than those with subjective symptoms at the beginning of the study (p=0.018). Patients with immunoglobulin E (IgE) mediated CMPA had more cutaneous symptoms (84%) than those not mediated by IgE. In 25 patients (14.9%), CMPA was IgE mediated, of whom only 24% resolved their intolerance before 1 year of age. Mean age of resolution was 18.77±6.25 months.

The most commonly used substitution formulas in our study were hydrolysed lactose free milk protein formulas.

Conclusion and relevance The findings of the study showed that the presence of IgE mediated CMPA, gastrointestinal and/or cutaneous symptoms had negative effects on tolerance. No perinatal or nutritional risk factors were found to predict the persistence of CMPA.

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No conflict of interest.

4CPS-006 USE OF AMMONIUM TETRATHIOMOLYBDATE IN WILSON DISEASE

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Background and importance Wilson disease is a rare autosomal recessive disorder. It is characterised by an excessive accumulation of copper in the body, mainly in the liver, brain and cornea, leading to different manifestations, in which neuropsychiatric and hepatic manifestations predominate. Therapeutic management is based on the use of copper chelating agents (D-penicillamine, trientine) and drugs that hinder the absorption of copper (zinc salts). Ammonium tetrathiomolybdate, an experimental treatment, has also been used for periods of 8 weeks in patients with a neurological presentation under compassionate use.

Aim and objectives To evaluate the effectiveness and toxicity of ammonium tetrathiomolybdate in a patient with Wilson disease.

Material and methods A 42-year-old man was diagnosed with Wilson disease with neurological manifestations at 33 years of age, and increased transaminase levels and the presence of Kayser–Fleischer ring in both eyes. One mutation, c3359T> A (p.Leu1120*), was identified on exon 15 in the ATP7B gene. He was treated with trientine for 4 months with clinical worsening, replacing trientine with zinc sulphate and ammonium tetrathiomolybdate. At 7 weeks, the last drug was retired because of progressive worsening of liver function. Given the clinical situation, D-penicillamine was added to the basic treatment that, 6 months later, was suspended due to marked deterioration in neurological and functional conditions. Maintenance treatment with zinc sulphate was continued. In the following months, neurological symptoms progressively improved, maintaining liver function. Seven years later, due to neurological worsening, treatment was started again with ammonium tetrathiomolybdate 60 mg daily and 8 weeks later it was increased to 120 mg daily (20 mg between meals three times a day and 20 mg with each meal three times a day).

Results After 15 months of treatment with ammonium tetrathiomolybdate combined with zinc sulphate, the patient experienced improvements in motor and cognitive–behavioural symptoms, and maintained normal haematological and hepatic function. Before starting treatment with ammonium tetrathiomolybdate, at the analytical level, we found: copper in urine 56 µg/24 hours, ceruloplasmin 2 mg/dL and copper in blood 34 µg/dL; after 8 weeks (with a dose of 60 mg/day) the values were 111 µg/24 hours, 2 mg/dL and 63 µg/dL, respectively, and currently the values are 44 µg/24 hours, 2 mg/dL and 16 µg/dL.

Conclusion and relevance In our patient, ammonium tetrathiomolybdate was effective and well tolerated for a prolonged period. It could be an alternative in patients with neurological manifestations.

REFERENCES AND/OR ACKNOWLEDGEMENTS

No conflict of interest.

4CPS-007 PHARMACEUTICAL CARE AS A MEANS OF PREVENTION AGAINST DRUG IATROGENESIS: CASE OF ORAL ANTICOAGULANTS

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Background and importance Oral anticoagulants (OAC) have a significant risk of adverse events, particularly in the transition of care were OAC are initiated, modified or transitionally interrupted. Pharmaceutical care through medication reconciliation and patient counselling could improve the benefit to risk ratio of these drugs.

Aim and objectives To use OAC therapy as prioritisation criteria for performing pharmaceutical care: medication reconciliation and pharmaceutical counselling.

Material and methods A prospective and interventional single centre study was conducted from March to September 2018 in the medicine and surgical units. Patients with an OAC prescribed from the outpatient sector were included. These patients received medication reconciliation at admission and discharge as well as patient specific pharmaceutical counselling about OAC to provide education. Their knowledge was assessed with a multiple choice questionnaire.

Frequency and type of reconciliation discrepancies were studied at admission and discharge. The gravity rating of this discrepancies was measured using the Cornish *et al* scale, with three levels of severity: low, moderate and high.

At patient discharge, a summary of the knowledge acquired by the patient about OAC and medication reconciliation was provided to them.

Results A total of 162 patients were included in the study. Medication reconciliation at admission allowed the detection of 133 unintentional discrepancies (0.8/patient) of which 16 represented a high risk to the patient, including 9 errors about OAC prescribing. Concerning medication reconciliation at discharge, 51 unintentional discrepancies (0.3/patient) were detected: 12 represented a high risk to the patient, including 8 errors about OAC prescribing.

The acceptance rate of the discrepancies was 86% in total and reflected the degree of severity of the pharmaceutical interventions. This result reached 96% if we took into account discrepancies with a real clinical impact. Concerning the pharmaceutical multiple choice questionnaire, the success rate was 66%.

