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

REFERENCES AND/OR ACKNOWLEDGEMENTS

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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.

REFERENCES AND/OR ACKNOWLEDGEMENTS

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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.