modifying antirheumatic drugs (bDMARDs) are used to slow down disease progression.

Aim and objectives To analyse the reasons for treatment discontinuation with biological drugs in patients diagnosed with rheumatoid arthritis in our hospital.

Material and methods A retrospective study was performed in which all patients diagnosed with rheumatoid arthritis treated with biological drugs at some point (between 2007 and 2016) were included. Data on biological drug dispensations, causes of treatment discontinuation, sex and age of the patients were collected. We use Excel to analyse the data.

Results 136 patients diagnosed with rheumatoid arthritis treated with a biological drug were included, with a total of 251 treatments (85 etanercept, 50 infliximab, 48 adalimumab, 23 abatacept, 11 certolizumab, 7 golimumab and 5 tocilizumab). Patients received a median of 1.8 biological drugs (range 1–6 drugs). Mean patient age was 41.12 ± 11.33 years, and 81.9% of all patients were women. 103 patients discontinued therapy at some point in their treatment with the prescribed biological drug, corresponding to a total of 196 of 251 (78.1%). 33 patients continued with the same drug that they started treatment. 63 (74.1%) discontinuations were due to etanercept, 41 (82.0%) to infliximab, 39 (81.2%) to adalimumab, 16 to abatacept (69.6%), 20 to rituximab (90.9%), 7 to certolizumab (63.6%), 5 to golimumab (71.4%) and 5 to tocilizumab (100%). The main causes of treatment discontinuation were adverse events (29.6%), followed by secondary failure (24.5%) and primary failure (18.4%). Other reasons were patient reasons (3.6%), patient's illness (3.6%), remission (3.1%) and immunogenicity (1.5%). 14.8% of discontinuations were unknown. Allergic or skin reactions were the most common adverse events.

Conclusion and relevance Certolizumab was the biological drug with the lowest discontinuation rate, followed by abatacept, golimumab and etanercept. Among the different reasons for treatment discontinuation with biological drugs, adverse effects were the main cause (29.8%), with about 50% related to allergic or skin reactions.

REFERENCES AND/OR ACKNOWLEDGEMENTS

Conflict of interest No conflict of interest

5PSQ-180 IMPACT OF SEDATIVE DRUGS ON VITAL SIGNS DURING PROCEDURAL SEDATION AND ANAESTHESIA: A RETROSPECTIVE COHORT ANALYSIS

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Background and importance Anaesthetic drugs are vital during surgical procedures to lower patient discomfort but they carry significant risks for adverse events. Regular follow-up of patterns in anaesthetic related adverse drug events (ARAEs) is therefore required.

Aim and objectives To examine ARAE occurrence and trends during procedures (gastro-/colonoscopy (GCS), cardiac ablation (CA)) requiring general anaesthesia in a university hospital.

Material and methods Inclusion criteria were: adult patients undergoing GCS or CA between 1 July 2017 and 30 June

2019. Retrieved procedures were chronologically sorted after which a 10% randomised sample was taken, and stratified according to procedure, age and gender. For each patient, characteristics were retrieved from the medical file, including risk score, home medication (HM), premedication, procedure characteristics (eg, used anaesthetics/antidotes, anaesthesiologist's experience, timing) and whether ARAEs occurred (oxygen saturation <90%, blood pressure drop $\geq 20\%$, bradycardia <45 beats/min and apnoea). Predictors were selected using Spearman analysis, retaining variables with $p < 0.2$, which were then entered in a stepwise backward logistic regression. A times series analysis was done to assess time dependent trends.

Results 1355 CAs and 1475 GCSs were retrieved, leading to 283 (135 CA/148 GCS) procedures selected for analysis, with 44 (15.5%; 37 CA/7 GCS) anaesthesia files incomplete or missing. Most patients experienced at least one ARAE (174/239) with the majority experiencing low blood pressure (169/174), followed by bradycardia (15/174), oxygen desaturation (3/174) and apnoea (1/174). When looking at predictors for any ARAE, use of inhalation anaesthetic (OR 2.74; $p = 0.024$) and midazolam premedication (OR 5.03; $p = 0.035$) were the most important, with opioid HM also showing a trend (OR 7.49; $p = 0.054$). For bradycardia, patients receiving amiodarone/verapamil HM (OR 5.70; $p = 0.034$) or with an inhalation anaesthetic (OR 5.36; $p = 0.003$) had a higher risk, while ACE inhibiting HM increased the desaturation risk (OR 73.32; $p = 0.046$). Regarding low blood pressure and apnoea, no patient or procedure related factors could be found. Time series analysis revealed no time dependent trends in ARAE occurrence or incomplete files.

Conclusion and relevance The impact of ACE inhibitors on ARAEs is well described, with a preprocedural stop suggested. However, long term consequences are not clear. Furthermore, preprocedural midazolam may need to be reviewed, as other measures to decrease anxiety are also effective. Finally, increased attention to anaesthesia documentation is needed.

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5PSQ-181 IS INSTANT ALWAYS BETTER? PHARMACOKINETICS OF TABLET VERSUS GRANULATE FORMULATION OF PARACETAMOL IN FRAIL OLDER ADULTS

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Background and importance Pain is highly prevalent in old, frail adults with paracetamol as the mainstay treatment. Pain management is regularly suboptimal and using different paracetamol formulations might improve pain control. It is not