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Dr. Torsten Hoppe-Tichy, Chief Pharmacist, Heidelberg University Hospital

The art of writing an abstract and getting it accepted

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Nothing to disclose

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Questions

1. Are more abstracts accepted (green card) or rejected (red card) in the EAHP abstract evaluation process?

2. Is it possible to create an abstract presenting a single patient case? (yes/no)

3. Can you proof (*present*) that a drug is efficient and safe by studying 5 patients? (yes/no)

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Status Quo

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Scientific Committee of EAHP: The Process

19 SC-members (+2 staff):
PT, ES, FR, UK, PL, BG, NL, GR, IT, AT, CH, CZ, SK, DK, FI, BE, DE, SE

5 meetings/y

setting up scientific program for congress and other EAHP-events

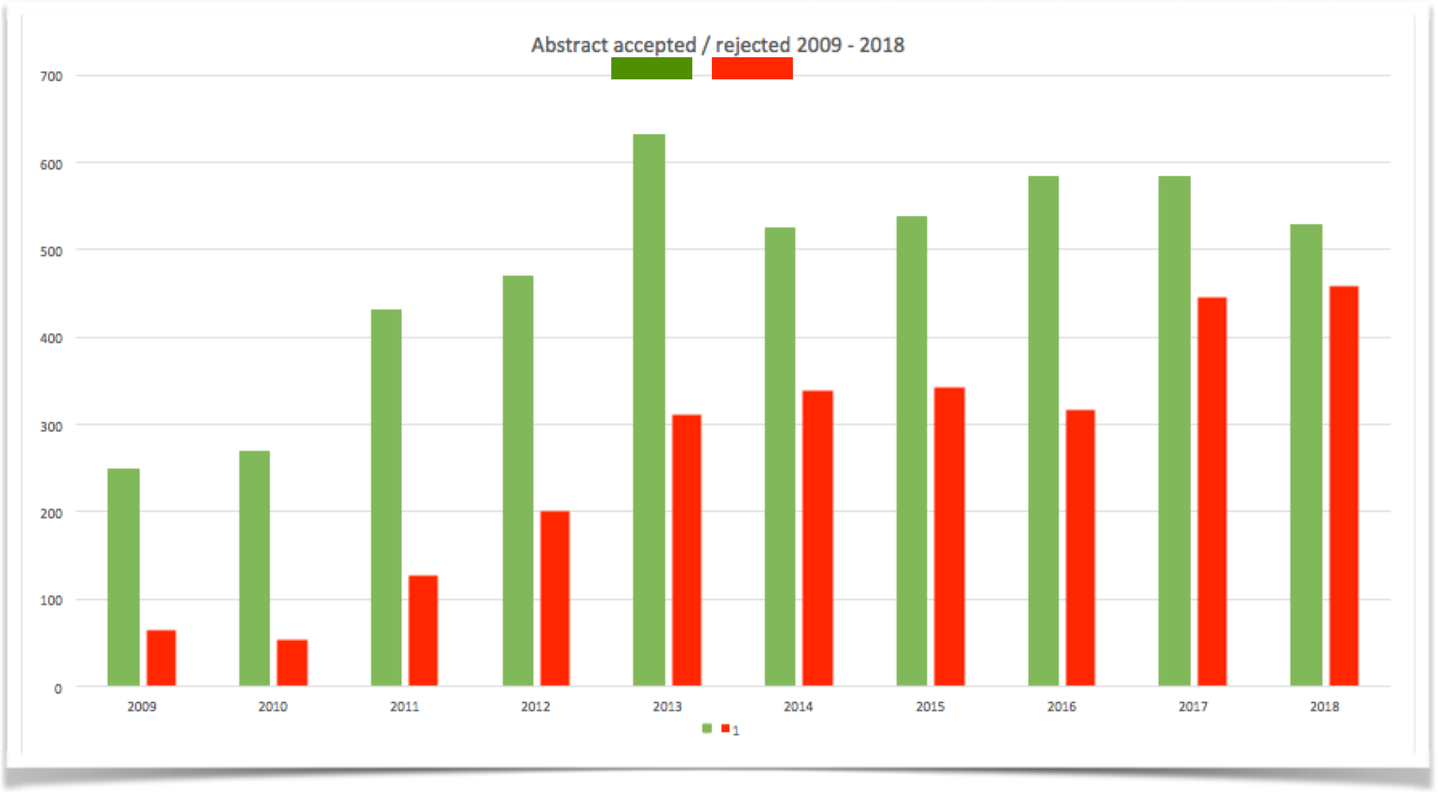
„poster-review session“ ➜ > 1000 abstracts to review

