pharmacy department during chemotherapeutic drugs-dispensing to cancer patients by means of a questionnaire of 19 questions organised around three items:

- Socio-demographic characteristics.
- Knowledge about recommended treatments and their interactions.
- Drugs and herbal medicine used in self-medication.

Results With an average duration of 9 min per patient, 156 interviews were conducted with a participation rate of 80.77% (n=126). Average age was 52 ± 7.81 . The study population was characterised by particularly precarious socioeconomic conditions such as 74 unemployed patients. One-hundred and eleven patients did not know their treatments, 100% of this sample were unaware of any interactions with other drugs, while 19 patients denied any self-medication without medical advice. For the rest of the patients (n=107), the two main reasons for the use of self-medication were: the relief of adverse effects (n=80) and the potentiation of the therapeutic effect (n=22) by use of herbal medicine including *Marrubium vulgare* and *Euphorbia resinifera*. The analgesics were in the majority for 66 patients followed by drugs for digestive disorders in 24 patients. Vitamins were taken by 15 patients. For 52 patients who used analgesics, the intake was punctual. It was less than 7 days for 19 patients who consumed drugs from the digestive sphere.

Conclusion A series of pharmaceutical interviews were set up at the UFGPSP to make patients aware of the dangers of self-medication and to inform them about their recommended treatments, the management of adverse effects and the main risky interactions to avoid.

REFERENCES AND/OR ACKNOWLEDGEMENTS

Thanks to my co-worker for carrying out this study with me.

No conflict of interest.

5PSQ-150 TRADITIONAL MISUSE OF CAMPHOR POWDER: CONCERNING TWO CASES OF PAEDIATRIC POISONING

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Background In our country recourse to recipes of traditional medicine and homemade cosmetics is very frequent because of the high rate of illiteracy, low purchasing power and the large number of herbalists. Camphor is an inexpensive product, easily accessible and ubiquitous in almost all homes, making it a potential toxic for misuse, especially in children.

Purpose To present the story of two cases of intoxication consecutive to a beauty recipe based on camphor powder, in order to describe the importance of the sensitisation role exercised by the clinical pharmacist during the discharge interview. **Material and methods** We analysed the files of the two patients during their hospitalisation in June 2018, and then

we conducted face-to-face interviews with the mothers of the addicted children, and the attending physician.

Results The anamnesis gave information on a poisoning with a synthetic powder based on camphor imported from China in the two patients.

Patient 1: Girl aged 2 months, without antecedents, admitted to the paediatric emergency department in a state of ceaseless crying with a refusal of food. The clinical examination was without any particular characteristics. The standard biological test was normal. The infant was under neurological, digestive and cutaneous supervision.

Patient 2: Girl aged 6 years, admitted following atonic seizures with syncope and foam, followed by an installation of abdominal pain accompanied by food vomiting following ingestion of the milk. Evolution was favourable after 48 hours of symptomatic management.

The interview with the mothers revealed that they were two neighbours who received a traditional recipe for the hair care of a third neighbour after which they mixed camphor powder with olive oil, then applied it to their children's hair for 1 hour, causing the appearance of these signs. As a result, a 30 min exit pharmaceutical interview was given to mothers to explain the dangers of using excessive traditional recipes.

Conclusion The interview with the mothers revealed that three other people used this preparation for their children, except that the duration of exposure was less than 30 min, which could justify the absence of harmful symptoms. It is advisable to integrate items on traditional recipes during pharmaceutical interviews with patients.

REFERENCES AND/OR ACKNOWLEDGEMENTS

No conflict of interest.

5PSQ-151 ARE PROPOFOL EMULSIONS STABLE WHEN INTRAVENOUSLY CO-ADMINISTERED WITH REMIFENTANIL?

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Background Propofol, a general anaesthetic, and remifentanyl, an opioid analgesic, are used to both induce and maintain sedation. They often need to be administered simultaneously via the same venous catheter lumen. This predisposes to potential compatibility issues with undesirable consequences such as catheter obstruction and, ultimately, embolism. Propofol is a fat emulsion and available formulations differ considerably in fat composition. Diprivan contains 100% pure long chain triglycerides (LCT) whereas Propolipid and Propofol-Lipuro contain 50% LCT and 50% medium-chain triglycerides (MCT). The three formulations also differ in the type and amount of other excipients. There is no exhaustive information on all three propofol formulations.

Purpose Our aim was to determine and compare the emulsion stability of propofol formulations Propolipid, Propofol-Lipuro and Diprivan when administered together with remifentanyl.

Material and methods To simulate Y-site compatibility, remifentanyl (Ultiva) 50 µg/ml was mixed in vials with 10 mg/ml concentrations of Propolipid, Propofol-Lipuro and Diprivan, respectively. The mixing ratios of remifentanyl:propofol were 1:1 and 10:1. Controls consisted of each propofol formulation

analysed separately. Analysis was conducted immediately after mixing and 4 hours' later. Emulsion stability was determined by calculating the percentage of fat residing in globules larger than 5 µm (PFAT5), measuring pH and mean droplet diameter.

