

post-treatment (NRPT). Data were collected from medical records and the electronic prescription programme. Effectiveness was evaluated in terms of NRPT with alemtuzumab. Safety was assessed by reported treatment of AE.

**Results** Eleven patients, 63.6% women, mean age 38 (24–54) years, were included. Median time from RRMS diagnosis was 10 (4–20) years and mean baseline EDSS was 3.5 (2–5.5).

Patients were previously treated with a median of 3 (2–4) drugs: interferon beta-1a (IFN $\beta$ -1a) intramuscularly (45.5%), IFN $\beta$ -1a subcutaneously (27.3%), glatiramer acetate (27.3%), natalizumab (90.9%), fingolimod (27.3%) and dimethyl fumarate (18.2%). Seven patients completed two courses of alemtuzumab, and the second course is pending in three patients. One administration was suspended due to an infusion related reaction (IRR), requiring intensive care. The mean relapse rate was 0.36 (0–2). All patients experienced IRRs: lymphopenia (63.6%) and skin disorders (72.7%). Most were mild and limited in time, except for one patient with skin rash, pruritus and oedema, requiring discontinuation of treatment. Other AE were urinary tract infection (18.2%) and herpes zoster infections (9.1%).

**Conclusion and relevance** According to our results, alemtuzumab was effective in clinical practice due to a low relapse rate. However, further studies with a larger number of patients are needed to confirm these results. IRRs were frequent. Nevertheless, AE were mild and well tolerated.

#### REFERENCES AND/OR ACKNOWLEDGEMENTS

None.

No conflict of interest.

#### 5PSQ-062 EFFECTIVENESS OF ADALIMUMAB IN INFLAMMATORY BOWEL DISEASE AND INFLUENCE OF RESPONSE TO FIRSTLINE TREATMENT

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**Background and importance** Adalimumab is an antitumour necrosis factor- $\alpha$  (anti-TNF) agent indicated in ulcerative colitis (UC) and Crohn's disease (CD). Primary non-response to anti-TNF has been suggested as predictive of poor response to re-treatment with another anti-TNF.

**Aim and objectives** To assess the effectiveness of adalimumab as the second anti-TNF agent administered, evaluating the influence of response to the first anti-TNF agent.

**Material and methods** A descriptive retrospective study to July 2019 was conducted. All patients with inflammatory bowel diseases (IBD) treated with adalimumab as the second anti-TNF agent were selected. Variables collected were age, gender, diagnosis, previous anti-TNF therapy, reason for switch, response to anti-TNF, therapy duration and Mayo clinic score (MCS). Effectiveness was measured by MCS at 12, 36 and 60 months. Clinical remission (R) was MCS  $\leq$  2 points, clinical response (CR) was a decrease from baseline in MCS  $\geq$  3 points and lack of response (LOR) was none of the above. Patients with LOR and treatment suspension in 1 week were considered as LOR in the following weeks. Influence of response to the first anti-TNF agent was evaluated using the relationship between types of response to the first and second treatments. Primary non-response to anti-TNF was defined as LOR after induction of anti-TNF treatment: before week 10

for infliximab and before week 4 for adalimumab. Secondary non-response to anti-TNF treatment was considered as LOR after induction therapy.

**Results** Fifty-eight patients were included: 39.6% men and 60.4% women. Mean age was 41.6 (86–17) years. Diagnoses: 34.5% UC and 65.5% CD. All patients were pretreated with infliximab (first anti-TNF). Switching to adalimumab was caused by: 2 (3.4%) primary non-response, 45 (77.6%) secondary non-response and 11 (19%) intolerance. Mean adalimumab treatment duration was 29.7 (1–120) months. MCS at 12 months: 43.9% R, 19.3% CR and 36.8% LOR. MCS at 36 months: 29% R, 7.9% CR and 63.1% LOR. MCS at 60 months: 22.9% R, 2.8% CR and 74.3% LOR. One patient with primary non-response to infliximab (1/2, 50%) presented primary non-response to adalimumab; and another with secondary non-response to infliximab (1/45, 2.2%) had primary non-response to adalimumab.

**Conclusion and relevance** Adalimumab showed long term effectiveness in IBD patients pretreated with another anti-TNF, maintaining >20% of patients in clinical remission at 60 months. Adalimumab's primary non-response proportion was lower in patients with secondary non-response to a first anti-TNF than in those who had a primary non-response, but studies with larger sample sizes are necessary.

#### REFERENCES AND/OR ACKNOWLEDGEMENTS

No conflict of interest.

#### 5PSQ-063 SERIOUS CELLULITIS IN A PATIENT WITH ATOPIC DERMATITIS TREATED WITH BARICITINIB: A CASE REPORT

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**Background and importance** Baricitinib is an orally available inhibitor of Janus kinases that is used to treat moderate to severe rheumatoid arthritis. In the literature, baricitinib seems to be an alternative in dermatologic diseases as off-label treatment. The baricitinib technical sheet describes that the most frequent serious infections in clinical trials were herpes zoster and cellulitis.

**Aim and objectives** To describe a severe case of cellulitis in a patient with atopic dermatitis previously treated with baricitinib.

**Material and methods** This was a descriptive, retrospective clinical case. The data (diagnostic tests, therapy and clinical course) were obtained by review of electronic medical records.

**Results** A 63-year-old man with hypertension and diabetes mellitus was diagnosed with severe atopic dermatitis in 2017. Previous treatments for atopic dermatitis were corticosteroids, ciclosporin, methotrexate and apremilast, all suspended due to lack of efficacy or adverse reactions. Treatment with baricitinib was initiated after being processed by our hospital pharmacy and authorised by the medical director, in May 2019.

Four months later, the patient was admitted to the traumatology service for severe extensive cellulitis with associated phascitis and pharmacological immunosuppression (lymphocyte count in the first determination was  $0.51 \times 10^3/\mu\text{L}$ ). Baricitinib was suspended and empirical antibiotic therapy was started with meropenem and linezolid. In addition, the patient