different groups of 2 SC-members reviewing +100 abstracts

accepted - rejected

rate of rejected/accepted abstracts increases

different EAHP-policy in „the old days“



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Dr. Torsten Hoppe-Tichy, Chief Pharmacist, Heidelberg University Hospital

The art of getting an abstract accepted

Focus on abstracts from the field of antimicrobial therapy

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What is the motivation to prepare an abstract?

Sharing important information

for the benefit of colleagues

for the benefit of patients

It is not about participating at a congress or getting a travel grant!

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Key question

What is new?

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Examples of Research

Pharmacokinetics (PK)

PK/PD (e.g. continuous infusions)

Stability of infusions

Safety (?)

Interventions to influence consumption, resistance, costs, adverse events, …

Drug Use Evaluation (DUE)

… … …

Advice

Sometimes we want to find out („research“) if a drug works like in literature or is used in the labelled indication

This will not always generate a paper/poster/presentation

Key questions

- What is new, what is my data adding to already published data?
- Why do we think that something is special in some hospitals/patients?
- What could be different to literature data?
- Why is my data important for patients/hospitals?

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In practice!

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How do I *(personally)* check abstracts?

Title vs. Purpose vs. Conclusion

- Is this on line?
- Is everything which is mentioned in Title and Purpose also covered by the Conclusion?
- Is this research of interest for others?

Are there any results in the abstract?

- Preliminary data?

Where is the information?

EFFECTIVENESS OF NEW DIRECT ACTION ANTIVIRALS IN CHRONIC HEPATITIS C

Background

Hepatitis C virus (HCV) is a global health problem, because infection frequently leads to chronic hepatitis C eventually progressing to liver cirrhosis and liver cancer.

Purpose

To analyze the effectiveness of new direct action antivirals (AADs) in patients with HCV.

Material and methods

A prospective, 26-month observational study in which all monoinfected patients with HCV were treated with AADs: simeprevir (SMV), sofosbuvir (SOF), daclatasvir (CVD), paritaprevir/ombitasvir/ritonavir (OBV/PTV/rtv), dasabuvir (DSB) and sofosbuvir/ledipasvir (LDV/SOF) in different combinations. The main variable analyzed was disease healing, measured as undetectable load (<15 IU/ml) at 3 months post-treatment, while sustained viral response at 6 and 12 months was the tool used to determine the variable secondary expression as a sustained virological response (SVR). The following data were collected: demographic (sex and age), patient (grade of fibrosis (F), naive or pretreated with bitherapy (peginterferon+ribavirin) or first generation antivirals (telaprevir and boceprevir) virus (genotype (G)) and treatment (drug combinations and toxicity).

Results

106 patients were followed up: 56% were men (57±10 years). HCV genotype distribution was: 1a (25%), 1b (60%), 2a (2%), 3a (9%) and 4 (4%). The degree of fibrosis was mostly identified with F4 and F3 (57% and 25%, respectively). 64% were "naive" to treatment, while 22% were „nonresponders" to bitherapy and 14% were considered "recapters" to bitherapy or to any of the first generation antivirals. The most used combinations of AADs were LDV/SOF (56%) and OBV/PTV/rtv+DSV (26%), among which cases of toxicity that required treatment discontinuation were observed (2 cases due to toxicity hepatic with OBV/PTV/rtv and 1 case for gastrointestinal toxicity with LDV/SOF). The main variable could be evaluated in 95 patients, with 98% of cures expressed as undetectable viral load at 3 months after the end of treatment. SVR was maintained at 6 and 12 months post-treatment in 62% and 55% patients, respectively. SVR at 3 months post-treatment was detected in 2%, having been treated with: SOF+DCV (G3a, F3) and LDV/SOF (G1a, F4).

