A retrospective, observational, descriptive study was conducted in HIV patients who started ART in 2014 and 2018. Data collected from the electronic medical history and prescription protocol reflected a decrease in the use of TDF/FTC as starting treatment and more patients with indetectable VL. Our study identified a notable decrease in the cost of ART per patient/year.

**Conclusion and relevance**

The demographic profile of patients changed little over the study period. Sexual transmission continued to be the main route of infection despite official prevention strategies. The new recommendations for early initiation of ART in all HIV patients led to better results than deferred treatment (higher values of CD4 at baseline and at 4 weeks, and more patients with indetectable VL). In turn, the use of INSTI associated with initial ART has increased due to its power and good tolerance. The cost/patient decreased slightly despite commercialisation of generics due to the appearance of INSTI and TAF.

**REFERENCES AND/OR ACKNOWLEDGEMENTS**

No conflict of interest.

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**Abstract 4CPS-177 Table 1**

<table>
<thead>
<tr>
<th></th>
<th>2014</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients (n)</td>
<td>15</td>
<td>15 (dropout at week 2: 1 patient)</td>
</tr>
<tr>
<td>Men (%)</td>
<td>93</td>
<td>73</td>
</tr>
<tr>
<td>Age (years)</td>
<td>44.9 (28–68)</td>
<td>41.5 (14–72)</td>
</tr>
<tr>
<td>Transmission route (%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heterosexual</td>
<td>46</td>
<td>33</td>
</tr>
<tr>
<td>Homosexual</td>
<td>27</td>
<td>47</td>
</tr>
<tr>
<td>Parenteral</td>
<td>27</td>
<td>20</td>
</tr>
<tr>
<td>Time from diagnosis to the beginning of ART (days)</td>
<td>1025 (12–4116)</td>
<td>93 (6–489)</td>
</tr>
</tbody>
</table>

**Abstracts**

**4CPS-177 COMPARATIVE STUDY OF PATIENT PROFILES AND INITIAL ANTIRETROVIRAL TREATMENT IN 2014 VERSUS 2018**

T. Gonzalez Furelos*, A. Casas Martínez, I. Rodríguez Penín. Xerencia Xestión Integrada Ferrol, Pharmacy Service, Ferrol, Spain

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**Background and importance**

Antiretroviral therapy (ART) has evolved over the years, leading to a change in initial therapy strategies.

**Aim and objectives**

To describe and compare the profile of patients who started ART in 2014 and 2018. To assess chosen treatment schemes and cost per patient.

**Material and methods**

A retrospective, observational, descriptive study was conducted in HIV patients who started ART in 2014 and 2018 in a second level hospital. Data collected from the electronic medical history and prescription programme were demographic data, transmission route, viral load (VL) and CD4 lymphocytes at the beginning and after 4 weeks of treatment, chosen ART and treatment cost/patient/year.

**Results**

Combination ART therapy chosen in 2014: two nucleoside reverse transcriptase inhibitors (NRTIs) (87% tenofovir–disoproxil/emtricitabine (TDF/FTC) and 13% abacavir/lamivudine (ABC/3TC)), a non-nucleoside reverse transcriptase inhibitor (NNRTI) (13.3% efavirenz and 20% rilpivirine) or a protease inhibitor (PI) (46.7% darunavir–cobicistat (ELV/c)). One patient initiated TAF/FTC+DRV+ELV/c due to a restrictive resistance profile. The cost of ART per patient/year was 8632€ in 2014 and 7405€ in 2018.

**Conclusion and relevance**

The demographic profile of patients changed little over the study period. Sexual transmission continued to be the main route of infection despite official prevention strategies. The new recommendations for early initiation of ART in all HIV patients leads to better results than deferred treatment (higher values of CD4 at baseline and at 4 weeks, and more patients with indetectable VL). In turn, the use of INSTI associated with initial ART has increased due to its power and good tolerance. The cost/patient decreased slightly despite commercialisation of generics due to the appearance of INSTI and TAF.

**REFERENCES AND/OR ACKNOWLEDGEMENTS**

No conflict of interest.

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**4CPS-178 TRANSCRIPTION OF SUPPORTIVE MEDICATION FOR INPATIENT CHEMOTHERAPY BY DESIGNATED ONCOLOGY WARD PHARMACISTS**

1. C. Imaz*, 2. E. Smith, 1. A. Fox, 1. D. Wright, 3. C. Carson. 1. University Hospital Southampton NHS Foundation, Pharmacy, Southampton, UK. 2. University Hospital Southampton NHS Foundation, Southampton Pharmacy Research Centre, Southampton, UK. 3. Queen’s University Belfast, School of Pharmacy, Belfast, UK

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**Background and importance**

Following several incidents where patients’ supportive treatments were omitted, a safety measure in the verification process for inpatient chemotherapy (IPChx) treatment was implemented. Oncology ward pharmacists (OWPs) must ensure supportive medications are transcribed from ARIA (chemotherapy prescribing software) to JAC (inpatient prescribing software) before chemotherapy is released to the ward. Current practice is for clinicians to complete the transcribing, and delays in prescribing these may delay chemotherapy administration. This can impact on the pharmacy service, hospital workflow, and patient care and satisfaction.

