initiated treatment with IL-17 inhibitors. Data of sex, age, diagnostic, previous biological treatment, start date and last dispensation date were collected.

Il-17's persistence was calculated in months using the Kaplan–Meier method and log-rank test to compare the survival along diagnostic, drug and line of treatment using SPSS Statistics, considering a p value <0.05.

Results A total of 80 patients were included (33 with ixekizumab (60% Ps, 40% PsA) and 47 with secukinumab (49% Ps, 51% PsA). 36% were men, median age 54 (IQR 42–60) years. 31.25% were treated as first line, 13.75% as second line and 55% at third line or more with a median of two previous biological drugs.

46.25% discontinued treatment during the study (60% ixekizumab, 50% secukinumab). 55% of patients had been treated for more than a year with IL-17 (35% of them for more than 2 years) and the rest 45% interrupted treatment before completing a year (58% for less than 6 months).

IL-17's persistence was 24.1 months (95% CI 17.9 to 30.2) vs 30.9 months (95% CI 24.3 to 37.4) for ixekizumab and secukinumab, respectively, and did not show a significant difference (p=0.774).

Comparing between groups, there were no differences in ixekizumab's persistence in Ps vs PsA (24.5 vs 14.2 months, p=0.97), secukinumab's persistence in Ps vs PsA (32.5 vs 24.3 months, p=0.6), Ps' persistence of ixekizumab vs secukinumab (p= 0.79) and PsA's persistence of ixekizumab vs secukinumab (p=0.83). Regarding the persistence of the treatment line this was similar in each group, and did not show any statistical differences.

Conclusion and relevance Both IL-17 inhibitors show a similar and considerable persistence of nearby 30 months globally. No significant differences were found either between between the drugs, diagnostics nor line of treatment.

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Conflict of interest No conflict of interest

5PSQ-094 REASONS FOR DISCONTINUATION OF SELECTIVE IMMUNOSUPPRESSIVE BIOLOGICAL TREATMENTS AGAINST PSORIASIS

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Background and importance Psoriasis is a chronic inflammatory skin disease. Pharmacological therapy in moderate-severe psoriasis requires systemic hospital-dispensed treatments (SHDT) whose objective is to improve quality of life.

Aim and objectives The primary endopoint of the study was to determine the cause for discontinuity (CD) of SHDT against psoriasis. The secondary objective was to analyse the CD by drug.

Material and methods An observational, descriptive and retrospective study was carried out on the population diagnosed with psoriasis and SHDT between 2016 and 2020 under follow-up by dermatology at our hospital. Data were obtained from the medical records and prescription medications program.

The CDs were grouped into seven items: lack/loss of efficacy, lack of adherence, patient decision, unacceptable toxicity, loss to follow-up, death, and others.

The drugs included were: adalimumab, apremilast, brodalumab, certolizumab pegol, etanercept, guselkumab, infliximab, ixekizumab, risankizumab, secukinumab, tildrakizumab and ustekinumab.

Results 205 SHDTs for psoriasis were reviewed: 70 ustekinumab, 37 adalimumab, 28 secukinumab, 24 apremilast, 15 etanercept, 15 ixekizumab, 9 guselkumab, 4 brodalumab, 2 infliximab and 1 tildrakizumab. 86 treatment discontinuations were described: 53.5% lack/loss of effectiveness, 20.9% lack of adherence, 10.5% loss of follow-up, 7% other reasons, 4.7% unacceptable toxicity, 4.7% death and 3.5% patient decision.

51.2% of the incidents were with ustekinumab. 17.4% of discontinuations occurred in the adalimumab group, 9.3% apremilast, 9.3% etanercept, 9.3% secukinumab, 2.3% infliximab and 1.2% guselkumab.

100% of the infliximab discontinued treatments were due to lack of adherence, 100% of the treatment discontinuities due to unacceptable toxicity were associated with apremilast, and 100% of the losses to follow-up were detected in ustekinumab.

Conclusion and relevance The main CD in SHDT for psoriasis in our centre is due to lack/loss of response. Ustekinumab has been the drug that has registered the most discontinuations and losses to follow-up; this is explained by it being the treatment with the highest prevalence in the study. Visiting the hospital for infliximab administration has been shown to reduce adherence and interrupt treatment in patients who receive it.

The increment in SHDT that appeared in recent years to treat psoriasis increases the therapeutic options. Knowing the main CD of the different drugs and the characteristics of the patients helps to individualise the treatment.

REFERENCES AND/OR ACKNOWLEDGEMENTS

Conflict of interest No conflict of interest

5PSQ-095 COMPARISON BETWEEN THE MAXIMUM RECOMMENDED DOSE OF AZATHIOPRINE ACCORDING TO THE ENZYMATIC ACTIVITY OF THIOPURINE METHYLTRANSFERASE AND 6-THIOGUANINE LEVELS WITH THE MAXIMUM TOLERATED DOSE

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Background and importance Azathioprine (AZA) is an analogue of purines used in inflammatory bowel disease (IBD) treatment. AZA is transformed by thiopurine methyltransferase (TPMT) into its metabolites,including 6-methylmercaptopurine (6-MMP) and 6-thioguanine (6-TGN).