Conclusion

The data obtained in the series studied show a high percentage of cure and low toxicity that requires the suspension of treatment. The least effective combinations were: SOF+DCV and LDV/SOF.

Effectiveness → undetectable load (3 mon), SVR (6 and 12 mon)

n=106 (95 evaluable)

Treatment

Outcome

Did we miss something? (p-value?)

And what about the literature?: Is it new, is it different, is it producing new guidelines, … …?

Just one problem to be solved in the future

Someone is asking a question about safety of a virustatic combination therapy on Hep C

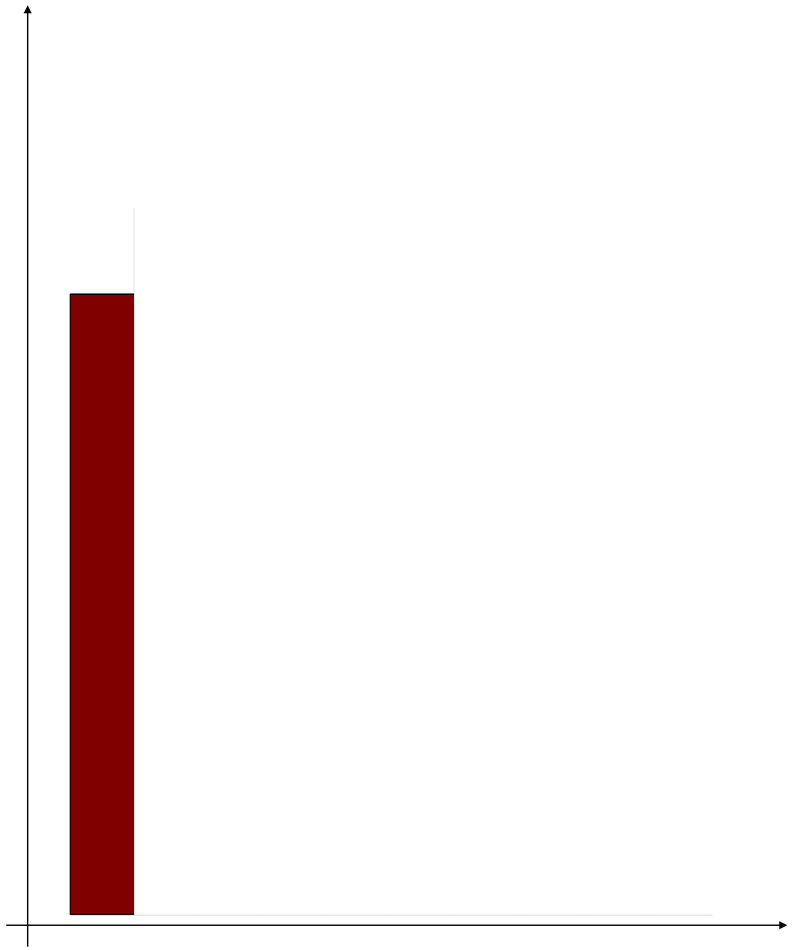
Many hospital pharmacies are involved
(⇒ multicenter approach)

The combined data from all centers are the result

BUT ...

- more than 30 abstracts with single center results
- sometimes n<10, but conclusion is: „Safe“

