that the ethanol will affect the patient and, thus, deserves attention.

Special caution should be taken with those patients at higher risk (alcoholism, liver disease, epilepsy). Special care should also focus on others drugs the patient may take that might interact with ethanol.

Patients should be advised not to drive or use machines soon after the chemotherapy treatment has been given and to inform the staff of any ethanol-related effect.

When assessing new formulations, pharmacists should also consider the ethanol content apart from the convenience of dilution.

Abstract GRP-059 Table 1

Drug	Patients	Dose (mg)[1]	Administrations[2]	g Ethanol/dose
Gemcitabine	69	1553.8	6.4	15.34(6.91–22.71)
Paclitaxel	63	149.78	6.02	9.86(4.74–28.83)
TOTAL	132			

[1] Medium dose.
[2] Number of administrations/patient.
10 g of ethanol = 1 glass of wine or beer.

No conflict of interest.

GRP-060 EVALUATION OF A PHARMACEUTICAL CARE PROGRAM TO PATIENTS WITH IMPAIRED RENAL FUNCTION

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Background According to EPIRCE study results (Epidemiology of Chronic Kidney Disease in Spain), approximately 11% of the adult Spanish population suffers from some degree of Cronic Kidney Disease (CKD).

Purpose Evaluate a Pharmaceutical Care Program to hospitalised patients with impaired renal function and determine the degree of acceptance.

Materials and Methods Prospective intervention study of 9 months (January–September 2012) at a regional 110 beds hospital. Patients with creatinine clearance (CRCL) < 50 ml/min/1.73 m^2 and a prescribed medication where is needed a CKD adjustment were selected. CRCL was estimated using the Cockroft-Gault equation (60 kg for women and 70 kg for males).

The patients identification was performed using the electronic prescription programme (eOsabide) and the laboratory INFOMEGA application. The data collected in the study were: age, sex, serum creatinine, pharmacotherapy and clinical service profile. The crossing data has been made in Access 2003.

The dose adjustment report's was made in writing in the patient's medical record (Osabide global). At 24–48 hours, the acceptance was evaluated.

Results A total of 618 hospitalised patients were included in the study (16 had a CRCL < 10 ml/min, 342 a CRCL between 10 and 30 ml/min and 309 a CRCL between 30 and 50 ml/min).

899 (14%) of 6.248 prescriptions were considered non-adjusted and were informed (27 were advices and 113 not evaluated because patient's discharge).

Fifty one per cent of the interventions were accepted.

Antibiotics were 26% of the interventions, anticoagulants in 39%, benzodiazepines in 18%, antiemetics in 6% and digitalis in 5%.

Conclusions Pharmaceutical care plays an important role in the drug treatment of patients in renal failure.

The implementation of the project has been well received among clinicians.

No conflict of interest.

GRP-061 EVALUATION OF DOSE RECOVERY FROM TABLET MANIPULATION FOR ENTERAL TUBE ADMINISTRATION

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Background Liquid formulations of medicines are required for administration through enteral feeding tubes (EFTs). Due to the limited availability of liquid medicines, crushing or dispersing tablets is frequently undertaken by nurses, carers and patients using a variety of different methods. The most accurate method of tablet manipulation has not been determined.

Purpose To determine the best method of tablet manipulation through comparison of dose recovery.

Materials and Methods Naproxen was selected as the model drug as no liquid formulations are available. The tablet was prepared using one of 6 methods identified from a previous survey: Dispersion in a syringe, dispersion in a medicine pot, crushed and dispersed using a crushing syringe, crushed and dispersed using a crushing device, crushed and dispersed in a pestle and mortar or crushed using two spoons. The resulting dispersion was flushed via an 8Fr polyurethane EFT (Corpak) into a receiving flask; repeated 6 times for each method. Dose recovery was determined using HPLC. Excel and statistical software was used for data analysis.

Results Tablet dispersion in the barrel of a syringe produced the highest dose recovery. All other methods delivered a dose outside the BP acceptable range of 95–105%. Full results in table 1.

Conclusions Dispersal in the barrel of a syringe did not significantly affect dose recovery. This study demonstrates that methods currently in use may deliver an insufficient dose; further research is required using different medicines and the effect of dispersion particle size on tube blockage.

Abstract GRP-061 Table 1

Method	% dose recovered	SEM	p
Control	100%	0.9	
Dispersal in syringe	98.0%	0.5	0.1493 NS
Crushing syringe	94.5%	1.2	0.0178
Dispersal in medicine pot	90.5%	3.4	0.0982 NS
Pestle and mortar	90.1%	1.5	0.0037
Crushing device	90.1%	2.7	0.0433
Crushing between 2 spoons	88.8%	1.1	0.0003

No conflict of interest.

GRP-062 EVALUATION OF GENTAMICIN THERAPY FOR ELDERLY HOSPITALISED PATIENTS

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Background New guidelines for the use of aminoglycosides were published by French National Health Authority in March 2011 [1]. They recommended 3–5 mg/kg/d for 48–72 h. Before, aminoglycosides doses were reduced in line with the creatinine clearance, which is frequently reduced in elderly patients.

Purpose To determine whether aminoglycoside treatment conformed to the guidelines. If not, the risks are a reduction in antibiotic effectiveness and the development of bacterial resistance among a vulnerable population.

Materials and Methods Elderly patients hospitalised in an acute geriatric unit or in a follow-up and rehabilitative care ward were included in a retrospective study with 2 inclusion periods: 3 months