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 inappropriate 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 antiinfectious agents (sulfonylureas), first-generation antihistamines, antipsychotics, bisphosphonates, cholinesterase inhibitors (CI), nonsteroidal antiinflammatory drugs (NSAIDs), opioids (oxycodeone), proton pump inhibitors (PPIs), sedative-hypnotics, 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.

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

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

REFERENCES AND/OR ACKNOWLEDGEMENTS
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.

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 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.

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/FTC/TDF 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). Nonpositive 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.
Background HIV post-exposure prophylaxis (PEP) aims at preventing HIV transmission through the intake of antiretroviral treatment (ART), after an occupational (OC) or non-occupational context (NOC) exposure.

Purpose In order to determine the safety and effectiveness of HIV PEP this study aimed to characterise patients who initiated PEP.

Material and methods Retrospective descriptive study, between January 2016 and September 2018. All the patients above 18 years old who presented risk of HIV contact and were medicated with PEP in the hospital pharmacy (HP), were included. Data were obtained from electronic medical records.

Results A total of 105 PEP were dispensed in HP, 52.4% in an OC and 47.6% in a NOC, mostly female (64.8%) with a mean age of 35.5±12.9 years.

In OC, females prevailed (83.6%). PEP intake was justified when there was contact with infected fluids through: accidental puncture (83.6%), eyeball contamination (12.7%) and skin-mucus membranes lacerations (3.6%). 41.5% were healthcare work-related accidents.

Regarding NOC, 56.0% were male. Prescriptions reasons were: unprotected sex 34.7%, condom rupture 32.7%, rape 22.5% and others 10.2%.

Source HIV serology was unknown in 70.5% of the cases. From the 105 PEP treatment initiated, six were suspended after knowing the source of HIV negative serology.

The initial ART mostly used was raltegravir (RAL) + emtricitabine/tenofovir (3TC/TDF) (78%). Others ART were initially used (22%), provided either by the emergency service or by another HP. RAL +3 TC/TDF combination was the main choice due to its tolerability profile and recent guidelines.1

Twenty-six patients experienced adverse reactions (AR) such as gastrointestinal discomfort, dizziness and heart palpitations.

63.8% patients completed 6 months post-exposure serological follow-up, with no cases of seroconversion, and were discharged. 18.1% of patients missed the follow-up serology and appointments, and the remaining patients are still under evaluation. Prophylaxis was proposed to five patients, four of them for systematic risk behaviours and one for serodiscordant partner.

Conclusion PEP has proved to be effective and safe (low severity AR) preventing HIV transmission. Variation of ARV used in PEP reflects the updating of the guidelines.1

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1. Updated Guidelines for Antiretroviral Postexposure Prophylaxis After Sexual, Injection Drug Use, or Other Nonoccupational Exposure to HIV. United States, 2016, CDC.

No conflict of interest.