Case series or “global” approach



Consumption data

Adverse drug reactions

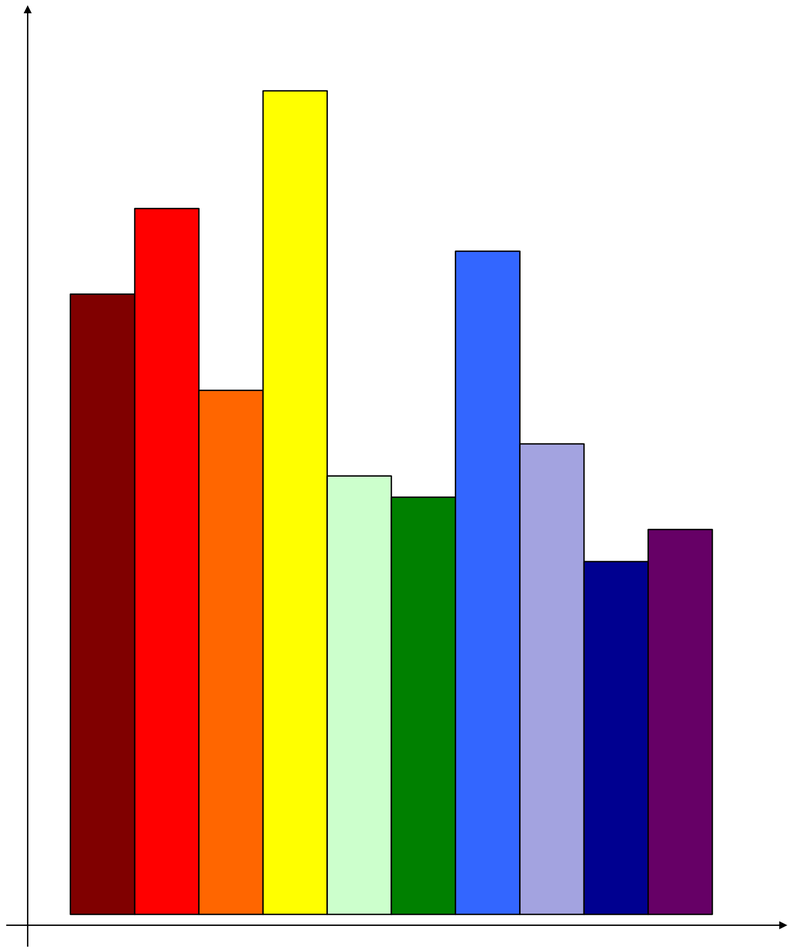
Efficacy

Safety

Outcome

… or …

Case series or “global” approach



Consumption data

Adverse drug reactions

Efficacy

Safety

Outcome

Is it new?

EVALUATION OF THE EFFECTIVENESS OF COLISTIMETHATE SODIUM: CONVENTIONAL VERSUS HIGH DOSE REGIMEN

Background

The administration of loading dose and high-dose of colistimethate sodium (CMS) have been related to greater effectiveness.

Purpose

To determine if the use of loading dose and high dose of CMS correlates with patient outcomes.

Material and methods

A retrospective study was made including patients treated with intravenous CMS for at least 72 hours (january-2010 - january-2017). When initial and follow-up cultures were available, microbiological success was defined as eradication of them. Clinical improvement was defined as normalization of inflammatory markers and abscence of fever for at least 24 hours. In group1 patients didn't received loading dose and CMS maintenance dose was ≤ 6 MU/day. In group2 loading dose was administered and maintenance dose was more than 6 MU/day. In case of renal insufficiency, renal adjustment was considered.

Results

Thirty-five patients were included, eighteen in group1 and seventeen in group2. Although there weren't significant differences between both groups, a higher proportion in group2 were critically ill, 35,3 % vs 16,6 % (p=0,208). A more proportion of patients in group1 had minimal concentration inhibitory of 2mcg/mL. A higher proportion in group1 received concomitant therapy with aminoglucosides, 30% vs 17,4% (p=0,329). Carbapenems were the most common concomitant therapy in group2, 39,1% vs 15% (p= 0,063). Initial positive culture for Gram negative bacteria was avalaible in 29 patients (82,9%), in 26 patients was a follow-up culture. In 42,85 % (n=6) of patients with avalaible follow-up culture in group2 achieved microbiological succes versus 33,3% (n=4) in group1 (p=0,6189). Eight patients (44,4%) in group1 and seven (41,2%) in group2 achieved clinical improvement at day-7 (p=0,8452). At day-14 eight patients (44,4%) in group1 and six patients (35,3%) in group2 had obtained clinical improvement (p=0,5808). In the univariate analysis being a critical patient increase the risk of absence of clinical improvement at day-7 (OR= 0,29 p=0,160) and at day-14(OR=0,125 p= 0,066).

Conclusion

A higher proportion of patients with loading-dose plus high-dose of CMS obtained microbiological success. A similar proportion of patients got clinicall improvement at day-7. Nevertheless, a smaller proportion of patients with high-dose got clinical improvement at day-14, this could be explained because of the higher proportion of critical patients.

Colistin: How should It Be Dosed for the Critically Ill?

