Aim and objectives The aim of this study was to assess the efficiency and real life safety of intravenous artesunate (IA) for the treatment of severe malaria.
Material and methods We performed a retrospective, monocentric, observational study. All patients who received IA from January 2016 to September 2019 were included. Data were collected from the pharmacy service computerised system, patient records and nominative expanded access authorisation forms. The primary endpoint was efficiency, assessed by the microscopic negativation of the parasitaemia. The secondary endpoint was safety, assessed by monitoring haemoglobin, transaminases, blood platelets, kaliaemia and creatinaemia.
Results Sixty-nine patients were treated with IA in our hospital. Among all patients, 59 patients (86%) had not received chemoprophylaxis. The average time between leaving the infected zone and hospital admission was 11±7 days. Patients received 3.1±0.7 doses of IA. Sixty-five patients presented at least one criterion requiring the use of IA (the most common was >4% hyperparasitaemia in 39 patients). Forty-six (67%) patients had a microscopic negativation of their parasitaemia after 3 days of treatment and 100% at day 7. Regarding tolerance, only 52% had a decrease in their haemoglobin level of >2 g/L during the whole hospitalisation. Platelets and transaminase values were normal (184–440 G/L and <35 UI/L, respectively) after 7 days of treatment in 51 patients. Nine patients displayed an abnormal kaliaemia (more than or less than 3.4–4.5 mmol/L) for more than 1 day. Finally, only 4 patients exceeded the basal level for creatinaemia (45–84 µmol/l) for more than 1 day. Three adverse events (anaemia) were reported to the pharmacovigilance centre, among which none was severe.
Conclusion and relevance The IA treatment was effective and well tolerated in all patients. These results seem to be in favour of a broader and ease of use of IA.

REFERENCES AND/OR ACKNOWLEDGEMENTS
No conflict of interest.

5PSQ-088 MONITORING OF THE INTRODUCTION OF CHLORHEXIDINE RELEASING POLYURETHANE MEDICATION IN PILOT WARDS OF A LARGE CITY HOSPITAL

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Background and importance Central venous catheters, peripherally inserted central catheters, Port-a-cath and Midline are fundamental systems to manage acute and chronic treatments in both inpatients and outpatients. Available dressings must provide a protective barrier, avoid the dislocation of these medical devices and be comfortable for the patient. Chlorhexidine releasing polyurethane medications can prevent bacterial colonisation and, consequently, the occurrence of infections.
Aim and objectives The objective of the study was to monitor the introduction in some wards of a chlorhexidine releasing dressing and collect data relating to its appropriate use and exit site.
Material and methods Basing on the typology of the patients and treatments, four pilot wards were chosen (intensive care unit, dialysis, oncology and neurosurgery). After team building meetings, an ad hoc form was introduced and provided to the internal pharmacy service following every application/change of a dressing. The form contained information on the patient's name and surname, age, diagnosis, type of catheter, treatment, date of first application of the dressing, exit site and reason for dressing substitution. The form was used to fill an Excel database and sum up data using descriptive statistical methods.
Results From October 2018 to June 2019, the dressing was used in 126 patients (55% men, n=69): 53% (n=67) in the intensive care unit, 37% (n=47) in oncology and 7% (n=9) in dialysis. Thirteen patients with an exit site grade (G) >0 were given the medication: 7 of these patients from dialysis had a 1 ≤G ≤3 already present at the first application, and 4 in oncology and 2 in intensive care developed a G=1 that lasted for a single application and then regressed to G=0. The average number of days of application of the medication was 6. Of the 290 chlorhexidine containing dressings provided to the units, 27 were changed before day 7 (maximum time in place), 67% (n=18) because of 'self-removal of the previous dressing', 30% (n=8) due to 'dirty medication' and 19% (n=5) because the dressing was 'wet'.
Conclusion and relevance In 219 of 231 cases, at replacement of the dressing, the exit site grade was G=0, suggesting that this medication may have helped the preservation of skin integrity. In dialysed and oncologic patients, the exit site grade is more difficult to manage, probably due to the complexity of the pathology and therapy.

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5PSQ-089 CYTOKINE RELEASE SYNDROME REACTION: THE CLINICAL PHARMACIST IN THE CHIMERIC ANTIGEN RECEPTOR T CELL THERAPY TEAM

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Background and importance Chimeric antigen receptor (CAR) T cell therapy is being studied for the treatment of haematologic malignancies. CARs are synthetic receptors that reveal the specificity, purpose and metabolism of T cells. The first step in making CAR-T cells is to insert a gene into the cell in order to express a new antigen binding site on its surface and to redirect the T cell to the new target. Since CAR-T is a personalised therapy, the medicine should be administered to the patient for whom it was intended. For this reason, the clinical pharmacist plays a key role in clinical surveillance, care coordination and patient education.
Aim and objectives The aim of this work was to assess the pharmacist as risk manager in a CAR-T multidisciplinary team comprising professionals who take care of cancer patients. Beyond the implementation of the hospital system, the pharmacist is essential in the follow-up of patients after administration because of the complexity of the side effects as well as antidote management.
Material and methods Cytokine release syndrome (CRS) is one of the most common side effects of CAR-T therapy, in which there is a fast release of cytokines involved in the inflammatory process. It seems that the onset of CRS is related to the efficacy of the therapy, even though this side effect is