Conclusion and relevance This study has highlighted that OAC represents a relevant criterion of prioritisation to the long term implementation of pharmaceutical care. This secures the management of patients receiving OAC if pharmaceutical care is present along the whole route of care, from admission to discharge. The last step of our approach will be improvement in the transmission of data to community caregivers.

REFERENCES AND/OR ACKNOWLEDGEMENTS
No conflict of interest.

4CPS-008 RISK FACTORS ASSOCIATED WITH READMISSION TO THE EMERGENCY DEPARTMENT IN PATIENTS WITH PREVIOUS GASTROINTESTINAL HAEMORRHAGE SECONDARY TO ORAL ANTICOAGULANT THERAPY

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Background and importance Several studies have analysed the risk factors for admission to the emergency department (ED) due to gastrointestinal haemorrhage (GH) related to oral anticoagulant therapy (OAT). However, the effect of treatment modification at discharge on readmission rates and short term mortality are not known.
Aim and objectives To describe the frequency and risk factors associated with readmission rates to the ED in patients with previous GH secondary to OAT at 30 days and 1 year after discharge and its mortality.
Material and methods This was a retrospective observational study conducted in a tertiary hospital. Adult patients treated with OAT who consulted an ED due to coagulation disorders were included (January 2017–June 2019). Multivariate analysis was designed, including clinical variables, with a value of $p<0.2$ in a previous univariate analysis. The factors analysed included age, sex, comorbidities (chronic renal failure (CRF), heart failure, diabetes, hypertension, dementia, cirrhosis) and concomitant treatment (AINE, antiplatelet therapy, IBP).
Results Seventy-four patients were included (mean age 83 (62–97) years). Forty-one (55.4%) were treated with vitamin K antagonists (VKA) and 33 (44.6%) with direct oral anticoagulants (DOAC). Initial OAT was changed at discharge in 17 (24.2%) patients to another OAT (4 cases) or to heparin (13 cases). Three of them presented to the ED 30 days after discharge and 6 during the year due to a blood clotting problem. Among the 57 patients with no change in OAT (31 VKA, 26 DOAC), 6 presented again to the ED in the 30 days after discharge and 10 during the year after discharge because of a coagulation disorder. No patient deaths were linked to OAT problem.

Multivariate analysis revealed that treatment modification at discharge did not affect readmission rates but being treated with DOACs tended to protect against readmission during the first year after discharge (OR 0.47 (0.15–1.11)). Regarding risk related factors, CRF was the only variable associated with 30 day readmission (OR 3.10 (1.02–9.41)) whereas taking antiplatelet drugs tended to increase the risk of readmission in the first year (OR 2.44 (1.07–8.41)).

Conclusion and relevance DOACs could play a protect role against readmission whereas CRF and antiplatelet therapy tended to increase the risk of readmission at 30 days and in the first year after discharge. However, more data are needed to confirm our results.

REFERENCES AND/OR ACKNOWLEDGEMENTS
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No conflict of interest.

4CPS-009 DURATION OF DUAL ANTIPLATELET THERAPY IN CORONARY ARTERY DISEASE: IS PHARMACIST INTERVENTION NECESSARY TO IMPROVE PATIENT SAFETY?

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Background and importance According to the 2017 updated guidelines from the European Society of Cardiology on dual antiplatelet therapy (DAPT), the optimal duration of DAPT remains a controversial topic. The decision must be dynamic and re-evaluated during the course of treatment. Hence it is essential that patients must be monitored in order to avoid coronary complications but also to prevent bleeding risk.
Aim and objectives To identify patients with long term DAPT, their indications and clinical conditions, and to evaluate bleeding risk. To explore if a pharmaceutical intervention, to adapt therapy duration according to the guidelines, is needed.
Material and methods A cross sectional descriptive study was conducted. We used a corporate business intelligence tool to identify patients $\geq$75 years of age on DAPT (a combination of aspirin plus platelet P2Y12 receptor blocker) for more than 3 years and without monitoring by the cardiologist during the last year. We recorded data on: (1) clinical context—acute coronary syndrome (ACS) and stable coronary disease after percutaneous coronary intervention (PCI); (2) indications for long term DAPT—prior myocardial infarction, prior stent thrombosis and multivessel PCI; (3) bleeding risk (PRECISE-DAPT score).
Results Seventy-four patients (64.9% men; mean (SD) age 84 (5.86) years) were included in the analysis. The clinical condition for DAPT indications were 82.4% stable coronary disease after PCI, 9.5% ACS and 8.1% patients with high risk cardioembolic stroke. The reason for a longer duration were: 55% multivessel PCI; 23% previous myocardial infarction; and 18.9% past history of stent thrombosis. The PRECISE-DAPT score was calculated in 49 patients: in 81.6% the score was $\geq$25 which could imply a high bleeding risk.
Conclusion and relevance The duration of DAPT therapy was longer than the recommended guidelines in a considerable number of patients. Most patients received DAPT after PCI with stent implantation. The value of the PRECISE DAPT score was above the recommended cut-off point. Pharmacist intervention with cardiologists and general practitioners may be necessary to avoid long term DAPT if patient safety is not improving.

REFERENCES AND/OR ACKNOWLEDGEMENTS
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