

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 negatation 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 negatation 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 ($184\text{--}440$ 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 $3.4\text{--}4.5$ mmol/L) for more than 1 day. Finally, only 4 patients exceeded the basal level for creatinaemia ($45\text{--}84$ $\mu\text{mol/l}$) 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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10.1136/ejhp-pharm-2020-eahpconf.405

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 $1 \leq G \leq 3$ 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.

REFERENCES AND/OR ACKNOWLEDGEMENTS

No conflict of interest.

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

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10.1136/ejhp-pharm-2020-eahpconf.406

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

extremely dangerous and on target. Pharmacists should manage CRS by ensuring the supply of tocilizumab, a monoclonal antibody against interleukin 6 indicated as an antidote, or by using situximab, off-label.

Results Currently, six patients are being treated with CAR-T cell therapy and safety outcomes are ongoing. All have had CRS reactions and received tocilizumab.

Conclusion and relevance Based on these results, the immediate availability of antidote and timely treatment of CRS reactions (mandatory activity for the pharmacist) is necessary to ensure the therapeutic and safety benefits for patients. The study shows the essential role of the pharmacist in covering the risks of this type of therapy and in reducing the seriousness of side effects in an innovative therapy such as CAR-T cells.

REFERENCES AND/OR ACKNOWLEDGEMENTS

No conflict of interest.

5PSQ-090 PHARMACIST'S CONTRIBUTION TO IMPROVING CUSTOMER SATISFACTION AT HOSPITAL CARE UNITS

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10.1136/ejhpharm-2020-eahpconf.407

Background and importance To improve the quality of its services and the satisfaction of its customers, our hospital's pharmacy has experimented with a weekly pharmaceutical presence in the operating room to collect and process pharmacy claims and complaints, which may improve communication between the pharmacy team and the operating room.

Aim and objectives To highlight the importance of a pharmaceutical presence at the care units through collection and processing of complaints at a pilot service: the operating room.

Material and methods To analyse the claims of the medical and paramedical staff collected during the weekly pharmaceutical presence in the operating room over a period of 1 month, and to assess measures undertaken for the treatment of these claims.

Results During the study period, 58 complaints were collected: 69% related to medical devices and 31% to drugs. Data processing revealed the following findings: most of the complaints concerned articles ordered but not yet delivered by suppliers (15%), available articles with limited quantity (14%), unavailable articles for which no requests were made (14%), articles that did not belong to our hospital nomenclature (12%), articles available at the central pharmacy but not available at the operating room pharmacy (10%) and articles for which the annual forecast quantity was already consumed (10%). Measures taken by the pharmacy team: relaunch suppliers for articles already ordered; increase endowments (within the limits of availability); propose indication limitations for articles with critical stock; ordering items whose annual forecast quantity was not totally consumed; proposed alternatives for articles that did not belong to our hospital nomenclature;

endowment of the operating room pharmacy by the articles available at the central pharmacy and making special orders, with limited quantities, for articles for which the annual forecast quantity was already consumed.

Conclusion and relevance The pharmaceutical presence in the staff of the operating room has helped to better understand the needs of users in order to meet these needs within the limits of what is possible. In fact, the involvement of the pharmaceutical team in care units makes it possible to improve customer satisfaction and to increase the overall quality of therapeutic care.

REFERENCES AND/OR ACKNOWLEDGEMENTS

None.

No conflict of interest.

5PSQ-091 ANALYSIS OF POTENTIALLY INAPPROPRIATE MEDICATIONS IN CHRONIC COMPLEX PATIENTS AND IN PATIENTS WITH ADVANCED CHRONIC DISEASE IN THE EMERGENCY DEPARTMENT

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10.1136/ejhpharm-2020-eahpconf.408

Background and importance The aging of the population implies a growing prevalence of chronic diseases and poly-pharmacy as well as drug related problems (DRP). Elderly patients have complex care needs that are difficult to carry out in the emergency department (ED) which may entail an increase in potentially inappropriate medications (PIM).

Aim and objectives To detect PIM in chronic complex patients (CCP) and in patients with advanced chronic disease (ACD) after a stay in the ED.

Material and methods A retrospective observational study was conducted in November 2018 in an ED of a second level hospital. Variables recorded were demographic data, cause of admission, CCP/ACD and treatment before/after the stay in the ED. STOPP-START criteria and the criteria of Chronicity Prevention and Care Programme (PPAC) of the Department of Health of Catalonia were used.

Results One hundred patients (50.9% men) were included with a mean age of 80.6±11.3 years: 84.7% were CCP and 15.3% had ACD. The main reasons for admission to the ED were acute bronchitis and low back pain. The average number of drugs prescribed per patient was 9.6 (3–18).

In this study, 242 PIM were detected in 90 patients (83.9% in CCP; 16.1% in ACD), an average of 2.7±1.4 per patient. Three quarters of PIM were because of chronic treatment. Sixty-three PIM were detected with the PPAC criteria, the most prevalent was '09: benzodiazepines and other hypnotics for ≥6 months'; 51 were START criteria (the most frequent being 'SA 6: ACEI in well documented heart failure') and 128 STOPP criteria (the main criterion being 'SD 5: Benzodiazepines for ≥4 weeks').

The PIM of 14 patients may have been related to the cause of admission to the ED, in particular due to falls and fractures. All had drug related falls prescribed in their chronic treatment.