Materials and Methods A retrospective study was conducted from February to April 2012. All patients treated with VPA were included and grouped depending on whether VPA was part of their home treatment or not.

Variables collected were: dose, indication, total VPA serum concentration (C), drug interactions classified as ≥C by Lexi-Comp, glomerular filtration rate (GFR), Child-Pugh score, albumin and bilirubin.

Results 80 patients were treated with VPA, 24 of whom were on VPA before admission (15 epilepsy, 9 psychiatric disorders and 1 unknown reason).

Reasons for admission were: 5 convulsions, 12 psychiatric disorders and 15 cases unrelated to VPA. At discharge 27 patients continued on VPA with a mean dose similar to the dose at admission.

C was determined in 14 patients: 5 were within the reference range (50–100 mg/L); 2 above, achieving therapeutic levels before discharge and 7 below. In these latter cases, 3 had an albumin <4.2 g/dl, but none reached C > 50 mg/L after correcting it with the J. Hermida formula which is a theoretical method for normalising C in hypoalbuminemic patients. GFR, Child-Pugh score and bilirubin were normal. Mean time between changes in dose and C determinations was 1.5 days (0–5 days).

21 drug interactions were detected in 15 patients, involving a total of 10 drugs. Only 2 interactions were reported: VPA meropenem and VPA lamotrigine.

Conclusions Changes in free fraction of VPA, due to hypoalbuminemia, liver or kidney disease and hyperbilirubinemia, must be detected. C should be measured once a steady state has been achieved (3–5 days).

Drug interactions affecting VPA should be added to the pharmacy service’s interaction notification programme.

No conflict of interest.

PHC-029 THERAPEUTIC DRUG MONITORING OF DARUNAVIR IN TWO DIFFERENT TREATMENT MODALITIES

doi:10.1136/ejhpharm-2013-000276.373

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Background Darunavir (DRV) is a protease inhibitor (PI) that when boosted with ritonavir is effective against both wild-type and PI-resistant HIV. It’s relatively long half-life supports once-daily dosing and can lead to hepatic damage. Both factors could affect vancomycin elimination. Moreover, the use of drugs of abuse could also affect vancomycin clearance.

Purpose To characterize vancomycin pharmacokinetic parameters in non-cirrhotic alcoholics, patients with alcohol-induced cirrhosis and intravenous drug abusers (IVDAs).

Materials and Methods Retrospective study in the aforementioned patients treated with vancomycin in whom therapeutic drug monitoring (TDM) was performed, between 2009–2012, in a tertiary University Hospital. Clinical and pharmacokinetic reports from TDM (PKS Abbott) were reviewed to obtain demographic characteristics, hepatic/renal surrogates, initial/recommended dosage, steady state (SS) distribution volume (VdSS), clearance (CL), CSSmin and CSSmax. The therapeutic target was 7–12 mg/L for CSSmin. Patients with renal failure (Ccr < 60 mL/min) were excluded. Results are shown as a mean±SD (T-test for comparisons with controls).

Results Sixty-five patients were included. Demographic data were similar between the groups. 87.7% were men. Pharmacokinetic data is shown in table 1. As regards pharmacokinetic parameters, significant differences were only observed in CL in cirrhotic patients (#p = 0.02).

Conclusions Vancomycin CL is significantly decreased in cirrhotic patients, probably due to hepatorenal syndrome. Initial dose reduction might be considered. Vancomycin CL tends to be higher in alcoholics and IVDAs. Higher doses could be needed to obtain therapeutic concentrations. Therefore, vancomycin TDM is highly advisable in all these groups of patients.

Abstract PHC-029 Table 1

<table>
<thead>
<tr>
<th>Number of patients</th>
<th>Control</th>
<th>Non-cirrhotic alcoholic</th>
<th>Cirrhosis</th>
<th>IVDA</th>
</tr>
</thead>
<tbody>
<tr>
<td>CL (L/h)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.27±1.47*</td>
<td>6.40±2.16</td>
<td>4.27±1.18</td>
<td>6.53±1.91</td>
<td></td>
</tr>
<tr>
<td>Vd(ι) (L/Kg)</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>0.75±0.33</td>
<td>0.64±0.16</td>
<td>0.68±0.10</td>
<td>0.59±0.09</td>
<td></td>
</tr>
<tr>
<td>Initial dosage (mg/kg/day)</td>
<td>29.23±5.75</td>
<td>26.55±7.57</td>
<td>27.28±9.01*</td>
<td>28.05±6.12*</td>
</tr>
<tr>
<td>C50 (mg/L)</td>
<td>7.96±3.49</td>
<td>7.91±4.26</td>
<td>10.37±4.51</td>
<td>5.30±3.04</td>
</tr>
</tbody>
</table>

*p > 0.05; #p = 0.02

No conflict of interest.