Accordingly, the most common interventions were discontinuation of treatment (60%), switch to oral therapy (20%) and de-escalation (12%). Overall, 14% of errors intercepted were classified as being of moderate severity and 9.4% as serious. A significant reduction in the consumption of quinolones was achieved (from 15.0 to 12.6 defined daily doses/100 patient-days), with no significant change in the consumption of other antibiotics.

Conclusion HIGEA has identified opportunities to optimize antimicrobial use. Future work must aim to incorporate new custom-built clinical rules, including those to alert the need for prompt initiation of antimicrobial therapy.

REFERENCES AND/OR ACKNOWLEDGEMENTS

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No conflict of interest,

5PSQ-034 LINEZOLID AND SEROTONIN SYNDROME

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Background Serotonin syndrome (SS) is a potentially life-threatening clinical condition associated with the use of drugs that promote serotonergic neurotransmission. It is characterised by mental, autonomic and neuromuscular symptoms. Incidence is unknown and it is frequently underdiagnosed.

It is unknown how to predict who will develop it, so combinations of serotonergic agents should be avoided. It is essential to maintain a high clinical suspicion and knowledge of medications that can cause it. In 2016, the FDA issued a statement that included a list of drugs that increase serotonin. One of these drugs is linezolid, an antibiotic that is not usually associated with serotonergic effects.

Purpose Study frequency and relevance of this interaction between linezolid and serotonergic agents.

Material and methods Retrospective study of patients admitted under treatment with linezolid during 2017. Pharmacotherapeutic histories were analysed for all patients who received treatment with linezolid in electronic prescribing software (Farmatools). In those patients in whom concomitant use of serotonergic agents was detected, clinical histories were checked to see if they had been diagnosed with SS.

Results We found 77 patients treated with linezolid, 11 (14%) had concomitant prescriptions with serotonergic agents. In no case were more than two serotonergic drugs used at the same time. The most frequent interaction was with fentanyl (36%), followed by tramadol (27%): other less frequent were pethidine, sertraline, venlafaxine and citalopram. By therapeutic group, the most frequent interaction was with opioids (72% of patients with interaction), the rest with antidepressants. In no case was SS diagnosed.

Conclusion The number of patients with concomitant prescriptions of serotonergic agents was low and for most of them, risk was acceptable due to the lack of a therapeutic alternative. The incidence of SS can not be determined by the reduced data, although it can be estimated as low, since no case has been presented. The likelihood of experiencing SS has increased in recent years as a result of the extensive use of drugs with serotonergic actions. However, it is possible that it occurs more frequently with other medications, since linezolid is an antibiotic for hospital use and usually restricted, which requires the validation of a pharmacist, who can detect this type of interaction.

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No conflict of interest.

5PSQ-035 ANALYSIS OF THE MEDICATION TREATMENT OF COMMUNITY-ACQUIRED PNEUMONIA TREATED IN THE COMMUNITY AND HAVING RESULTED IN HOSPITALISATION

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Background Acute community-acquired pneumonia (CAP) is a widespread infection worldwide, causing many hospitalisations and deaths. The repeated and inappropriate use of antibiotics is the main cause of the emergence of bacterial resistance that can lead to therapeutic dead ends.

Purpose This study assessed the pharmacological management of CAP in community and hospital settings, according to the applicable national standards (NS).

Material and methods This was a retrospective and observational study, performed over 1 year in 13 short-stay wards in a 2,000-bed health facility. The patients included had a CAP previously treated in the community, knowing that each patient could be treated with one or more antibiotic strategies. Two infectious physicians and a senior clinical pharmacist analysed the compliance of antibiotic orders to NS for the medication choice (M), the medication dosage (P) and the treatment duration (D).

Results A total of 204 patients were included. The rates of patients with at least one non-compliance were 67.9% and 45.9% respectively in the community (n=187 patients) and hospital (n=181). The antibiotic therapies were non-compliant to NS for 44.5% on M (n=238 antibiotic therapies), versus 33.2% (n=226) respectively in the community and hospital, 20.6% on P (n=218) versus 4.9% (n=226) and 30.6% on D (n=206) versus 19.0% (n=216). In the emergency department (n=47), 23.8% and 6.1% of antibiotic orders were non-compliant for M and P, respectively.

Other works published in the literature on the rate of intra-hospital nonconformities present results similar to ours. This innovative study (hitherto never performed in the outpatient sector in France) reminds us of the importance of respecting the recommendations for optimal recovery of patients with CAP, avoiding multiple re-hospitalisations and preserving the efficacy of the existing antibiotic arsenal.

Conclusion Non-compliance to NS for antibiotic therapies can be explained by the multiplicity of prescribers, a lack of communication, a difficult access to clinico-therapeutic recommendations, microbiological information and medical imagery tests.

There is an urgent need to strengthen continuous training and to set up better coordination of care between community and hospital health professionals.

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No conflict of interest.

5PSQ-036 POLYPHARMACY AND DEPRESCRIBING IN HIV-INFECTED ELDERLY POPULATION

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Background Human immunodeficiency virus (HIV)-infected elderly population (IEP) must become a deprescribing critical group due to premature aging and high risk of age-related comorbidities and drug interactions.

