs and 17 (25.1%) with ≥ 3 drugs. Fifteen (17.2%) patients finished treatment during the study period. The mean adherence rate was 94.6% (SD 16.4): for fingolimod it was 93.2% (SD 18.9), for teriflunomide 99.2% (SD 11.4) and for dimethylfumarate 92.7% (SD 14.4). Five patients treated with fingolimod, three treated with dimethylfumarate and two treated with teriflunomide had adherence <80%, with no significant differences between the drugs. Mean persistence of treatment was 6.7 years (95% CI 6 to 7.3). We did not find statistically significant differences in adherence (in percentages or by classifying it as <80% or $\geq 80\%$) based on whether patients had been previously treated or based on the number of previous treatments. There was no correlation between percentage adherence and duration of treatment.

Conclusion and relevance We observed high adherence to oral-DMT with a mean rate of 94.6%. Only 10 (11.5%) patients had adherence <80%. This value is higher than those observed with injectable DMT (41–88%) and similar to the values obtained with oral drugs. Moreover, persistence of treatment was long.

REFERENCES AND/OR ACKNOWLEDGEMENTS

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