

DOACs, renal function, drugs associated with bleeding and comorbidities.

### Results

**Abstract 5PSQ-009 Table 1**

	Haemorrhagic event	
	UGIH	ICH
Cases (n (%))	108 (70.1)	46 (29.9)
Age (years) (mean (range))	67.2 (25–104)	74 (42–100)
Women (n (%))	34 (31.5)	18 (39.1)
Under acenocumarol therapy (n (%))	10 (6.5)	9 (5.8)
Under DOAC therapy (n (%))	4 (2.6)	3 (1.9)
Apixaban	1	2
Dabigatran	1	0
Edoxaban	2	0
Rivaroxaban	0	1
Incorrect DOAC posology	1	0
Appropriate indication	4	3
NSAID	0	0
GC	0	0
SSRI	1	0
PAA	1	1
Total risk drugs	2	1
Gastric lesions	4	0
Liver disease	0	0
Coagulopathy	0	0
Hypertension	4	3
Total risk comorbidities	8	3

**Conclusion and relevance** The population showed a prevalence for UGIH and ICH of 1% from ES admissions, and 4.5% of these were associated with DOAC use. Only in one case was the posology inappropriate and in all patients the indication was suitable. It was observed that comorbidities may affect bleeding risk more than drugs although we should not underestimate the importance of concomitant drugs.

### REFERENCES AND/OR ACKNOWLEDGEMENTS

No conflict of interest.

### 5PSQ-010 BENEFITS PROVIDED BY RECOMBINANT LONG HALF-LIFE COAGULATION FACTORS IN PATIENTS WITH SEVERE HAEMOPHILIA 'A' IN PROPHYLAXIS

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**Background and importance** New recombinant long half-life factors VIII (RLHF) have been added to the therapeutic arsenal with the aim of improving the treatment of patients with severe haemophilia A as prophylaxis. After 2 years of treatment, we want to analyse if it has resulted in a real improvement.

**Aim and objectives** To determine the decrease in the number of infusions, consumption of international units (IU) of factor and how this has influenced spending. We also determined if the change has meant an improvement in adherence to treatment.

**Material and methods** This was an observational prospective study in a hospital with a reference unit for congenital coagulopathies that included all patients who began treatment with RLHF and had been on treatment for at least 3 months: rurioctocog (Adynovi), lonoctocog (Afstyla) and efmoroctocog (Elocta). Treatment with RLHF was compared with conventional factor VIII (CF) that was administered before the change, during the whole period with RLHF and the whole last period (CF). Adherence, number of infusions, IU consumed and cost/month were compared. Adherence was calculated considering the number of IU dispensed at the pharmacy and the number of IU prescribed. Changes >10% were considered relevant. Adherence values >100% were treated as 100%. Microsoft Office Access and Excel were used for the recording of variables and statistical analysis.

**Results** Thirty-five patients were included, all men, with a median age of 19 (ICR 12–28) years; all patients had previously received recombinant factor VIII except for two patients who had received plasmatic factor. We found that 31% of patients improved their adherence by more than 10% by switching to RLHF: 14% of patients reduced their adherences by >10% and 55% of patients maintained their adherence. Patients with <90% adherence with the previous treatment was 37% and with RLHF was 22%. Median monthly infusions were 12 and a median of 2 monthly infusions was reduced by switching to RLHF. The median number of IU saved per patient/month was 7000 (ICR (–8000); 1000) IU. This resulted in a median savings per patient/month of 3182 (ICR (–3.654); (–5)€).

**Conclusion and relevance** RLHF is a discrete advance in haemophilia therapy and it decreased the number of infusions/month with a small improvement in adherence. Less IU was consumed/month, and this was a cost saving.

### REFERENCES AND/OR ACKNOWLEDGEMENTS

No conflict of interest.

### 5PSQ-011 COMPLICATIONS OF DRUG CONTAINING PARENTERAL NUTRITION: A COHORT STUDY

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**Background and importance** Parenteral nutrition (PN) is an intravenous formulation composed of a wide variety of nutrients. Adding drugs to PN have certain advantages although associated drawbacks have been described, such as the risk of instability and incompatibility with macro or micronutrients.

**Aim and objectives** To evaluate if the addition of certain drugs to PN was associated with a higher incidence of PN complications.

**Material and methods** This retrospective observational cohort study included hospitalised patients treated with personalised PN from July 2018 to July 2019. Paediatric patients and those who received PN for >3 days were excluded. Variables collected: age, sex, cause of hospitalisation, PN administration route, presence of drugs in PN, duration of PN treatment and PN complications. PN were classified as drug containing PN if somatostatin, ranitidine, insulin or metoclopramide were added.

Descriptive and correlation analyses between PN complications and the rest of the studied variables were carried out. Statistical analysis was performed by OR and logistic regression using IBM SPSS Statistic 24 package.

**Results** A total of 185 patients were included, 56.2% men, median age 60.5 years (18–89 years): 26 patients were excluded. The causes of hospitalisation were neoplasia in 44.86%, digestive pathologies in 34.05%, infections in 11.35% and other pathologies in 9.73%.

