4CPS-149 INITIAL THERAPY FOR NEOVASCULAR AGE RELATED MACULAR DEGENERATION: ARE THE GUIDELINES MET IN CLINICAL PRACTICE?

¹M Hernando Verdugo*, ¹E Queipo García, ¹A Pariente Junquera, ²MI López Gálvez, ¹MT Sánchez Sánchez. ¹Hospital Clínico Universitario De Valladolid, Pharmacy, Valladolid, Spain; ²Hospital Clínico Universitario De Valladolid, Ophthalmology, Valladolid, Spain

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Background and importance The current clinical practice guidelines for the treatment of neovascular age related macular degeneration (nAMD) consist of a loading phase of 3 monthly intravitreal injections of anti-VEGF drugs, followed by individual maintenance pattern.¹ The treatment of choice is ranibizumab. The response to treatment is conditioned by the time elapsed between diagnosis and initial treatment.²

Aim and objectives To analyse the time elapsed between diagnosis and initial treatment in patients with nAMD and to assess compliance with the loading phase.

Material and methods This was an observational retrospective study in patients diagnosed with nAMD who began treatment with anti-VEGF drugs in 2018. Data collected were age, sex, affected eye, neovascular membrane, best corrected visual acuity (BCVA), drug, date of diagnosis and dates of administration of three loading doses. Patients treated bilaterally were counted as two different treatments.

Results Eighty patients were included (61.3% women, 38.7% men) with a mean age of 80.3±8.1 years. Eighty-three eyes were treated: 48.2% (40/83) right eye and 51.8% (43/83) left eye, and 84.3% (70/83) received ranibizumab, 12.0% (10/83) bevacizumab and 3.7% (3/83) aflibercept. Location of the neovascular membrane was subfoveal in 53.0% (44/83), juxtafoveal in 31.3% (26/83) and undefined/unknown in 15.7% (13/83).

Mean BCVA in the right and left eyes were 0.9±0.8 logMAR and 0.8±0.6 logMAR, respectively. Median number of days between diagnosis and first dose was 17 days (0–59), 32 days (18–193) between the first and second doses and 32 days (18–130) between the second and third doses.

Conclusion and relevance

- There was a delay between diagnosis and initial treatment of about 2 weeks, similar to that observed in other studies.² It would be necessary to reduce this time to achieve better vision outcomes.
- The time interval between the three loading doses was considered acceptable. It is important to meet this initial treatment regimen to obtain good results in terms of visual acuity.¹ It would be interesting to evaluate the real clinical benefit in these patients.

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No conflict of interest.

4CPS-150 ASSESSMENT OF BURDEN OF DISEASE IN TERMS OF HEALTH RELATED QUALITY OF LIFE IN PATIENTS WITH MULTIPLE MYELOMA NOT ELIGIBLE FOR AUTOLOGOUS STEM CELL TRANSPLANTATION

¹O Delgado Sanchez*, ²A Domingo, ³J De La Rubia, ⁴A García, ⁵A López, ⁶C Seguí, ⁷L Rumi, ⁸A Mengual, ⁹G Lostaunau, ¹⁰MV Mateos. ¹Hospital Son Espases, Pharmacy Department, Palma De Mallorca, Spain; ²Hospital General De Granollers, Haematology, Granollers, Spain; ³Hospital Dr Peset, Haematology, Valencia, Spain; ⁴Hospital Arnau De Vilanova De Lleida, Haematology, Lleida, Spain; ⁵Hospital Arnau De Vilanova De Valencia, Haematology, Valencia, Spain; ⁶Hospital General De Granollers, Pharmacy Department, Granollers, Spain; ⁷Hospital Arnau De Vilanova De Lleida, Clinical Trials Unit, Lleida, Spain; ⁸Hospital Arnau De Vilanova De Valencia, Pharmacy Department, Valencia, Spain; ⁹Celgene Slu, Medical Affairs, Madrid, Spain; ¹⁰Hospital Universitario Salamanca, Haematology, Salamanca, Spain

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Background and importance Multiple myeloma (MM) is an incurable disease that is associated with severe symptoms affecting health related quality of life (HRQoL). Here we report the impact of treatment on disease burden in terms of HRQoL and direct health costs.