Cornelia B. Landersdorfer, PhD[1] Roger L. Nation, PhD[1]

[1] Drug Delivery, Disposition and Dynamics, Monash Institute of Pharmaceutical Sciences, Monash University, Melbourne, Australia

Semin Respir Crit Care Med 2015;36:126–135.

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Cornelia B. Landersdorfer, PhD (e-mail: cornelia.landersdorfer@monash.edu).

Application of a Loading Dose of Colistin Methanesulfonate in Critically Ill Patients: Population Pharmacokinetics, Protein Binding, and Prediction of Bacterial Kill

Ami F. Mohamed,[a,b] Ilias Karaiskos,[c] Diamantis Plachouras,[c] Matti Karvanen,[d] Konstantinos Pontikis,[e] Britt Jansson,[a] Evangelos Papadomichelakis,[e] Anastasia Antoniadou,[c] Helen Giamarellou,[c] Apostolos Armaganidis,[e] Otto Cars,[d] and Lena E. Friberg[a]

Department of Pharmaceutical Biosciences, Uppsala University, Uppsala, Sweden[a]; Institute for Medical Research, Kuala Lumpur, Malaysia[b]; 4th Department of Internal Medicine, Medical School, Athens University, Athens, Greece[c]; Department of Medical Sciences, Section of Infectious Diseases, Uppsala University, Uppsala, Sweden[d]; and 2nd Critical Care Department, Medical School, Athens University, Athens, Greece[e]

What is the ratio behind repeating studies?

What about ethics?

Is there really a patient without loading dose in the last years?

Are those results valid?

EVALUATION OF ANTIBIOTICS CONSUMPTION IN A PEDIATRIC HOSPITAL BEFORE AND AFTER AN AWARENESS ACTION OF GOOD USE

Background

The consumption of antibiotics has increased in recent years in the hospital. This generates over time the appearance and increase of bacterial resistance that threatens the effectiveness of treatments.

Purpose

The objective of the study was to evaluate the consumption of antibiotics in different departments of the paediatric hospital before and after an awareness action for a good use of antibiotics.

Material and methods

Initially, we evaluated the consumption of critical antibiotics by the hospital's departments from July 2016 to July 2017. The results of the evaluation led to the implementation of corrective measures and secondly to a revaluation of this consumption after 3 months of action.

Results

An increase in the consumption of antibiotics of an average of 18%, was observed in the year 2017 for the 6 departments. This upward trend particularly concerns the department of gastroenterology with an increase of 35%, the department of endocrinology and neurology by 30%, neonatal intensive care unit by 15%, child intensive care unit by 11% and others departments by 1%. Unlike the department of infectiology which decreases by 17% in the year 2017. In order to overcome the problem of overconsumption, some measures have been taked: as the requirement of the results of the antibiogram for the prescripton containing critical antibiotic, Review protocols for the use of antibiotics ,Strengthen hygiene measures to reduce the incidence of nosocomial infections. After 3 months of the implementation of the corrective actions, we noticed a decrease in consumption of an average of 28 % by all departments: a decrease of 51% for the department of Gastroenterology, 33% for the child intensive care, 26% for neonatal intensive care, , 19% for the department of infectiology, 21% for the department of endocrinology and neurology , 20% for the others departments.

Conclusion

The increase in consumption of antibiotics is explained by the increase in nosocomial infections, diagnostic uncertainty, probabilistic prescription of antibiotics . Finally, we can say that the actions undertaken have given positive results and that a continuous monitoring of the consumption of antibiotics must be carried out to rationalize the good use of antibiotics.

What is a „critical antibiotic“?

What is in the „awareness action for a good use of antibiotics“?

How high was the increase in nosocomial infections?

bed days, patients, LOS, infections, … …

What counting unit has „consumption“?

➜ €, mg/g, „pieces“, … …

Why no correction (denominator) for infections?

bed days, patients on therapy, pediatric DDD, … …

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What about relevance?

CAN17-0614. SURVEY PREVALENCE POINT ON INFECTIONS ASSOCIATED WITH HEALTHCARE AND ANTIMICROBIAL USE

Background

Antibiotics (AB) are among the most prescribed drugs in clinical practice and about 20-50% are improperly prescribed. Healthcare services should develop strategies to promote adequate use of AB, guaranty quality outcomes and patient safety. The use of clinical guidelines and the local knowledge of antimicrobial resistance optimize its use and minimize the selection of multidrug-resistant bacteria.