The PN administration route was a central catheter in 76.9% of patients and a peripheral catheter in the remaining patients: 43.24% (n=80) of patients suffered plasmatic electrolyte alterations during PN treatment and 11.89% (n=22) suffered catheter infections. No statistically significant differences were observed for age, sex, cause of hospitalisation, catheter type, incidence of metabolic complications or electrolyte alterations ( $p>0.1$ ). A larger number of catheter infections occurred in patients receiving drug containing PN (OR 2.69 (1.08–6.67)).

Median duration of PN treatment was 12 days (3–138). Treatment duration was longer for patients receiving drug containing PN (21.03 vs 14.44 days,  $p<0.05$ ). Duration of PN treatment was correlated with the onset of catheter infections ( $p<0.0001$ ).

**Conclusion and relevance** No correlation was found between the addition of drugs to PN and most studied complications. Patients who received drug containing PN had a higher risk of catheter infections. The longer duration of treatment with drug containing PN may be the cause of the increased incidence of infections.

#### REFERENCES AND/OR ACKNOWLEDGEMENTS

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No conflict of interest.

#### 5PSQ-012 DRUG INTERACTIONS AND POLYPHARMACY IN A COHORT OF HIV POSITIVE HAEMOPHILIC PATIENTS

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**Background and importance** The haemophilic population is getting older and therefore they need to confront other comorbidities in addition to those associated with congenital coagulopathy.

**Aim and objectives** To determine the complete pharmacological treatment of a cohort of HIV positive haemophilic patients to determine potential drug interactions (PDI), and to compare them with a reference cohort of haemophilic patients (RP).

**Material and methods** A cross sectional observational study was conducted in HIV positive haemophilic patients, aged over 18 years, and receiving active treatment in February 2019 in a haemophilia unit of a third level hospital. A multidisciplinary team comprising infectious diseases, haematology and pharmacy was established. Biodemographic, clinical and pharmacological variables were recorded. PDI were analysed using the database Micromedex. Moderate and severe PDI were selected. The data were obtained from clinical history (SAP), electronic prescription programme (SILICON) and the electronic prescription system (SIRE). RP was selected from Mannucci *et al* (2018).

**Results** The cohort consisted of 40 HIV positive haemophilic patients with a median age of 49 years (36–75).

Clinical variables included type of haemophilia: A (80%), B (5%), factor X deficit (2.5%) and Von Willebrand disease (2.5%). Severity was classified as severe (67%), mild (27.5%) and moderate (5%).

Pharmacological variables: recombinant factor (75%: 62.5% extended half-life (EHL) and 37.5% first generation) and plasma derived factor (25%); antiretroviral treatment: tri-therapy (57.5%), bi-therapy (40%), monotherapy (2.5%); total number of drugs (compared with RP): excluding HIV and haemophilia drugs 2.9 ( $\pm 3.0$ ) versus 2.4 ( $\pm 2.5$ ), 22.5% had polypharmacy (>5 drugs) versus 17%; including HIV and haemophilia drugs 3.7 ( $\pm 3.6$ ) versus 4.4 ( $\pm 3.1$ ), 47.5% had polypharmacy versus 38%. Significant differences were not detected ( $p>0.05$ ).

Thirty-seven PDI were detected and reported (severe 15, moderate 22) which correspond to a rate of 0.6 ( $\pm 1.4$ ) PDI per patient versus 1 ( $\pm 2.0$ ) compared with RP ( $p>0.05$ ). None corresponded to haemophilic factors. Twenty-four PDI did not require therapy modification, 9 required close monitoring and 4 required an immediate modification to prevent adverse effects on the patient.

**Conclusion and relevance** Our population had a profile of polypharmacy and PDI similar to another RP. Immediate treatment modification was required in 4 out of 37, indicating the need to actively identify PDI in the HIV positive haemophilic population. This detection reduces the risk of toxicity or ineffectiveness of antiretroviral therapy. The involvement of the pharmacist in the management of the haemophilic patient contributes to optimisation of the pharmacotherapeutic plan.

#### REFERENCES AND/OR ACKNOWLEDGEMENTS

No conflict of interest.

#### 5PSQ-013 ANALYSIS OF THE RISK OF QT INTERVAL PROLONGATION IN INSTITUTIONALISED ELDERLY PATIENTS IN A NURSING HOME

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**Background and importance** Prolongation of the QT interval in the ECG can trigger an arrhythmia (torsades de pointes) that usually resolves spontaneously, although sometimes it can cause ventricular fibrillation and sudden death. Drugs are a frequent cause of QT interval prolongation and therefore it is recommended that the risk of QT interval prolongation is assessed, especially in elderly polymedicated patients.

**Aim and objectives** To determine the prevalence of patients in a nursing home (NH) with prescription of drugs with a defined and potential risk for producing prolongation of the QT interval, and to assess the concomitance of these drugs and history and/or cardiac pathologies.

**Material and methods** A descriptive cross sectional study was conducted in all patients in a NH who had active electronic prescriptions. The main variable was percentage of patients treated with drugs with a defined and potential risk of QT interval prolongation (DR-QT and PR-QT, respectively), according to the levels of evidence in the AZCERT list. Concomitant prescription of these drugs in a single patient was