Aim and objectives Primary endpoints were HRQoL (baseline and at 5 months), reported by EuroQol-5D (EQ-5D) and QLQ (quality of life questionnaire)-C30/QLQ-MY20 questionnaires and direct health costs.

Material and methods QoLMMBuS (NCT 02946333) is an ongoing, prospective, observational study conducted in 53 Spanish sites in patients with MM not eligible for autologous stem cell transplantation (ASCT). The interim cut-off date was November 2018.

Results A total of 161 evaluable patients were enrolled between November 2016 and October 2018. Median age (range) was 77.6 (73.9–82.6) years, 44.7% were men, and 57.8% of patients had Eastern Cooperative Oncology Group (ECOG) stage 0/I, 41.6% stage II (R-ISS), 66.2% disease isotype IgG and 33.1% disease isotype IgA. High risk cytogenetics were detected in 18% of patients. In total, 156 patients received lenalidomide (32.0%) or bortezomib (68.0%) as first-line therapy. With a median follow-up of 5.0 months (3.5–11.1), response rates were: complete response in 17.9%, very good partial response in 28.4%, partial response in 38.8% and progression of disease in 1.5%: 61.5% of patients remained on firstline therapy. EQ-5D and QLQ C30 (at 5 months) showed an increase in HRQoL mean values for the key domains of global health status/QoL, physical, role and emotional functioning, although patients experienced worsening in dyspnoea (p=0.003). The mean QLQ-MY20 values showed a significant improvement for the domains of disease symptoms (p=0.037) and future perspective (p=0.010) and worsening for side effects and body image. A total of 56.4% patients experienced at least one adverse event and 77.8% and 79.9% of patients went to visit their doctor or outpatients, respectively. Hospital admissions reported were 154 with a mean (SD) time of 18.3 days for hospitalised patients. Mean direct cost of hospitalisation/patient was 6670.9 €. Annual mean cost was 13 748€ per patient and 48.5% of the cost was related to hospitalisation.

Conclusion and relevance Lenalidomide and bortezomib were the main drugs used as firstline treatment of MM patients not

eligible for ASCT. These preliminary analyses indicate that patients experienced a significant improvement in disease symptoms and future perspective and a significant worsening in dyspnoea within the first months, with lower impact on direct health costs over time. The efficacy and safety profile remained favourable at the time of analysis.

REFERENCES AND/OR ACKNOWLEDGEMENTS

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4CPS-151 THE IMPACT OF AN INTEGRATED ELECTRONIC MEDICAL RECORD ON THERAPEUTIC DRUG MONITORING

P Firman*. *Royal Brisbane and Women's Hospital, Pharmacy Department, Royal Brisbane Hospital, Australia*

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Background and importance Healthcare is currently undergoing a transformation to a digital platform and implementing an integrated electronic medical record (ieMR). The ieMR delivers an integrated suite of digital services that improve safety, efficiency and quality in clinical workflow processes. This is changing the future of healthcare and the roles of healthcare professionals. The changing face of the healthcare system is an opportune time to review current processes. Therapeutic drug monitoring (TDM) is currently planned and ordered by medical officers at an outer metropolitan hospital. The role of the pharmacist is sporadic. There is currently minimal data about the impact of a digital hospital system on traditional roles and current processes within the healthcare system.

Aim and objectives To review the impact of ieMR on the TDM process within an outer metropolitan hospital.

Material and methods A retrospective audit was conducted on TDM over two 12 month periods. The periods were 2016 (a paper based hospital system) and 2018 (a digital hospital system). Patients were identified using the electronic pathology database. Patients were excluded if <18 years of age, it was an outpatient setting or within the emergency department. Progress notes, medication charts, ieMR and other relevant pathology were reviewed. They were assessed for appropriateness of the timing of collection, compliance to recommended TDM guidelines and the documented involvement of the pharmacist.