Aim and objectives (1) Compare the maximum recommended dose of AZA according to TPMT activity and the maximum

tolerated dose (MTD), (2) evaluate the MTD and 6-TGN levels and (3) analyse the prevalence of each activity of TPMT.
Material and methods Retrospective observational study in patients with IBD treated with AZA and determination of TPMT activity between February 2017 and May 2021. Demographic, clinical data, metabolites (6-TGN (target 300–550 pmol/0.2 mL) and 6-MMP) and phenotype (activity of TPMT (IU/mL), determined by HPLC) were collected. AZA dosage was adjusted according to TPMT activity: treatment not recommended (poor; TPMT <5.0 IU/mL)), 0.5 mg/kg (low; TPMT 5.1–13.7 IU/mL), 5 mg/kg (intermediate; TPMT 13.8–18 IU/mL), 2.5 mg/kg (moderate; TPMT 18.1–26.0 IU/mL) and 3.0 mg/kg (high activity; TPMT 26.1–40.0 IU/mL).
Results 131 patients were included, 61 (46.6%) women, mean age 34.7(SD 17.4) years. TPMT phenotype: low activity in 19 (14.5%) patients, intermediate activity 54 (41.2%) and moderate activity 58 (44.3%).

When analysing the dosage, in 30 (22.9%) patients the dosage according MTD was higher than according to the activity of TPMT, in 43 (32.8%) it was lower and in 58 (44.3%) it was within the range.

6-TGN levels in the patients receiving the MTD were higher than recommended in 35 (26.7%) patients, lower in 24 (18.3%) and within range in 72 (54.9%). Median 6-MMP/6-TGN ratio was 1.57 (SD1.7) in patients with 6-TGN levels <300 pmol/0.2 mL and only 3 (2.3%) had a ratio >4.

Mean serum creatinine was 0.70 (SD 0.35) mg/dL. Patients' renal function did not interfere in the elimination of AZA metabolites.

AZA posology was decreased in 31 (23.7%) patients and withdrawn in 22 (16.8%) due to adverse events. Most frequent adverse events detected were: digestive intolerance in 10 (7.6%) patients, leukopenia 7 (5.3%), lymphopenia 5 (3.8%), hypertransaminasaemia 4 (3.1%) and nausea 3 (2.3%).
Conclusion and relevance The phenotypes of intermediate and moderate activity of TPMT were the most prevalent. 6-TGN levels were high in almost a quarter of patients, increasing the risk of toxicity. In half the patients, the recommended dose based on TPMT activity was not coincident with MTD, suggesting the need to analyse other genetic factors that might influence AZA metabolism.

REFERENCES AND/OR ACKNOWLEDGEMENTS
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5PSQ-097 USE AND PERSISTENCE OF FIRST-LINE BIOLOGICAL TREATMENTS FOR PSORIASIS

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Background and importance Psoriasis is a chronic, relapsing, immunologically mediated inflammatory dermatosis. Disease control is key to the physical, emotional and psychological well-being of patients.
Aim and objectives The main objective of the study was to identify the biological drugs chosen by the dermatologists at our centre as the first-line to treat psoriasis. The secondary objective was to determine the persistence of the drugs used in the first-line treatments.
Material and methods An observational, descriptive and retrospective study was carried out on patients diagnosed with psoriasis who were treated with selective immunosuppressive biological medication in our centre between 2016 and 2020. Data were collected from the medical history and the medication prescription program.
Results A total of 160 patients who started biological treatment for psoriasis were included; 38.8% were women. The mean age of the patients was 52±14.5 years. The treatments used in first-line therapy of psoriasis were: ustekinumab 42.5%, adalimumab 21.3%, apremilast 12.5%, secukinumab 10%, etanercept 8.8% and ixekizumab 3.1%. Only 3 patients started with brodalumab, guselkumab or infliximab, and none with certolizumab-pegol, risankizumab or tildrakizumab as first choice treatment. Those therapies with only one patient on treatment were excluded from the secondary endpoint analysis.

The treatments with the longest persistence were: etanercept (1296±418 days), ustekinumab (1090±739 days), secukinumab (813±368 days), adalimumab (803±664 days), ixekizumab (715±343 days) and apremilast (713±336 days).

Only 43.13% of the initiations were anti-TNF-α drugs.
Conclusion and relevance The result of the study shows the preference of ustekinumab as the first option by the dermatologist at our centre in the treatment of psoriasis, over others that are included in the regional guides. The study results show the preference of ustekinumab as the first option by the dermatologists in our centre in the treatment of psoriasis, compared to other drugs that are included in the regional opinion.

The drug with the longest persistence was etanercept, followed by ustekinumab, probably because they were the first commercialised molecules. The treatment durations show great interindividual variability.

With the arrival of new biological drugs indicated in this pathology, it is the job of the specialist pharmacist to promote the rational and protocolised use of the drug within the hospital's pharmacotherapeutic commissions.

REFERENCES AND/OR ACKNOWLEDGEMENTS
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5PSQ-098 EXPERIENCE IN THE TREATMENT OF *CLOSTRIDIUM DIFFICILE* INFECTION

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Background and importance *Clostridium difficile* infection (CDI) can cause acute diarrhoea. One of the complications of CDI is recurrences. There are risk factors for multiple recurrences of the disease. Vancomycin and oral metronidazole are considered the treatment of choice. Other drugs, such as fidaxomicin and bezlotuxumab, may help in the control of recurrences.
Aim and objectives To analyse the use of fidaxomicin and bezlotuxumab in our hospital.

To analyse recurrences after treatment with fidaxomicin and early bezlotuxumab administration.
Material and methods Retrospective study including all patients treated with fidaxomicin from January 2014 to April 2021. Variables collected: age, gender, previous treatment