enterocystoplasty. HAV incurs direct and indirect costs to society.

Aim and Objectives Our study has two main objectives: to evaluate the improvement of the handicap of patients with urinary incontinence by bladder hyperactivity, after injection of botulinum toxin A then to evaluate the cost effectiveness ratio.

Material and Methods A retrospective observational study of 74 patients, who received education on self-catheterisation and treated with TBA at the Urology Department of between January 2018 and August 2022. A model was developed to estimate costs by comparing the cost of TBA versus a standard protocol (involving behaviour al therapy, incontinence pads, anti-cholinergic treatment and, catheters) excluding loss of productivity. A quality of life questionnaire was also administered to patients at the follow-up visits.

Results Profiles of TBA use: Primo-injection in 83.78%.For the indication, AVH without leakage in 32.43%, urinary incontinence by AVH in 35.14%, multiple sclerosis in13, 51%and spinal cord injury in 18.92%. The injections were performed in the operating room. A median paramedical time of30min to prepare the patient and the product. Injection conducted endoscopically lasted a median of8minwith a median hospital stay of 2 days.Clinical improvement in81% with a median duration of efficacy of98days.For adverse events: hypo or a contractile bladder requiring self-catheterisation (n=81%), generalised fatigue (n=40%) and muscle weakness (n=35%).Calculated costs: The cost of an injection is 7000MAD (price produced with the hospital package).The cost of standard treatment without self-catheterisation is 2340MAD (for anticholinergic treatment associated with behavioural therapy). If use of catheters the cost of the injection is8340MAD. If urinary retention occurs, the cost is 13000MAD. Our study shows that the hospital cost is higher than the standard treatment without self-catheterisation and less expensive if catheterisation was previously used, but with a significant improvement in the quality of life according to the questionnaire results.

Conclusion and Relevance For our centre, since 2014, TBA represents a new therapeutic option in second-line treatment.

REFERENCES AND/OR ACKNOWLEDGEMENTS
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Conflict of Interest No conflict of interest

4CPS-225 HEALTH IMPACT OF TREATMENT FOR INFLAMMATORY BOWEL DISEASE WITH BIOLOGICAL AGENTS FROM THE PATIENT'S PERSPECTIVE: A CROSS-SECTIONAL STUDY USING PATIENT REPORTED OUTCOME MEASURES (PROMS)

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Background and Importance The clinical manifestations of inflammatory bowel disease (IBD) compromise patient's daily life. In this regard, the use of Patient Reported Outcome Measures (PROMs) to determine health status, quality of life and treatment effectiveness from the patient's perspective can add significant value in clinical practice.

Aim and Objectives Assess disease impact in patients affected with IBDs using PROMs.

Material and Methods Cross-sectional study including outpatients treated with biological agents for ulcerative colitis (UC) and Crohn's disease (CD) ≥18 years. Socio-demographic and clinical characteristics were collected from clinical records: age, gender, type of IBD, diagnosis year, biological treatment, starting date of biological treatment, previous biological treatment, concomitant immunosuppressive treatment, previous surgeries due to IBD and smoking habits. We used 2 questionnaires to evaluate PROMs: IBD-Control (IBD-Control-8 sub-score plus visual analog scale (VAS), that range from 0-16 and 0-100, respectively, higher scores representing better disease control) and IBD-Disk (that ranges from 0-100, higher score representing higher IBD daily-life burden).

Results 42 patients with CD and 21 with UC were included (mean age 44.25 ± 14.67, 54% men). 44 patients were treated with infliximab (69.84%), 9 with ustekinumab (14.29%), 7 with vedolizumab (11.11%), 2 with golimumab (3.17%) and 1 with adalimumab (1.59%). 22 (34.92%) were previously treated with biological agents. 4 were diagnosed during the last 18 months while others were diagnosed before. 44 patients (69.84%) took oral immunosuppressant. 60 were treated >6 months with their current biological agent, the other 3 cases for 3-5 months.

Mean IBD-Control-8 score was 12.41 ± 3.87. Mean VAS score was 87.19 ± 18.17. Mean IBD-Disk score was 33.22 ± 25.95 (69.84% of patients being below 50 points). 4 out of 63 cases had worse overall measurements (IBD-Control-8 score ≤7, VAS score ≤60 and IBD-Disk score ≥63). 3 were women with CD and smoking habits (2 current smokers and 1 ex-smoker). 3 of them were treated with infliximab and 1 with vedolizumab (3 requiring concomitant immunosuppressants). 2 required previous surgery.

Conclusion and Relevance This study adds novel literature on health status of these patients using PROMs. Measurements were generally favorable but 4 patients out of 63 had worse overall measurements. Literature on this topic is scarce. PROMs are useful tools that could be incorporated in pharmaceutical practice.

REFERENCES AND/OR ACKNOWLEDGEMENTS

Conflict of Interest No conflict of interest

4CPS-227 REAL WORLD EVIDENCE OF THE USE OF DEFIBROTIDE FOR PROPHYLAXIS OF VENO-OCCLUSIVE DISEASE AFTER POST-HAEMATOPOIETIC STEM-CELL TRANSPLANTATION IN CHILDREN

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Background and Importance Hepatic veno-occlusive disease (VOD) is a life-threatening condition caused by the obstruction of liver sinusoids.

