1ISG-018 TEN-YEAR DRUG SURVIVAL ANALYSIS IN MODERATE TO SEVERE PLAQUE PSORIASIS FIRST-LINE TREATMENT

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Background and Importance Drug survival is defined as the time interval between treatment initiation and discontinuation. Several factors may influence drug survival such as efficacy, tolerability, and treatment adherence. Thus, drug survival can be used as a surrogate for treatment effectiveness. Biologics have changed the treatment paradigm in moderate to severe plaque psoriasis improving efficacy and tolerability.
Aim and Objectives We aimed to determine the 10-year drug survival for the biologics used in the treatment of moderate to severe plaque psoriasis where possible, in order to estimate real-world effectiveness and improve initial treatment decision making, considering biosimilar's favourable costs.
Material and Methods All adult patients (aged 18–65 years) with a diagnosis of moderate to severe plaque psoriasis who initiated treatment with the following biologics between 28 February 2012 and 28 February 2022 (10 years) were included: adalimumab, brodalumab, certolizumab, etanercept, guselkumab, infliximab, ixekizumab, risankizumab, secukinumab, and ustekinumab. Data were collected from pharmacy dispensing records and included a 6-month wash-out period before inclusion and a 1-year minimum follow-up for the last patient included. Data were censored, considering treatment discontinuation if no records were found in the last 3months of the follow-up period. Data were analysed using R statistical software.
Results A total of 1,353 patients were included (41.3% females, median-age 44 years). Only patients who initiated first-line adalimumab (n=124), etanercept (n=56) and ustekinumab (n=861) reached a 10-year treatment period. The 10-year drug survival (%, 95% confidence interval, n at risk) were: adalimumab (17.0, 10.2–28.3, n=5), etanercept (14.5, 6.74–31.1, n=2), ustekinumab (21.8, 18.1–26.3, n=29). Using adalimumab as reference, the Cox proportional hazard ratios for etanercept and ustekinumab were respectively: 0.90 (0.63–1.28, p=0.557) and 0.58 (0.46–0.72, p<0.001). Treating a patient for a 10-year period with biosimilar etanercept or ustekinumab cost an additional € 46,033 or € 84,504, respectively, comparing to biosimilar adalimumab.
Conclusion and Relevance A 10-year drug survival analysis was only available for adalimumab, etanercept and ustekinumab. Comparing to adalimumab, ustekinumab showed a significant higher 10-year drug survival (21.8 *vs* 17.0%, p<0.001). A strategy of switching from adalimumab to ustekinumab as soon as a biosimilar is available should be evaluated.

REFERENCES AND/OR ACKNOWLEDGEMENTS

Conflict of Interest No conflict of interest.

1ISG-019 DO ALL SURGICAL SPECIALTIES HAVE AN IDENTICAL CARBON FOOTPRINT WITHIN AN AMBULATORY UNIT?

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Background and Importance Operating theatres produce 30% of the healthcare system's greenhouse gas (GHGs) emissions. As part of its sustainable development strategy, our hospital has decided to assess the greenhouse gases emitted by an Ambulatory Surgery Unit (ASU). Opened in April 2018, the ASU has five operating theatres where eight surgical specialties can operate 22 patients a day.
Aim and Objectives The aim is to assess the carbon footprint of surgical specialties in order to identify the most GHG emitting sources.
Material and Methods Thanks to the hospital's Sustainable Development Commission (SDC), the carbon footprint of the surgical specialties was assessed by two community service students, one extern and one pharmacy resident. The GHG emissions generated in 2022 by water, electricity and energy consumption, equipment, drugs, gas, single-use medical devices (SUMDs) and re-sterilisable medical devices (RSMDs) procurement, Regulated Medical Waste (RMW) and Municipal Solid Waste (MSW), patient and staff movements were estimated based on ADEME factors. Emissions associated with the acquisition of Sterile Medical Devices, known as 'specific emissions', vary according to surgical specialty. The remaining emissions sources are called 'common emissions'.
Results In 2022, the ASU emitted 634 tonnes of eCO2. Common emissions reached 292 t eCO2: equipment (9%), energy (9%), travel (7%), RSMD (6%), drugs (4%), waste (1%) and gas (1%). Specific emissions account for 54% (342 tonnes eCO2). Orthopaedic surgery emits 166 t eCO2 per year, including 59 t eCO2 from common emissions. Orthopaedic, urological, dermatological, gynaecological, gastrointestinal and plastic surgery account for 171, 117, 84, 93, 93 and 85 kg eCO2 per patient respectively.
Conclusion and Relevance This study highlights the most GHG emitting positions (SMD procurement) and specialties (Orthopaedic surgery) in the ASU. Several actions have been taken towards sustainable development. Environmentally, the air-conditioning output is reduced when the operating theatre is closed, waste is distributed in paper or plastic garbage bins, and sevoflurane is the only gas administered. Economically, hospital stays are shorter than those for conventional surgery. Socially, the unit offers patients a peaceful environment. These findings were presented to the SDC. Suggestions were made to refine RSMD compositions with input from surgeons and replace SMD with RSMD whenever possible.

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1ISG-020 DRUG DAY THERAPY APPLIED TO LUSPATERCEPT: RESULTS OBTAINED IN AN ITALIAN ANTIBLASTIC DRUG UNIT

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Background and Importance Luspatercept is an erythroid maturation agent, indicated for myelodysplastic syndrome and β-thalassaemia, reimbursed by the Italian National Health Service as of 09/12/2021. Luspatercept binds to ligands of the transforming growth factor β family by blocking the Smad2/3 signalling pathway that induces maturation of late erythroid