**Aim and objectives**

To evaluate whether the transcribing pharmacist role reduces IPChx delivery time and occurrence of transcribing errors.

**Material and methods**

Stage 1 (control): the clinician led process of transcribing was mapped and the time taken for each stage recorded by OWPs for 4 weeks (February–March 2019) using a piloted data collection form. Stage 2 (active period): OWPs carried out the transcription. Transcription and delivery to patient times were again recorded using the same data collection form (June–July 2019). Stages 1 and 2 mean delivery to patient and transcribing process times were compared using a Student’s t test and Welch t test, respectively. Transcribing error rates for each stage were compared using a χ² test.

**Results**

The mean IPChx delivery time during the active period was 50.2 hours (range 24.7 to 75.7), a decrease of 23.7 hours (95% CI –15.4 to 62.8) compared with the control period (p=0.228). There was a notable decrease in
screening process time, from 7.8 hours (range 4 to 11.6) in the control to 3.5 hours (range 1.8 to 5.2) in the active period, a statistically significant difference of 4.3 hours (95% CI 0.2 to 8.5, p=0.039). The transcription error rate during the active period was 4%, lower than the 27% in the control period ($\chi^2$ (1)=36.46, p<0.001).

**Conclusion and relevance** Involving OWP s in transcribing supportive medication reduced the IPChx delivery time and the occurrence of transcribing errors. Nonetheless, inconsistencies between current practice and hospital targets raised important issues that may imply that a further evaluation of the whole IPChx process is required. Consequently, further research is required to establish if additional interventions are required to improve waiting times for oncology patients.

**REFERENCES AND/OR ACKNOWLEDGEMENTS**

Conflict of interest: Corporate sponsored research or other substantive relationships:

This project was completed as part of the MSc Advanced Clinical Pharmacy Practice programme at Queen’s University Belfast. This was funded with the Pharmacy Fund Award granted by the Southampton Pharmacy Research Centre at University Hospital Southampton NHS Foundation Trust.

**4CPS-179** THE WIDE REVIEW OF POLYPHARMACY IN THE FRAIL OLDER PERSON

1. Kinahan*, 2. Heeney, 1. Portiuncula University Hospital, Pharmacy Department, Co Galway, Ireland; 2. Portiuncula University Hospital, Pharmacy Department, Ballinasloe, Ireland

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**Background and importance** The WIDE (Wholistic Integrated Deprescribing Evaluation) review is an innovative model of patient-led, pharmacist facilitated medication review. It involves establishing patients’ priorities and experiences of their medicines, collaborating with primary care providers and evaluating if medicines should be deprescribed because their potential harms outweigh their potential benefits. Frailty is synonymous with vulnerability, including to medication harms. To assess the potential for harm, the WIDE review model incorporates the STOPP/START criteria and the medication appropriateness index (MAI) tools, the use of which have demonstrated improvements in patient outcomes. However, the impact of a patient-led deprescribing model has not yet been studied in this setting.

**Aim and objectives** To examine the impact and cost effectiveness of WIDE reviews.

**Material and methods** This quantitative prospective cohort study was conducted over 8 weeks.

**Inclusion criteria** inpatients aged >65 years and prescribed >5 regular medications who screened positive for frailty (PRISMA 7 score >3). Critically ill patients were excluded. Eligible patients were randomly allocated to the intervention or control group.

Regular medications were enumerated and screened using the STOPP/START criteria on admission and discharge. The intervention group received a WIDE review and their MAI score was calculated on admission and discharge. In conjunction with the patients and their consultants, deprescribing plans were devised and communicated to their GPs and community pharmacists.

**Results** A total of 20 intervention and 20 control group patients were enrolled. Patient characteristics (age, sex and length of stay) were similar for both groups. A total of 65% of STOPP and 62% of START criteria were addressed in the intervention group versus 12% and 5%, respectively, in the control group. In the intervention group, 83 medications were stopped, 23 doses were reduced and the total MAI score was reduced by 64%. Cost savings to the annual drug budget alone represented a 9:1 return on investment of hospital pharmacist time. Most discontinuations and dose reductions were sustained (98%) and 92% of future recommendations were enacted on 6 months of follow-up.

**Conclusion and relevance** Pharmacists performing patient-led WIDE reviews significantly improved medication appropriateness and realised compelling cost savings. A large scale, multisite study is warranted to demonstrate the reproducibility of these results.

**REFERENCES AND/OR ACKNOWLEDGEMENTS**

No conflict of interest.