or dissemination syndrome. Safety was evaluated describing adverse events (AE).

Results 35 COVID-19 patients from endemic areas were admitted and treated with ivermectin 6 mg/8 hours for 2 days. 52% of patients were women, with an average age of 42.84 ± 11.38 years. The patients treated with ivermectin were from Latin America, and the most frequent countries were: 48% Bolivia, 24% Nicaragua, 12% Ecuador, 8% Colombia and 8% Peru. Immunosuppressive treatment was: 83% dexamethasone 6 mg/24 hours, 14% methylprednisolone bolus 250 mg, 12% tocilizumab 400 mg and 3% no immunosuppressive treatment. Three (9%) of the patients presented with positive *S. stercoralis* serology. However, they did not develop *S. stercoralis* hyperinfection or dissemination syndrome. Furthermore, no patient had eosinophilia, with an average eosinophiles blood count of $0.04 \pm 0.09 \times 10^3/\mu\text{g}$. None of the patients had adverse events.

Conclusion and relevance Prophylactic treatment with ivermectin was safe. Patients from endemic areas who should start immunosuppressive treatment as soon as possible could be treated prophylactically with ivermectin. Nevertheless, the number of patients and positive cases were small and more studies are needed to generate evidence.

REFERENCES AND/OR ACKNOWLEDGEMENTS

Conflict of interest No conflict of interest

Section 5: Patient safety and quality assurance

5PSQ-119 PROTON PUMP INHIBITOR PRESCRIPTION PATTERNS AND ASSOCIATED COMPLICATIONS IN THE PAEDIATRIC INTENSIVE CARE UNIT

¹J Montreuil*, ²E Lacotte, ³P Thibon, ¹E Delavoipiere, ⁴C Dupont, ⁵D Brossier, ¹I Goyer. ¹Chu De Caen, Pharmacy, Caen, France; ²Chu De Rouen, Paediatrics, Rouen, France; ³Chu De Caen, Centre D'appui Pour La Prévention Des Infections Associées Aux Soins Normandie, Caen, France; ⁴Chu De Caen, Paediatrics, Caen, France; ⁵Chu De Caen, Paediatric Intensive Care Unit, Caen, France

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Background and importance Proton pump inhibitors (PPIs) are regularly prescribed in the paediatric intensive care unit (PICU) for prevention of stress ulcer and upper gastrointestinal bleed (UGIB). There is no clinical consensus regarding PPI use in the PICU. The reported incidence of UGIB in the PICU is low (0.4–5%). Having ≥ 2 risk factors has been associated with a higher risk of clinically relevant UGIB in the PICU (severity score at admission PRISM >10 , coagulopathy, mechanical ventilation). Despite identification of these risk factors, studies fail to show that stress ulcer prophylaxis significantly decreases UGIB in the PICU. Moreover, recent studies in mostly adult patients have associated PPIs in the acute setting to a higher risk of nosocomial infections and hyponatraemia.

Aim and objectives To describe PPI prescription patterns in the PICU and explore potentially associated clinical complications such as nosocomial infections and hyponatraemia.

Material and methods A single centre, retrospective, cohort study was conducted on PICU patient charts from 1 January 2017 to 31 December 2018.

Results 768 patients were included of whom 234 received a PPI (30.6%). PPI exposed patients were younger ($p < 0.05$), weighted less ($p < 0.05$) and were more likely to have had surgery ($p < 0.05$), a central venous access ($p < 0.05$), parenteral nutrition ($p < 0.05$), coagulopathy ($p < 0.05$), mechanical ventilation ($p < 0.05$) and a longer PICU stay ($p < 0.05$). The most common indication for PPI was stress ulcer prophylaxis ($n=178$, 76.1%) but only 12.4% ($n=22$) had ≥ 2 UGIB risk factors. Nosocomial infection rate was 9.4% in the PPI group versus 2.2% in the non-exposed group ($\text{RR}=3.40$ (95% CI 1.76 to 6.57), $p < 0.05$). Once adjusted for confounding variables, PPI exposure was independently associated with a higher risk for nosocomial infection ($\text{OR}_a=2.42$ (95% CI 1.17 to 5.14), $p=0.02$). PPI exposure was associated with an increased risk of hyponatraemia ($\text{RR}=5.18$ (95% CI 2.16 to 12.43), $p < 0.05$).

