started a new IV chemotherapy regimen a month before death. About lines of treatment, 45.25% (38) of the patients received first-line chemotherapy, 20.25% (17) in second line, 21.4% (18) in third line and 13.1% (11) received more than 3 lines of chemotherapy. In 48.75% (39), the percentage of the last dose of IV chemotherapy administered was ≤80%. All patients were admitted to the Oncology floor at some point in the last 30 days of life, with an average stay of 9.73 days.

Conclusions The percentage of patients receiving IV chemotherapy in the last 14 days of life and that of those who started with a new regimen a month before death are much higher in our hospital than in similar studies. In view of the results obtained, more than half of these patients received IV chemotherapy in the last month of life. This makes us ask ourselves what factors contributed to this decision to treat, were the benefit and toxicity correctly assessed and was it really necessary to have active cancer treatment in the last days of life?

No conflict of interest.

OHP-082 USE OF STANDARD PROTOCOLS FOR TOTAL PARENTERAL NUTRITION IN A TERTIARY UNIVERSITY HOSPITAL
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Background One of the clinical pharmacist’s main functions in parenteral nutrition is to ensure the quality and safety of the solutions prepared. It is too laborious to do this with each preparation. So in our hospital it was decided to design 21 standard Total Parenteral Nutrition (TPN) protocols.

Purpose To analyse the prescriptions for TPN and their compliance with the standard protocols available.

Materials and Methods A retrospective study was conducted over a period of one year (October 2011–October 2012). The composition of all TPN administered to adults was recorded, as well as the addition of various drugs such as insulin or somatostatin. Data were obtained from the pharmacy service’s nutritional database.

Results 629 adult patients were treated with TPN and received 8342 bags of TPN; 3129 (37.5%) fitted the standard protocols. The changes in the composition of TPN in non-standard TPN bags were: glucose added to 117 (2.3%) bags, lipids in quality 2276 (44.4%) and in quantity 374 (7.5%), nitrogen to 223 (4.5%); electrolytes: sodium to 238 (4.6%), calcium to 7 (0.1%), magnesium to 181 (3.5%), potassium to 3054 (59.6%) and phosphorus to 245 (4.8%); volume to 117 (2.3%), somatostatin to 545 (10.6%) and insulin to 862 (16.8%).

Composition of protocols ranged from: nitrogen: 6 to 20 g, increasing the amount of nitrogen from 2 by 2 g; glucose: 150–200–250–300 g, lipids 0–50–75–100 g, kcal non-protein/g nitrogen from 87.5 to 187.5 and volume 1350–2000–3000 mL. All protocols contained the same amount of electrolytes (sodium: 75 mEq, potassium: 6 mEq, calcium: 15 mEq, magnesium: 15 mEq, chloride: 90 mEq, acetate: 75 mEq and phosphorus: 10–20 mMol), vitamins and trace elements.

Conclusions 61% of administered TPN needed to be modified with respect to standard protocols in order to meet the nutritional requirements of individual patients. So we are considering revising the protocols regarding the quality of lipids and amount of potassium.

No conflict of interest.