64 prescriptions a month and 59 were appraised by the operational multidisciplinary teams. Haematology was the most prescribing unit (49.8%). Caspofungin (35%), using the intravenous route, or posaconazole (35%), using the oral route, were the most prescribed antifungals. Indications were probabilistic 35% of the time, prophylactic 34% of the time and documented 30% of the time. Documented infections were mainly invasive candidiasis (57%) and pulmonary aspergillosis (32%). Among the 653 prescriptions, 96 were the subject of a pharmaceutical opinion, mainly for improper dosage (50%) or missing a loading dose (29.2%); 84% of prescriptions were re-evaluated by the infectious diseases specialist. Opinions were mainly about switching molecules (32%) and stopping therapy (28%). A total of 75.8% of prescriptions were successfully updated. Comparing our results with those obtained in 2015 in our hospital, the global conformity of the prescription (indication, molecule choice, posology, treatment length, lack of therapeutic alternatives) was up from 81.5% to 87%.

Conclusion and relevance Implementation of operational multidisciplinary teams helped reduce the number of issues and thus contributed to improve in the quality of prescriptions.

REFERENCES AND/OR ACKNOWLEDGEMENTS
No conflict of interest.

4CPS-057 THERAPEUTIC DRUG MONITORING OF VORICONAZOLE
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Background and importance Voriconazole has shown high interpatient variability in plasma steady state trough concentration (C_{trough}). It presents a narrow therapeutic range, with C_{trough} <1 μg/mL, related to treatment failure, and >4 μg/mL with toxicity.

Aim and objectives To describe plasma voriconazole concentrations (PVC) in an adult cohort treated in a tertiary university hospital. Also, to identify potential causes of interpatient variability in C_{trough} and to find an association between clinical outcomes and adverse events (AE) with PVC.

Material and methods This was an observational retrospective study with no intervention. All patients with a determination of PVC were included. SPSS was used for statistical analysis.

Results A total of 165 C_{trough} were analysed from 51 patients (60.8% men). Median age and weight were 65.2 years (IQR 54.5–71.3) and 70.0 kg (IQR 62.0–81.0), respectively. Ten patients (19.6%) had a body mass index >30 kg/m², 6 (11.8%) had a drinking history and 1 patient suffered from liver failure. Voriconazole treatment indication was invasive fungal infection in most patients (80.4%), candidaemia (9.8%) and other (9.8%). Median voriconazole dose was 5.8 mg/kg (IQR 4.9–6.6) and median treatment duration was 140 days (IQR 65–176).

Reasons for treatment discontinuation were cure/negative culture (42.8%), appearance of drug related AE (16.4%), treatment inefficacy (9.1%) and other (30.9%). Co-medication with steroids was present in 71 cases (45.0%) and only one significant drug–drug interaction was reported (rifampin).

Median C_{trough} was 2.4 μg/mL (IQR 1.4–3.6). C_{trough} values were <1 μg/mL in 26 cases (15.8%) and >4 μg/mL in 34 (20.6%). From these, the dose was adjusted in 10 and 5 cases, respectively, resulting in 66.7% of the time that the next PVC was within the recommended range.

We observed a trend towards higher PVC in patients reporting AE (p=0.177) and lower in alcoholic patients (p=0.053). Within those cases with a C_{trough} <1 μg/mL, co-treatment with corticosteroids and women showed significantly lower plasma values (p=0.015 and p=0.052, respectively).

Conclusion and relevance We confirmed high variability in voriconazole C_{trough} in routine clinical practice. Co-treatment with corticosteroids, women and alcoholic patients were factors related to lower C_{trough} values. Thus in these patients, it might be suitable to perform therapeutic voriconazole monitoring in clinical practice to help optimise antifungal treatment.

REFERENCES AND/OR ACKNOWLEDGEMENTS
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4CPS-058 MANAGEMENT OF THE HOSPITALISED PATIENT WITH FLU
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Background and importance Clinical practice guidelines recommend oseltamivir in hospitalised patients with influenza but its use in clinical practice is limited.

Aim and objectives To determine the criteria for use of oseltamivir in hospitalised patients and to analyse the prescription of concomitant antibiotics.

Material and methods An observational, descriptive, retrospective study was conducted in patients treated with oseltamivir (November 2018–February 2019) in a second level hospital. For therapeutic appropriateness, the drug was prescribed on an indication based on clinical history and supported by appropriate laboratory tests (cure rates of 90% and detection of clinical improvement in 30% of patients). The viral load was less than 10,000 copies/mL with viral haemagglutination inhibition (anti-H1N1 and anti-H3N2) and reverse transcription polymerase chain reaction (RT-PCR) in the following periods: acute phase, 7–10 days after the first symptoms; convalescent phase, 15–21 days after the first symptoms. The cut-off was respectively 1:160 and 1:64. In patients with suspicion of secondary infections, oseltamivir was used as an auxiliary treatment in patients with negative PCR. The drug was prescribed at a dose of 75 mg twice a day orally, for 5 days. The patients were then followed up daily until resolution of symptoms.

Results Oseltamivir was prescribed in 160 patients, mostly from the internal medicine service (58.1%) and pneumology (22.5%), with an average entry duration of 8 days.

PCR was performed in 111 patients (69.4%) and confirmed the diagnosis in 103 (64.3%), such as flu A. In eight patients with negative PCR, oseltamivir was discontinued. Cases confirmed by age range were: 3 (<18 years), 31 (18–65 years) and 69 (>65 years). The most common pathological history was high blood pressure (HTA) (27.7%), dyslipaemia (19.3%), cardiovascular disease (18.5%), lung disease (14.7%), diabetes (10.1%), immunosuppression (6.3%) and chronic kidney disease (CKD) (7.8%). As risk factors, 21.4% were active smokers, 14.6% were obese and there were no pregnant women.

Regarding complications, 8.7% required the intensive care unit, 3.9% died and 11.7% returned to hospital.

The most common oseltamivir dosing regimen was 75 mg/12 hours. In 13 patients with CKD, 75% who had a ClCr 10–30 mL/min had the dose adjusted to 30 mg/24 hours. In contrast, 11.1% of patients with ClCr 30–60 mL/min, the dose was adjusted to 30 mg/12 hours. Duration of treatment

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