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Abstracts

P61 PATIENT PERSPECTIVES ON SWITCHING TO AN INFlixIMAB BIOSIMILAR IN PAEDIATRIC INFLAMMATORY BOWEL DISEASE (PIBD)

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Aim To establish patient perspectives on switching to an infliximab biosimilar, which will enable the PIBD team to improve patient experience during future biosimilar switches.

Methods Families of patients receiving treatment with an Infliximab biosimilar (Remsima®) 2 years after switching from the originator (Remicade®) were selected from the active patient database for telephone interview. One family who chose not to switch was also included for interview. A 5-question interview was prepared, which asked parents to rate their overall experience according to a satisfaction rating scale from 1–5. Parents were asked about their knowledge of reasons for switching, if they needed to look up additional information resources and, finally, ways to improve the switching process.

Results 18 patients were identified, 16 parents were available for interview. 13 parents gave overall positive feedback with satisfaction scores of 4 or 5 on the numerical satisfaction scale. 3 parents were dissatisfied with the switching process, giving scores of 0, 1 and 3. This resulted in an average satisfaction score of 4.1. The majority of satisfied parents had little knowledge of the switch, not remembering details and indicating the switch was best performed this way. Nonetheless, most recognised costs as the reason for switching. The majority of parents did not need to look up additional information resources, 2 parents named The Crohn’s and Colitis Charity and Facebook support groups as useful resources. Two dissatisfied patients requested to switch back to Remicade® therapy due to side effects. The family of the patient who chose not to switch made this decision because Remsima® was not yet available in the United States, where they also received treatment.

Conclusion Biosimilar biologics continue to be approved by the EMA as originators come off patent. Efficacy of infliximab biosimilars in paediatric IBD patients is extrapolated from adult rheumatology data, with limited long term outcome data. Successful switches for NHS trusts lead to financial benefits; these savings allow for NHS investment to enable more patients to be treated. Parent autonomy and, in paediatrics, parental views must be respected during this switching process. The majority of interviews with parents were positive, re-affirming the process of this switch. Parental perceptions of side effects attributed to Remicade® highlight the importance of discussing realistic outcomes of therapy with both the originator and biosimilar. When questioned, the parent who refused to switch explained that they did not have faith in the efficacy of the biosimilar and had major concerns of treatment failure. A fear of treatment failure may be described as a ‘nocebo’ effect4 which hypotheses that negative attitudes incur less effective results. Increasing our awareness of patient perceptions on switching biosimilars and monitoring reasons for switch failure will better inform us going forward with future biologic switches.

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P62 CYCLOPHOSPHAMIDE AND MAINTENANCE MYCOPHENOLATE MOFETIL FOR THE TREATMENT OF ANTI-N-METHYL-D-ASPARTATE RECEPTOR (ANTI-NMDAR) ENCEPHALITIS IN A PAEDIATRIC PATIENT

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Background Anti-NMDAR encephalitis is one of the commonest known types of autoimmune encephalitis with an increasing recognition in the paediatric population. It is characterised by abnormal behavioural and cognitive symptoms, seizures and movement disorders where treatment failure or failure to treat can result in long term disabilities or mortality.

A 4-year-old patient with a background of autism was admitted to the paediatric intensive care unit (PICU) due to encephalitis with convulsive status epilepticus where he remained intubated for 22 days and was later diagnosed with anti-NMDAR encephalitis. The patient had persistent abnormal choreoathetoid movements and intermittent seizures despite multiple anti-epileptics, two courses of corticosteroids, two courses of intravenous immunoglobulin, two cycles (10 sessions per cycle) of plasmapheresis and a course of weekly rituximab. Due to the lack of response from these initial pharmacological interventions, the use of cyclophosphamide and mycophenolate mofetil was considered. Cyclophosphamide and mycophenolate mofetil inhibits the proliferations of B- and T-lymphocytes which acts as the basis of its immunosuppressive actions. However, available evidence on the dosing and monitoring information in the paediatric population for this unlicensed indication is limited.

Pharmacy Contributions After discussion with the multi-disciplinary team (MDT) with extensive input from the paediatric neurologist, a literature search was conducted to determine an appropriate dosing regimen. As this was an off-label use, the paediatric neurologist and the attending consultant took clinical responsibility. Intravenous cyclophosphamide was started at 750 mg/m² once a month for three cycles and oral mycophenolate mofetil was started at 600 mg/m² twice a day as...