Purpose

Analyze AB prescriptions in 5 different hospital wards (cardiology, cardiothoracic, general surgery, nephrology and Intensive Care Unit), describe and report results with the aim to improve awareness and adequate antibiotic use.

Material and methods

Observational and cross-sectional study with two audits undertaken. First audit (FA) on May 26th and a second audit (SA) on August 26th. Data collected from medical records included number of patients with AB therapy, number of AB prescribed per patient; AB indication, type of prescription, dose, frequency, route of administration, duration and compliance to local or national recommendations.

Results

In the FA 43 (n=43) patients were exposed to AB, 13 (30 %) are women, with an average age of 67 years (+/- 14,1). A total of 58 AB were prescribed, 7 (12, 1%) as prophylactic therapy, 36 (62%) as empiric therapy and 15 (25,9%) according to microbiological agent identified. Three nonconformities were identified: 41% of the patients had lack of clinical justification for AB therapy registered in medical record, 7% have a prescription of AB therapy for longer than recommended and 2% had a prescription of an AB for an infection caused by a resistant microorganism. In the SA 28 patients were exposed to AB, with an average age of 64,4 years (+/-14,09), 12 (42,8%) are women. A total of 35 AB were prescribed, 21 (60%) according to microbiological agent identified, 11 (31%) as empiric therapy and 3 (9%) as prophylactic therapy. One nonconformity was identified: 7% of the patients had lack of clinical justification for antibiotic therapy registered in medical record.

Conclusion

The AB audit allowed an awareness and commitment to change and adopt the proper measures to optimize AB therapy (registration of clinical justification for AB use in medical record, adherence to recommendations and collection of adequate samples before start AB therapy).

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Point-prevalence analysis/study

(→ Please check language)

„… to improve awareness and adequate antibiotic use.“

If the authors want to say that an intervention took place between FA and SA to change the use of AB then the intervention measures are the message

What about interest for other European Hospital Pharmacists?

Why is this important for an EAHP Congress visitor from ABCland?

Is this process unknown in XYZland?

TREATMENT WITH LIPOGLYCOPEPTIDS : HOW TO OBTAIN THESE NEW MEDICATIONS IN XYZland ?

Background

Responsible for nosocomial infections, Methicillin Resistant Staphylococcus Aureus can cause cutaneous infections, bone infections or pneumonias. Specific health measures are taken in order to prevent the spread of this multi resistant bacteria. Vancomycin is the antibiotic of choice to treat MRSA infections. New lipopeptids such as daptomycin, telavancin, dalbavancin and oritavancin are an alternative to vancomycin to treat cutaneaous infections and nosocomial pneumonias.

Purpose

A lipopeptid treatment regimen could be initiated by the physician to cure a severe infection caused by MRSA. Only daptomycin is currently available in XYZland. We reported in this abstract the procedural steps to obtain telavancin, dalbavancin and oritavancin when the patient is infected by a bacteria resistant to daptomycin.

Material and methods

To answer our question, we called the XYZland National Agency for Medicines and Health Products Safety (NA).

Results

Telavancin has a Marketing Authorisation Application (MAA) in the ZZZ as well as in XYZland for the treatment of nosocomial pneumonias due to MRSA. Although the medication has a MAA in XYZland, this drug is not commercialized. To acquire telavancin, an import authorisation is necessary. The pharmacist has to fill a certificate providing the generic name, its indication, the posology and the border exporter. The pharmacist then sends the application to the NA. After this request is received, the NA decides on whether or not to import the telavancin. Dalbavancin is used for the treatment of adults with complicated skin and skin structure infections caused by Gram-positive bacteria, including MRSA. Oritavancin is indicated for the acute moderated or severe cutaneous infections. As these two medications have not yet the MAA, they could be obtained via a named patient Temporary Authorisations for Use (ATU) requested by NA. This named ATU serves as an import authorisation.

Conclusion

The availability of these three lipopetids extends the therapeutic strategy for the patients who have a severe infection to MRSA. However, the procurement of these drugs remains a time-consuming process. Therefore, these anti-staphyloccocci agents are used in last intention to treat patients colonized by multi-resistant bacterias.

