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**

   No conflict of interest.

**5PSQ-012**

**DRUG INTERACTIONS AND POLYPHARMACY IN A COHORT OF HIV POSITIVE HAEMOPHILIC PATIENTS**

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10.1136/ehjpharm-2020-eahpconf.329

**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 haemophilia 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 (±3.0) versus 2.4 (±2.5), 22.5% had polypharmacy (>5 drugs) versus 17%; including HIV and haemophilia drugs 3.7 (±3.6) versus 4.4 (±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 (±1.4) PDI per patient versus 1 (±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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10.1136/ehjpharm-2020-eahpconf.330

**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
also assessed. As secondary variables, we studied the main therapeutic groups prescribed with DR and PR-QT and the concomitance of their prescriptions along with a history and/or cardiac pathologies. Demographic, clinical and analytical data were obtained from the electronic clinical history and treatment data from the electronic prescription programme.

Results As of 4 July 2019, 87 patients with active electronic prescriptions in a NH were selected. Average age was 66 years (52–101), 55.2% (48/87) were men and 70% were assisted (70/87). Among these patients, 13% were being treated with a DR-QT drug (11/87) and 13% with a PR-QT drug (11/87). Two patients were receiving a DR-QT and a PR-QT drug. Two patients were receiving two PR-QT drugs. The main therapeutic groups of DR-QT drugs were antihypertensives (45%), antidepressants (36%), antiarrhythmics and other (9%). The main therapeutic groups of PR-QT drugs were antipsychotics (38%), antidepressants (31%), genitourinary (15%), musculoskeletal and others (8%). Three patients treated with DR-QT drugs and six patients treated with PR-QT drugs had a history and/or cardiac pathologies. No patient receiving a DR and a PR drug had a history and/or cardiac pathologies. Two patients who were receiving two PR-QT drugs had a history and/or cardiac pathologies, mainly arterial hypertension.

Conclusion and relevance One-quarter of institutionalised elderly patients in a NH were being treated with DR and/or PR-QT drugs, in almost half of the cases with a history and/or cardiac pathology. The main therapeutic groups involved were antidepressants and antipsychotics.

REFERENCES AND/OR ACKNOWLEDGEMENTS

No conflict of interest.

5PSQ-014 RETROSPECTIVE EVALUATION OF RESUSCITATION MEDICATION UTILISATION IN HOSPITALISED ADULT PATIENTS WITH CARDIAC ARREST

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Background and importance Early medication administration in cardiac arrest improves outcomes. Non-compliance with advanced cardiovascular life support (ACLS) guidelines, including errors in medication administration, have been shown to decrease return of spontaneous circulation (ROSC) and cardiac arrest survival.1 2

Aim and objectives The primary objective was to evaluate the association between adrenaline administration in inhospital cardiac arrest (ICHA) patients with non-shockable rhythm and patient outcomes. The secondary objective was to assess compliance of adrenaline and amiodarone administration in accordance with ACLS guidelines.

Material and methods ICHA patients aged ≥18 years were identified from the resuscitation registry of 2016 of two large public hospitals and categorised according to their initial rhythms. For patients with non-shockable rhythms, the association between ICHA outcomes, ROSC, survival to discharge and time of epinephrine administration were analysed by logistic regression.

Results Among 349 patients with non-shockable rhythm, median time to epinephrine administration was 3 min (IQR:1–6 min). Early epinephrine administration (<5 min), compared with late epinephrine administration (>5 min), was significantly associated with the rate of ROSC (49.2% vs 34.9%; adjusted OR 1.630; 95% CI 1.008–2.635, p=0.046). Time to epinephrine administration (as continuous interval) was significantly associated with the rate of ROSC (p=0.002) and survival to discharge (p=0.029). After adjusting for potential confounding factors, increased ROSC remained significant but the survival to discharge lost significance.

Conclusion and relevance Our study found that time of epinephrine administration was significantly associated with better results in ROSC and survival to discharge in ICHA patients with non-shockable rhythm. When we divided ICHA patients with non-shockable rhythms into early and late administration groups, early epinephrine administration was associated with significantly improved ROSC but not survival to discharge after adjusting for potential confounding factors. Compliance rate with ACLS guidelines was >80% regarding epinephrine and much less for amiodarone. Therefore, clinical pharmacy services should focus on methods to enhance amiodarone usage in cardiac arrest.

REFERENCES AND/OR ACKNOWLEDGEMENTS


No conflict of interest.

5PSQ-015 COMPARING THREE CRITERIA FOR ASSESSMENT OF WHAT MEDICINES INCLUDED IN NATIONAL HOSPITAL FORMULARY ARE CLASSIFIED AS POTENTIALLY INAPPROPRIATE MEDICATIONS FOR OLDER PATIENTS

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Background and importance Some medicines are described as potentially inappropriate medications (PIM) for older patients. At least one PIM is regularly prescribed in 25–56% of hospitalised elderly patients,1 2 and have been associated with adverse drug reactions in this population.

Aim and objectives To identify what medicines classified as PIM by three different tools are present in national hospital formulary of medicines (NHFM) and to check what information, if any, is in the summary of product characteristics (SmPC) about precautions in older patients.

Material and methods A search (September 2019) of the Portuguese NHFM, through the National Medicines and Health Products Authority (INFarmed) website, was made for all medicines included in the EU(7)-PIM list, in the STOPP V2 criteria and in the 2019 Beers criteria. For each PIM found in the NHFM, the SmPC was analysed to check the recommendations made for older patients.