Conclusion and relevance Our study showed an overuse of PPIs in our PICU, with poorly documented indications. PPIs were statistically and independently associated with an increased risk of nosocomial infections in our population. Prospective randomised trials are needed to evaluate the risk–benefit ratio of PPIs in the PICU. Our results suggest the need for a more rational use of PPIs in the PICU and highlight the lack of clinical guidelines and safety data regarding stress ulcer prophylaxis in critically ill children

REFERENCES AND/OR ACKNOWLEDGEMENTS

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5PSQ-120 USE OF PROTON PUMP INHIBITORS IN A GERIATRIC HEALTHCARE CENTRE

A Ruiz Gómez*, OM García Molina, M Sáez Garrido, A Laorden Carrasco, JÁ Cano Molina, M Díaz Ramón, F Golnabi Dowlatshahi, E González Lozano. Hospital Clínico Universitario Virgen De La Arrixaca, Pharmacy, Murcia, Spain

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Background and importance The use of proton pump inhibitors (PPIs) has increased considerably in recent years, probably due to their prescription in unjustified clinical situations or their prolonged maintenance without prescription revision, which can expose the patient to adverse effects.

Aim and objectives To determine the prevalence of PPI prescriptions without a clear indication in elderly patients institutionalised in a geriatric healthcare centre (GHC) that would require their deprescription assessment, as well as to quantify the prevalence of fractures in these patients.

Material and methods An observational, descriptive, cross sectional study was conducted in all institutionalised patients in a GHC associated with a tertiary hospital in May 2020. The variables collected were: sex, age, PPI prescription, indication, duration of PPI treatment, number of drugs prescribed, concomitant prescription of a gastrolesive drug and bisphosphonates, history of upper gastrointestinal bleeding or gastroduodenal ulcer, and history of fracture. Suitable indications for a PPI were those included on the label.

Results GHC is a 120 bed residence with 95 patients. 73.7% were women and mean age was 82.3 ± 8.3 years. At the date of the study, 78 patients (82.1%) were being treated with a PPI, of which a clear indication according to label was found in 51.3%. The prescribed PPIs were: omeprazole 20 mg in 96.2%, lansoprazole 15 mg in 1.3% and lansoprazole 30 mg

in 2.6%. At least 41% of the patients had been treated with PPIs for more than a year; for the rest of the patients, no prescription data were available prior to joining the pharmacy service. The mean number of drugs prescribed per patient was 8.3 ± 5 , 1.2% were being treated with an NSAID, 42.3% were taking acetylsalicylic acid concomitantly at antiplatelet doses and 3.8% were given bisphosphonates. The prevalence of patients being treated with a PPI and with a history of fracture was 48.7%.

Conclusion and relevance There was a high prevalence of patients without a clear indication for the prescription of PPIs in the GHC. This makes it necessary to review the treatments to assess possible deprescription of these drugs. In addition, their administration could be related to an increased risk of fractures due to its high prevalence.

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Conflict of interest No conflict of interest

5PSQ-121 FIDAXOMICIN RELATED METABOLIC ACIDOSIS: A CASE REPORT

¹B Sema Serrano, ²A Serrano Martínez, ¹A Valladolid Walsh*, ¹I Pérez Alpuente, ¹V Lerna Gaude, ¹M Clemente Andújar, ¹R Aldaz Francés. ¹Complejo Hospitalario Universitario De Albacete, Pharmacy, Albacete, Spain; ²Complejo Hospitalario Universitario De Albacete, Haematology, Albacete, Spain

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Background and importance Fidaxomicin is a macrolide antibiotic used to treat intestinal *Clostridium difficile* (CD) infection in the absence of metronidazole or vancomycin treatments. Pharmacovigilance collects information, and analyses and notifies cases of suspected adverse drug reactions (ADRs) to prevent them occurring in the future.

Aim and objectives To describe a case of metabolic acidosis in a patient treated with fidaxomicin and establish its possible association.