Results There were 10 medications included in the study, which covered 1686 and 1251 tests in 2016 and 2018, respectively. Of these, 40.6% at cost of \$AUD15 999.43 were collected at an inappropriate time in 2016 and 41.9% at a cost of \$AUD11 545.27 in 2018, making interpretation difficult. There was documented pharmacist advice in 8.6% in 2016 and in 13% in 2018 of all TDM results. The TDM function in ieMR was only used in 3% of all tests.

Conclusion and relevance TDM has a large impact on the therapy and outcome of patients. This review demonstrated

that ieMR did not have a significant impact on TDM and demonstrated a minimal role for the pharmacist. These preliminary results showed that a review of the current TDM process is required and with their drug and pharmacokinetic knowledge, a greater impact and role of the pharmacist is required.

REFERENCES AND/OR ACKNOWLEDGEMENTS

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4CPS-152 ANALYSIS OF PHARMACEUTICAL INTERVENTIONS IN THE EXCHANGE OF THERAPEUTIC EQUIVALENTS

S Nuñez Bracamonte*, MC González Pérez-Crespo, E Conesa Nicolás, C Juez Santamaría, A Lloret Llorca, CN García Matillas, I Fernández Martínez, JM Montoya Egea. *Hospital General Universitario Santa Lucía, Farmacia Hospitalaria, Cartagena, Spain*

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Background and importance Therapeutic equivalents are drugs with a different chemical structure but with similar therapeutic and adverse effect profiles when equivalent doses are administered.

Aim and objectives To analyse the pharmacotherapeutic interventions of proposing therapeutic equivalents (PIPTes) for prescribed not included in the pharmacotherapeutic guide medications (NIGM), as well as their degree of acceptance.

Material and methods A retrospective observational study was carried out over a period of 2 months. The PIPTes were realised during pharmaceutical validation. The following items were collected: age, sex, prescribed NIGM, acceptance of the PIPTe (it was considered accepted when changes were generated in the prescription), measure adopted by the doctor (change to the proposed equivalent, change to another equivalent, patient contribution or suspension of treatment) and the medical service.

Results A total of 211 patients (122 men) with a median of 76 years (20–98 years) were reviewed. A total of 2197 interventions were performed: 1294 (58.9%) were about NIGM. Of these, 228 (17.62%) were PIPTes, with the following distribution according to pharmacotherapeutic group: 78 (34.21%) ARA-II, 65 (28.5%) ACEIs, 34 (14.91%) statins, 32 (14.05%) calcium antagonists, 5 (2.19%) PPIs, 1 (0.44%) anti-H2 and 13 (5.7%) of other groups.

Most of the PIPTes were accepted (79.82% (182)). The degree of acceptance of each pharmacotherapeutic group was: 79.49% (62) for ARA-II, 89.23% (58) for ACEIs, 73.53% (25) for statins, 75.0% (24) for calcium antagonists, 40.0% (2) for PPIs, 100% (1) for anti-H2 and 69.23% (9) for other groups.

In 52.19% (95) of cases, the proposed therapeutic equivalent was changed (25 ARA-II, 41 ACEIs, 13 calcium antagonists, 10 statins, 2 PPIs, 1 anti-H2 and 3 other groups). In 25.82% (47) of patients the drug was contributed by the patient, 14.84% (27) were suspended and 7.14% (13) were changed to a drug different from the one proposed.

Conclusion and relevance The majority of the interventions performed by pharmacists were in relation to NIGM. ARA-II and ACEIs were the groups with the highest number of PIPTes. More than 75% of the PIPTes caused a change in the prescription, which resulted in more than 50% of cases substituting the NIGM for the equivalent proposed by the pharmacy service. This reflects the great contribution of the hospital pharmacist to therapeutic exchange programmes.