Results None of the propofol formulations resulted in increased PFAT5 immediately after mixing with remifentanyl in mixing ratios of 1:1 and 10:1. However, all formulations resulted in PFAT5 levels over what is acceptable 4 hours' after mixing with remifentanyl except for Propolipid and Diprivan in mixing ratio 1:1. No difference in mean droplet diameter was noticed and we did not see an association between the decreased pH that occurred and the stability of the emulsions. **Conclusion** Remifentanyl administered with propofol formulations in the same intravenous catheter may lead to emulsion instability. If the infusion rate is slow, separate intravenous administration of these drugs should be considered.

REFERENCES AND/OR ACKNOWLEDGEMENTS

No conflict of interest.

5PSQ-152 DO WE KNOW THE CONTENT OF HARMFUL EXCIPIENTS IN MEDICINES THAT NEONATES RECEIVE?

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Background Excipients in drug formulations have been historically considered harmless to the patient. However, this may not be true when they are used in specific populations, for example paediatric or neonatal patients. Because of the immaturity of newborns' metabolism, the continuous exposure can produce an accumulation of some excipients. In these cases, exceeding the acceptable daily intake (ADI) could induce some harmful effects.

Purpose Analyse the content of harmful excipients (HE) of the medications included in the hospital's neonatal intensive care unit (NICU) treatment guide.

Elaborate educational material about different toxicities of HE in neonates, addressed to physicians and nurses of NICU.

Material and methods We conducted a bibliographic revision concerning HE, their potential toxicity and if ADI was established in neonatology. With this information, we reviewed the summary of product characteristics (SmPC) of the pharmaceutical products (PP) and compounded preparations (CP) used in our NICU, to determine the qualitative and quantitative composition in HE.

Total daily excipient exposures, for each drug, were established by calculating the average amount of HE administered secondary to the recommended maximum daily drug doses for newborns that appears in Neofax (R).

Results Nine HE and their toxicities were considered and reviewed: benzoates, benzyl alcohol, aspartame, benzalkonium chloride, ethanol, polysorbate 80, propylene glycol, parahydroxybenzoates and sorbitol. Two-hundred and twenty-seven medicines (182 PP and 45 CP) were analysed. Of the PP, 52 contained at least one HE (28.6%) and in 13 of them (7%) the amount was greater than their ADI defined. The quantitative analysis was not possible with the SmPC in 28 of them. Of the CP, 17 (40%) had one or more HE but none exceeded the ADI recommended. Based on this information, we

arranged a training session for prescribers and nurses, and leaflets with the reviewed medications, their toxicities and the qualitative and quantitative content in HE.

Conclusion Harmful excipients are frequently present in medications available in the NICU. Raising the awareness of healthcare professionals is important in order to choose, if it is possible, safer alternatives.

The quantitative composition in HE was lacking in some SmPC despite it being a requirement from the EMA. The development of paediatric medicines with appropriate excipients is necessary.

REFERENCES AND/OR ACKNOWLEDGEMENTS

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5PSQ-153 DETECTION OF POTENTIALLY INAPPROPRIATE PRESCRIBING IN AN INSTITUTIONALISED POPULATION

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Background Different tools aimed for the detection of potentially inappropriate prescribing (PIPs) have been developed in the past years.

Purpose To describe and compare the prevalence of PIPs detected in institutionalised patients according to Beers, STOPP-START and PRISCUS criteria, and to identify the most involved therapeutic groups.

Material and methods Cross-sectional descriptive analysis which included a random sample of institutionalised patients, 65 years' old or older and with active drugs in electronic prescribing (EP) at the time of data collection (May 2018).

Variables were: age, sex, Charlson comorbidity index (ChI), number of PIPs detected with each tool applied and drug involved in the PIP.

To obtain the data, medical records and EP were reviewed. **Results** A total of 76 patients were analysed. Mean age was 88.39 years (± 5.6), with 94.5% of patients over 80 years: 80.3% were females. Median number of drugs/patient was 9 (2–18) with 56.6% of patients between 5–10 drugs and 28.9% over 10. Mean ChI was 6.92 (± 1.54), corresponding to a moderate-high comorbidity degree. At least one PIP was detected by one of the tools in 84% (n=64) of the patients. Three-hundred and six PIPs out of 655 analysed prescriptions were detected: 140 by STOPP criteria (1.8/patient), 119 by Beers (1.56/patient) and 35 by PRISCUS (0.46/patient). START criteria detected 12 drug omissions.

PIPs detected affected 176 drugs. 'Nervous system' (group N) with 70.4% was the most involved pharmacotherapeutic group, followed by 'Alimentary tract and metabolism' (group A) with 12%. Benzodiazepines and proton pump inhibitors were the most frequent drugs. Omission of drugs (START criteria) mainly affected anti-dementia drugs.

Conclusion The analysed population had a very advanced age and a considerably high degree of polypharmacy, as comorbidity is important. In our patients, the prevalence of detected PIPs was high. STOPP criteria had the highest quantitative detection capacity. Nervous system drugs were the most frequently involved.