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

http://ansm.sante.fr/var/ansm_site/storage/original/application/b33b6936699f3fefdd075316c40a0734.pdf

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.

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1. European AIDS Clinical Society (2017). EACS guidelines version 9.0, October 2017.

No conflict of interest.

5PSQ-038 SAFETY AND EFFECTIVENESS OF HIV POST-EXPOSURE PROPHYLAXIS

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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 are 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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No conflict of interest.

5PSQ-039 GLECAPREVIR/PIBRENTASVIR ASSOCIATION FOR CHRONIC HEPATITIS C VIRUS INFECTION: RESULTS IN HEALTH

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Background The European Medicines Agency authorised glecaprevir/pibrentasvir combination for treatment of hepatitis C virus (HCV) infection in July 2017. Treating hospital patients and the institutionalised population is essential in reducing transmission of virus infection.

Purpose To evaluate the effectiveness and tolerance of HCV patients treated with glecaprevir/pibrentasvir in hospital and penitentiary centres.

Material and methods Descriptive and retrospective study of HCV patients receiving glecaprevir/pibrentasvir from November 2017 to October 2018. Hospital and prison patients were selected. HCV prison patients were diagnosed and treated by the hospital and information was included in electronic medical history. Hospital and prison data were collected from electronic medical records: age, gender, patient type (naïve/pretreated), hepatic fibrosis stage, HCV genotype (G), medical departments, treatment duration, loss of follow-up after ending treatment, withdrawal treatments and HCV recurrence. Effectiveness was measured by end of treatment response (EOT) and sustained virologic response at week 12 (SVR12). EOT was defined as absence of HCV-RNA at end of treatment and SVR12 was determined as undetectable HCV-RNA 12 weeks after stopping treatment. Tolerance was assessed by related adverse effects (RA).

Results A total of 114 patients with a mean age of 51.7 (29–73) years were included, 101 (88.6%) males. Of all of them, 96 (84.2%) of patients were naïve. Hepatic fibrosis stage recorded: 10 (8.8%) F4, nine (7.9%) F3, 15 (13.1%) F2, 80 (70.2%) F0–F1. HCV genotype distribution: 44 (38.6%) G1a, 21 (18.5%) G1b, four (3.5%) G2, 21 (18.4%) G3 and 24 (21%) G4. Glecaprevir/pibrentasvir prescriptions: 30 (26.3%) internal medicine-infectious department, 33 (29%) digestive and 51 (44.7%) penitentiary centres. Duration of treatment was 8 weeks for 104 (91.4%) patients and 12 weeks for 10 (8.6%) (all cirrhotic patients). There were six (5.2%) loss of follow-up after ending treatment, being all digestive department patients. Withdrawal treatments: two (1.7%) patients (all prison patients). There was one (0.9%) HCV recurrence (an interferon-ribavirin-pretreated patient). One-hundred and eleven (97.5%) patients achieved EOT and 109 (96.1%) had RVS12. Seven (6.1%) patients reported nine RA: five (55.6%) asthaenia, two (22.2%) headache, one (11.1%) anxiety and one (11.1%) pruritus.

Conclusion High rates of EOT and RVS12 in real-world patients were observed. Few patients reported RA and all associated withdrawal treatments were recorded in the population of the penitentiary centres.

REFERENCES AND/OR ACKNOWLEDGEMENTS

None.

No conflict of interest.