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Is it safe or is it random?

CAN17-0871. USE OF FIDAXOMICIN IN THE TREATMENT OF CLOSTRIDIUM DIFFICILE INFECTION

Background

Fidaxomicin is a macrolide antibacterial drug. It is bactericidal and acts by inhibiting RNA synthesis. It is indicated for treatment of Clostridium Difficile Infections (CDI).

Purpose

To assess the compliance with the conditions of use of fidaxomicin in our hospital, as well as efficacy and safety in the treatment of Clostridium Difficile Infections (CDI).

Material and methods

Retrospective observational study of patients treated with fidaxomicin between May 2015 and May 2016. Patients were selected from the Outpatient module (FarmatoolsÂ®) and medical records (DirayaÂ®). We collected data about: age, sex, start and finish treatment date, justification for the use, recurrence number, adverse effects and previous antibiotic therapy.
Due to their high cost, its use has been restricted by the Infections and Pharmacy Comission under the following conditions: first recurrence as an alternative to vancomycin if its presents: recurrence risk criteria â‰¥2 (>65 years, serious underlying disease and use of antibiotics after treatment interruption CDI), have 1 or more severity criteria (â‰¥10 stools/day, fever >38.5ÂºC, leukocytes >15,000/m3, creatinine >1.5 times the prior to your hospital admission) and â‰¥1criteria of clinical impact (aggravate the underlying disease, difficulty for treatment ,to extend the hospital stay).
The treatment was considered effective with the resolution of diarrhea and fever symptoms.

Results

2 patients were included in the study period. Both were men with an average age of 77.5 years. The treatments were evaluated and prescribed by Infectious Diseases department. In the two cases, risk criteria for age and recurrences number were met, in severity criteria both also met and in regard to clinical impact both presented worsening of the underlying disease. Both resolved their symptoms after treatment with fidaxomicin and no one suffered relapse of CDI. No adverse reaction was registered.

Conclusion

In cases studied fidaxomicin inclusion criteria were met, and it also showed safety and efficacy for the treatment of CDI. Although it is an effective and well tolerated drug, its use should be restricted according to rational and cost-effectiveness criteria.

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Is it safe or is it random?

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2 patients

effective

well-tolerated

safe

no relapse

no adverse events

one 77 and the other 78?
or
one 55 and the other 100?

What are the *„rational and cost-effectiveness criteria“*

Could it be a case report?

A short one on „decimals“

We are all scientists

But … …

From 18 German Bundesliga soccer clubs only one is competitive in European championships

or

Only 0,55556% of German Bundesliga soccer clubs are competitive in the European championships

Sufan: We sometimes find out …

HAM15-0233. THE INFLUENCE OF SUFAN ON THE OXIDATIVE HOMEOSTASIS AND FATTY ACID COMPOSITION OF MYOCARDIUM AND LIVER IN THE CASE OF DAUNORUBICIN-INDUCED INTOXICATION

… plagiarism, refreshing of old publications, …

That's a „no go"!

Influence of nonglycozide cardiotonic on oxidative homeostasis and fatty acid patterns of lipids in myocardium and liver under conditions of daunorubicin intoxication

Record 1 of 3

Title: Influence of nonglycozide cardiotonic on oxidative homeostasis and fatty acid patterns of lipids in myocardium and liver under conditions of daunorubicin intoxication

Author(s): Nizenkovska, IV (Nizenkovska, IV); Chekman, IS (Chekman, IS); Oliynyk, SA (Oliynyk, SA); Briuzgina, TS (Briuzgina, TS); Gorchakova, NA (Gorchakova, NA)

Source: EXPERIMENTAL ONCOLOGY **Volume:** 22 **Issue:** 4 **Pages:** 236-238 **Published:** DEC 2000

Abstract: The effects of the new Ukrainian nonglycozide cardiotonic drug Sufan on the oxidative homeostasis and lipid fatty acid spectrum in the myocardium and liver of normal rats as well as the rats with daunorubycin intoxication were studied. Sufan has not been shown to affect the parameters under study in normal rats. Nevertheless this drug has been proved to be effective in decreasing daunorubicin toxicity by normalizing the shifts in fatty acid patterns and disturbances of oxidative homeostasis induced by daunorubicin.