Purpose To measure the prevalence of polypharmacy in HIV-IEP with antiretroviral therapy (ART). To analyse the need to introduce a deprescribing procedure in pharmaceutical care.

Material and methods An observational, descriptive, transversal study was carried out in April 2018 in a 2 60 000 healthcare area hospital.

All HIV-IEP (over 50 years) with active ART were included. Polypharmacy grades were defined as low (concomitant use of 6–10 medications), medium (11–20) and high (over 21), ART included.

Recorded variables: demographics (sex, age) and pharmacological (number of concomitant prescribed drugs (ART included) and polypharmacy grade). Data were obtained through electronic prescribing, medical records and the Landtools outpatient drug dispensation database.

A review of inappropiate chronic drugs in polymedicated VIH-IEP was carried out in order to prevent risk of falls, fractures, confusion, dementia, hospitalisation and mortality. Drugs included: anticholinergics, long-term antidiabetic agents (sulfonylureas), first-generation antihistamines, antipsychotics, bisphosphonates, cholinesterase inhibitors (CI), nonsteroidal antiinflammatory drugs (NSAIDs), opioids (oxycodone), proton pump inhibitors (PPIs), sedative-hipnotics, selective serotonin reuptake inhibitors (SSRIs) and tricyclic antidepressants (TA).

A descriptive statistical analysis was carried out with mean and standard deviation for quantitative variables including absolute and relative frequencies, via SPSS v.24 software.

Results Two-hundred and thirty-seven patients were included, 19.0% presented polypharmacy. Polymedicated patients were 66.6% males, median age 57 years (50–81).

The concomitant prescribed medication average was 8.4 ±2.5: 80.0% presented low-grade polypharmacy, 20.0% medium-grade and zero high-grade.

Inappropiate chronic drugs were found in 77.8% of the polymedicated group. Frequency distribution: 42.2% SSRIs, 37.8% PPIs, 22.2% sedative-hipnotics, 17.8% anticholinergics, 15.6% NSAIDs, 13.3% TA, 6.7% sulfonylureas, 6.7% antipsychotics and 2.2% oxycodone. No antihistamines, CI or bisphosphonates treatments.

Conclusion Despite the high rate of polypharmacy, it is lower than results observed in other studies (POINT study).[1] Our population shows a low-grade polypharmacy and a high incidence of inappropiate chronic drugs. Results prove the necessity to implement a deprescribing procedure in this group of patients.

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No conflict of interest.

5PSQ-037 ANALYSIS OF HUMAN IMMUNODEFICIENCY VIRUS POSTEXPOSURE PROPHYLAXIS IN A THIRD-LEVEL HOSPITAL

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Background The World Health Organisation recognises the need to improve uptake and completion rates for postexposure prophylaxis (PEP).

Purpose To analyse PEP dispensed by the pharmacy service to patients after an occupational (OE) or nonoccupational (NOE) exposure to the human immunodeficiency virus (HIV).

To compare usual clinical practice in our centre for PEP to European acquired immune deficiency syndrome (AIDS) Clinical Society guidelines.[1]

Material and methods A descriptive, observational and retrospective study performed in a third-level hospital regarding PEP dispensed from January 2015 to March 2018. The following data were retrieved from an electronic prescription program management tool (outpatients' clinical module) and electronic clinical records: sex, age, year, time from exposure, nature of exposure (sexual contact (SC) vs blood contact (BC)), OE vs NOE, service of the prescribing doctor, antiretroviral drugs (AD) prescribed, following monitoring in outpatient visit, positive infection detected after PEP, further episodes of PEP and positive infection nowadays.

We reviewed the current version of the European AIDS Clinical Society guidelines.[1]

Results Current guidelines recommend 4 week treatment with AD after OE or NOE as early as possible (no later than 48/72 hours). PEP regimen: emtricitabine/tenofovir disoproxilfumarato (FTC/TDF)+raltegravir (RAL) or darunavir/ritonavir (DRV/r) or lopinavir/ritonavir (LPV/r). Re-evaluation of PEP indication by HIV experts is recommended within 48–72 hours.

Clinical records of 57 patients were analysed: distribution per year 2015 24.5% (n=14), 2016 33.3% (n=19), 2017 33.3% (n=19), 2018 8.7% (n=5). Median age 29.9 years, 77.2% (n=44) males. Time from exposure <72 hour in 66.6% (n=38) of patients. Nature of exposure SC 61.4% (n=35), BC 14% (n=8), rest unknown. NOE 77,2% (n=44). Preventive medicine doctors prescribed 78.9% (n=45) of PEP, emergency room doctors 14% (n=8), and infectious diseases doctors 7% (n=4). AD prescribed were: elvitegravir/cobicistat/TDF/FTC 80.7% (n=46), RAL +TDF/FTC 15.7% (n=9), LPV/r+TDF/FTC 3.5% (n=2). Monitoring in outpatient visit 51.7% (n=30). Nopositive HIV infection was registered. Further episodes of PEP 5.2% (n=3).

Conclusion PEP is more frequently prescribed in young males after NOE by SC, and in our centre is not uniform regarding prescribing doctor, AD used or subsequent monitoring of patients.

Our clinical practice differs from European guidelines in AD use and patient monitoring. In order to comply with those guidelines, we will implement a protocol to optimise PEP prescription and patient follow-up.