Fifteen per cent of patients had a change in their treatment before falling. The average number of drugs per patient was nine per day. In these patients, the rate of prescription of drugs at risk of falling was high (87% for hypotensive treatments and 91% for inducing drowsiness treatments). A very high consumption of diuretics (40%) and benzodiazepines (60%) was observed. The combination of benzodiazepines was found in 16% of patients. Respectively, 24% and 65% of patients had a modification in their hypotensive and inducing drowsiness treatments.

Conclusion The use of drugs that increased the risk of falling was common in our hospital. The recent change in inducing drowsiness treatments seemed to increase the risk of falling.

Pharmaceutical interventions with prescribers on good prescribing practices in the elderly should be strengthened to minimise the use of drugs at risk of falling.

REFERENCES AND/OR ACKNOWLEDGEMENTS
Thanks to the Health Framework.
No conflict of interest.

**DISPENSATION OF FINITE MEDICATION AT DISCHARGE IN THE COMPLEX CHRONIC PATIENT**

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10.1136/ehjpharm-2019-eahpconf.560

**Abstract**

Within the programmes of continuous care of the complex chronic patient (CCP), there are initiatives to improve adherence and continuity of care. Most frequent is dispensing medication upon discharge.

A discharge finite medication (FM) programme for complex chronic diseases (DMCDP) was implemented in the continuity care unit of internal medicine (UCA) in our hospital.

**Material and methods** FM is defined as drugs that the patient doesn’t have and whose estimated duration of treatment is less than 30 days.

A prospective observational study was designed with all patients classified as CCP admitted to the UCA during the first 6 months of 2018, to compare cost and number of doses dispensed (DD) between the community pharmacy (CP) system vs the DMCDP programme.

An Excel database was created. Variables: age, sex, medication dispensed, therapeutic group, indication, duration and days until end of treatment, units dispensed and saved vs CP more adjusted to treatment presentation, estimated cost in CP according to Remedios, cost of hospital dispensation and opportunity cost. All data were analysed with XLS Stat for descriptive statistics.

Tools: history of primary care, electronic prescription, medication bag, informative interview on admission and discharge, medication sheet at discharge, hourly chart, FM in unit doses with posology until the end of treatment and in daily kits dated for medications with variable posology such as descending corticoid patterns. Remedios data base.

**Results** Sixty-six patients were studied. Age 83 (44–98) years. 94.17% old). 94.17% had undetectable VL. 54.2% patients were pluripathologic (59.3%), antibacterial (34.7%) and antithrombotic antihaemorragic (4.7%).

Cost savings in medication for the national health system greatest savings were AC (78%) and ABR(14%).

The biggest problem on admission and discharge was lack of time.

**Conclusion** A discharge medication programme led by a hospital pharmacist, reinforces understanding and compliance for each patient, decreases the risk failure due to lack of adherence, knowledge or accessibility problems. In addition, it promotes rational use, since dispensing of the exact units reduces the possibility of future self-medication at home.
with a median of three (2–4) comorbidities and 26.7% poly-
medicated with a median of seven (6–9) drugs per patient. The most common chronic diseases were: anxiety/depression (45.8%), dyslipidaemia (32.5%), hypertension (20.8%) and psychiatric disorders (19.2%). Benzodiazepines (32.5%), vitami-
in D (31.7%), proton-pump inhibitors (22.5%), statins (20%), antidepressants (18.3%) and antipsychotics (15%) were the most common drugs prescribed.

A total of 55 CSDIs were identified in 41 patients (34.2% of patients), of which 78.18% involved ARV drugs. Classes of drugs most involved in CSDIs were: pharmacokinetic enhancers (40%), protease inhibitors (38.18%), statins (25.45%), antipsychotics (25.45%) and antidepressants (14.54%). The risk of DRPs was high in 46.7% of patients. In statistical analysis (Mann–Whitney U test), the relationship between the number of comorbidities and the risk of DRPs and CSDIs was statistically significant (p<0.005) in both cases.

Conclusion The results of the study demonstrate the aging of the HIV +population and the consequences that this entails: an increased risk of presenting DRPs as well as the risk of CSDIs. Due to this, a meticulous and multidisciplinary approach is necessary in this population in order to identify the most susceptible patients.

REFERENCES AND/OR ACKNOWLEDGEMENTS
No conflict of interest.

BACKGROUND AND CLASSIFICATION OF ANALYSIS OF RITUXIMAB OFF-LABEL USE

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No conflict of interest.

Background Rituximab is a monoclonal antibody indicated in Spain in adults with non-Hodgkin’s lymphoma, chronic lymphatic leukaemia, rheumatoid arthritis and granulomatosis with polyangiitis and microscopic polyangiitis.

Purpose To evaluate the use of rituximab in a district hospital in off-label conditions which did not respond to corticosteroids or immunosuppressants treatment.

Material and methods We carried out a retrospective observational study of the use of rituximab off-label from its inclusion in the pharmacotherapeutic guide of the hospital in 2009 until July 2018.

Data collected: number of patients, sex, age, diagnosis, previous treatment with rituximab, concomitant treatment with rituximab, treatment schemes and adverse effects 6 months after the start of treatment. Digital clinical history and external consultations application were used. Statistical analysis was performed with SPSS version 24.

Results Number of patients: 21. Sex: 11 (52.4%) males. Mean Age: 53.3 (21–80). Diagnostic groups: six patients (28.6%) developed glomerulonephritis, five (23.8%) lupus, five (23.8%) vasculitis for cryoglobulins and ANCA positive, three (14.3%) myositis and two (9.5%) pemphigus. Treatment prior to rituximab: all patients were treated with prednisone, 11 (52.4%) with mycophenolate mofetil, 10 (47.6%) with azathioprine, 10 (47.6%) with cyclosporine A, six (28.6%) with hydroxychloroquine, three (14.3%) methotrexate, two (9.5%) with tacrolimus, one (4.8%) with immunoglobulins and one (4.8%) with monoclonal antibodies. Concomitant treatment with rituximab: all patients had been treated with prednisone, five (23.8%) with hydroxychloroquine, five (23.8%) with azathioprine, four (19%) with mycophenolate

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No conflict of interest.

BALANCE AND CLASSIFICATION OF PHARMACEUTICAL INTERVENTIONS IN A GENERAL HOSPITAL OF SPECIALTIES: THE PERSONALISED HOSPITAL PHARMACY

Background Pharmacare (PC) is the ‘supply of medicines with the purpose of achieving concrete results that of treatments significantly improves therapeutic safety, minimising the risk to the patient. These results provide quantifiable data to measure the activity of the clinical pharmacist, in addition to providing data on pharmacotherapeutic quality indicators.

REFERENCES AND/OR ACKNOWLEDGEMENTS
Database Pharmacy Unit.
No conflict of interest.

ANALYSIS OF RITUXIMAB OFF-LABEL USE

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