Accession Number: WOS:000166847600015

ISSN: 0204-3564

Questions from the SC

Sometimes the SC does not want to reject an abstract

They want clarification or they want a „new“ abstract with minor but relevant changes

If there is no answer in time the abstract is going to be rejected

Avoid to play the google translate game!

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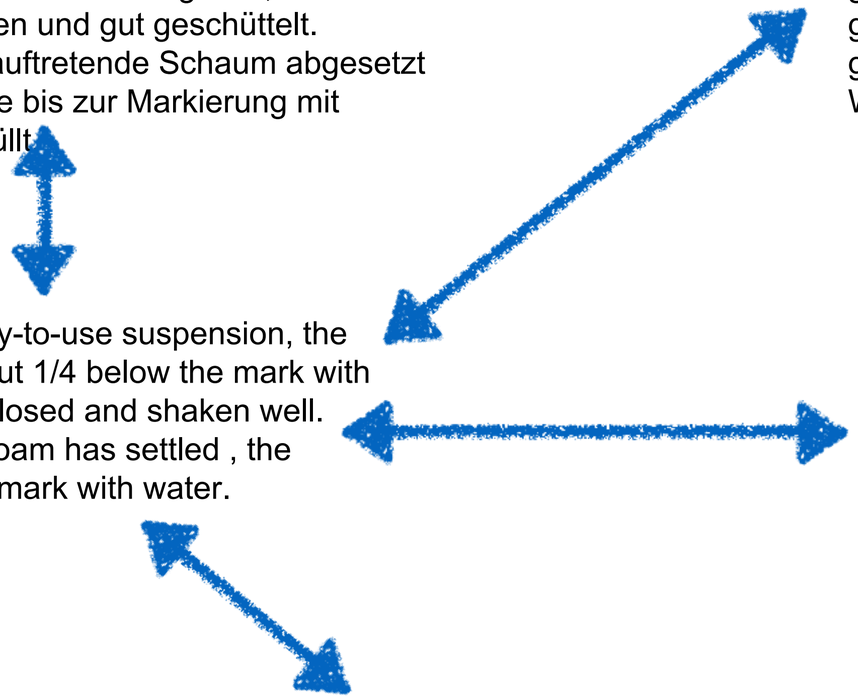
Zur Herstellung der gebrauchsfertigen Suspension wird die Flasche bis etwa 1/4 unter der Markierung mit Trinkwasser gefüllt, die Flasche verschlossen und gut geschüttelt. Nachdem sich der auftretende Schaum abgesetzt hat, wird die Flasche bis zur Markierung mit Trinkwasser aufgefüllt.

Um die bereit Suspension herzustellen, wird die Flasche zu ca. 1/4 unter die Marke mit Wasser gefüllt war, wurde die Flasche verschlossen und gut geschüttelt. Die Flasche nach der Schaum gesetzt hat auftretende bis zur Markierung mit Wasser gefüllt.



To prepare the ready-to-use suspension, the bottle is filled to about 1/4 below the mark with water, the bottle is closed and shaken well. After the occurring foam has settled , the bottle is filled to the mark with water.

Para preparar la suspensión lista para el uso, la botella se llena hasta aproximadamente 1/4 por debajo de la marca con agua, la botella se cierra y se agita bien. Después de la espuma occurring se ha asentado, la botella se llena hasta la marca con agua.

Para preparar la suspensión listo para su uso, la botella se llena hasta aproximadamente 1/4 bajo la marca con agua, la botella se cierra y se agita bien. A Monte Carlo después de que la espuma se ha asentado, la botella se llena hasta la marca con agua.

UK HD

Questions ➜ Answers

1. Are more abstracts accepted (green card) or rejected (red card) in the EAHP abstract evaluation process? 

2. Is it possible to create an abstract presenting a single patient case? Yes

3. Can you proof (*present*) that a drug is efficient and safe by studying 5 patients? No

To write the perfect abstract be sure ...

to ask the right question

to answer the question

to not generalize with low numbers

to show relevant data only

to conclude only the things you have studied

to check the language

Take home message

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… and don’t forget ➜

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NO!

We try our best!

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