Material and methods We describe the case of an 82-year-old man diagnosed with multiple myeloma and treated with two full cycles of bortezomib-dexamethasone. He was referred to the emergency department after presenting with melanic diarrhoea for 1 week. As a result, he was hospitalised and diagnosed with upper gastrointestinal bleeding, acute prerenal renal failure, mild thrombopenia, hypokalaemia and hyponatraemia. After fluid and electrolyte stabilisation, it was decided to start fidaxomicin 200 mg/12 hours due to fever, confusional syndrome, persistence of diarrhoea and positive CD toxin test. The following constants were measured to confirm metabolic acidosis: gas level of bicarbonate (HCO_3^-), partial pressure of carbon dioxide (pCO_2), hydrogen ion potential (pH) and anion GAP. The degree of drug adverse reaction causality was evaluated using the Naranjo algorithm.

Results Two blood gas tests on consecutive days confirmed very low HCO_3^- (9 mmol/L) and pCO_2 (16 mm Hg) with normal pH (7.4), after which the patient was diagnosed with compensated metabolic acidosis with normal GAP anion. Finally, it was decided to suspend fidaxomicin and in the following days the patient experienced a progressive clinical improvement. Naranjo's algorithm established the causality relationship as 'probable' (score of 6). The regional pharmacovigilance centre (RPC) was notified.

Conclusion and relevance The European Medicines Agency's technical sheet for fidaxomicin does not describe metabolic acidosis as an ADR. However, UpToDate Clinical Library reports <2% of cases of metabolic acidosis in adults treated with fidaxomicin. The RPC reported this case as the only fidaxomicin ADR notified in our country.

REFERENCES AND/OR ACKNOWLEDGEMENTS

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5PSQ-122 HEALTH RESULTS AFTER INFlixIMAB PHARMACOKINETIC MONITORING IN INFLAMMATORY BOWEL DISEASE

¹M Herrera Expósito*, ¹JE Martínez De La Plata, ²D Rubio Calvo, ³CM Pinto Nieto, ¹J Canto Mangana, ¹MA Castro Vida. ¹Hospital De Poniente, Pharmacy Department, El Ejido-Almería, Spain; ²Hospital De Poniente, Hospital Pharmacy, El Ejido-Almería, Spain; ³Hospital De Guadix, Pharmacy Department, Guadix-Granada, Spain

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Background and importance Infliximab (IFX) is a monoclonal antibody (inhibitor of alpha tumour necrosis factor (anti-TNF α)) which is used in the management of inflammatory bowel disease (IBD). However, some patients do not show clinical benefit for this therapy or they show loss of response over time. For this reason, it is advisable to individualise and optimise the therapy through therapeutic drug monitoring (TDM).

Aim and objectives To analyse the clinical situation of patients according to proactive monitoring of serum levels of IFX in IBD and pharmacokinetic recommendations in their management.

Material and methods A prospective study was carried out in a 350 bed general hospital. Patients with IBD and IFX determinations with pharmaceutical interventions performed between January 2019 and July 2020 were selected. Data collected were: sex, median age (range), analytical parameters before intervention (mean (SD) albumin, C reactive protein (CRP), α 1-acid glycoprotein (AGP), faecal calprotectin (FC)) and clinical status before intervention (good general condition (GGC), regular general condition (RGC) and bad general condition (BGC)). Mean (SD) IFX levels and anti-IFX antibodies (ATI) were measured and patients with concomitant immunomodulatory treatment were registered. According to population studies, new interventions were recommended by the pharmacy service (intensification, swap, deintensification, non-valuable). Analytical parameters (CRP, AGP, FC) and clinical status of the patient 3 months after the intervention were analysed. Data were obtained from the assisted electronic prescription programme and digital medical records.

Results 55 patients with interventions were monitored, 38 men (69.1%), mean age 39 (20–70) years. Analytical parameters before the intervention were: albumin 4.04 (0.3) g/dL, CRP 0.78 (0.75) mg/dL, AGP 87.35 (29) mg/dL and FC 190.25 (148.61) $\mu\text{g/g}$. Clinical status before the intervention was GGC 9 (19.36%), RGC 30 (54.55%) and BGC 16 (29.11%). IFX levels were 3.04 (4.22) $\mu\text{g/mL}$ and ATI 1.48 (2.61) $\mu\text{g/mL}$. Patients with concomitant immunomodulatory treatment 32 (58.18%). All recommended interventions were accepted: intensification 41 (74.55%), swap 10 (18.18%), deintensification 3 (5.45%) and non-evaluable 1 (1.82%). Analytical parameters 3 months after the intervention were: CRP