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

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

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 ≥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 ≥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.

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