Since 2014, in Italy the standard of care for the management of VOD is represented by defibrotide. Recent evidence suggested that defibrotide could help preventing the onset of hepatic VOD when allogeneic haematopoietic stem cell

transplantation is needed. On June 2022, however, a 'direct health professional communication' issued by the European Medicines Agency (EMA) invoked not to use defibrotide anymore for VOD prophylaxis due to lack of effectiveness.

Aim and Objectives The aim of this work is to explore the difference in the incidence of VODs at 30 days in 2 groups of children, with and without prophylaxis therapy with defibrotide before undergoing haematopoietic stem cell transplantation.

Material and Methods A single-centre, retrospective study was conducted at a University Hospital. All data were collected from electronic health records. These data were cross-checked with data from an integrated analytics application (Qlikview®, QlikTech International AB, King of Prussia, USA).

All paediatric patients (age <18 years) undergoing haematopoietic stem cell transplantation for onco-haematological diseases and considered at high-risk for developing VOD were enrolled. We observed an initial group, called the 'intervention' group, consisting of patients who had received the drug, compared with a 'historical' control group of patients with similar baseline characteristics but who did not have access to defibrotide.

Results Between 2020 and 2022, data were collected from 27 patients. The baseline characteristics of the two group were similar regarding of age (9 years old for both groups), gender and onco-haematological disease, all showing no statistically significant differences. In terms of outcome, we witnessed only one episode of VOD, in the treatment group (1 of 11 patients, 9%), at 30 days after transplantation. No episodes were documented in the controls.

Conclusion and Relevance According to the recent statement made by EMA, our data – although not definitive – show that proportion of VOD in children undergoing blood stem transplantation in patients who received a prophylaxis treatment with defibrotide was comparable with the one in children where no prophylaxis strategy has been adopted.

REFERENCES AND/OR ACKNOWLEDGEMENTS

Conflict of Interest No conflict of interest

4CPS-228 HIGH DOSE PHENOBARBITAL COMA IN PAEDIATRIC REFRACTORY STATUS EPILEPTICUS

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Background and Importance Status epilepticus (SE)is associated with high morbimortality. Early treatment has been demonstrated to decrease the risk of death and sequelae. When first-line drugs cannot solve SE, therapeutic coma should be initiated with midazolam(most used), propofol, thiobarbital or phenobarbital (better therapeutic profile with low evidence, especially in paediatrics) are used for this practice.

Aim and Objectives Describing high-dose phenobarbital (HD-PHB) used in therapeutic coma in paediatric refractory SE and their side effects. Exposing the pharmacokinetic monitoring to achieve barbiturate coma (BC).

Material and Methods Observational retrospective study of a third-level paediatric hospital conducted between 2012-2022. 51 paediatric intensive care unit (PICU)'s patients who received intravenous phenobarbital treatment were included, 6 of them underwent BC. Variables collected were age, weight, number of previous antiepileptic treatments, loading and maintenance doses of phenobarbital, phenobarbital plasmatic levels during coma, BC days until resolution of SE, exitus and adverse effects of HD-PHB.All data were obtained from the clinical history programme .

Results 51 patients were included, of them 6 (median 9 years [0.2-14.5] and 20.2kg) were treated with HD-PHB to achieve BC due to the presence of seizures refractory to propofol or midazolam: 5 had a previous history of epilepsy, treated with a median of 3 antiepileptics at home. The resolution was evaluated by encephalogram. The initial phenobarbital doses used to achieve BC were 60mg/kg/day [50-125]. Reported phenobarbital plasma levels achieved in the BC phase were 943µmol/L [743-1883]. Patients were in coma for a median of 4.5 days [1-6] and in all of them a suppression burst was observed in the encephalogram. Glasgow Scale before coma was 9[7-13] and during coma was 3[2-5]. After resolution of the status, tapering regimen was carried out until phenobarbital plasma levels were below 350µmol/L and a maintenance dose (10mg/kg/12h [2-20]) was continued. The adverse effects reported were haematological in 5 patients(decrease in haemoglobin and haematocrit levels) and hepatic in 2 patients (elevation of transaminases levels). One patient died before 6 months post-coma.

Conclusion and Relevance HD-PHB seems to be an effective therapeutic procedure in paediatric refractory SE. Pharmacokinetics is important to ensure the maintenance of coma and avoid toxicity. More pharmacokinetic studies are needed to establish a population model and clear protocols for BC management.

REFERENCES AND/OR ACKNOWLEDGEMENTS

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4CPS-229 THE ADDED VALUE OF A NATIONAL ELECTRONIC HEALTH RECORD FOR THE BEST POSSIBLE MEDICATION HISTORY OBTAINED BY A CLINICAL PHARMACIST

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Background and Importance Obtaining the Best Possible Medication History (BPMH) is an essential step in the medication reconciliation process, that should ideally be based on the most appropriate sources of information, such as patient health records, to which access is often limited. Implementation of a National Electronic Health Record (NEHR) system aims at streamlining this process by converging relevant data into a singular database.

Aim and Objectives This research aimed to assess the added value of NEHR to BPMH. In addition, the quality of NEHR-based BPMH was compared to the former physician/nurse-led Standard of Care (SoC), in order to explore the added value of clinical pharmacy services in obtaining BPMHs.

Material and Methods The study took place between 05.2022-08.2022 in the general surgery department of a county hospital, enrolling patients over 18 years of age, admitted from their homes, with at least one regularly taken prescribed medication and without major communication difficulties. Medication reconciliation was initiated by clinical pharmacists, based