effectiveness and low cost, the need for frequent monitoring and dose adjustments has highlighted the importance of introducing into clinical practice new oral anticoagulants (NOACs) to increase safety and obtain more predictable results.

**Aim and objectives** The aim of the study was to determine dose adequacy of three new oral anticoagulants (apixaban, dabigatran and rivaroxaban) prescribed in clinical practice.

**Material and methods** An observational prospective study was conducted in a tertiary hospital over a 6 month period. All patients with a prescription for apixaban, dabigatran or rivaroxaban were eligible for the study. Demographic (age, gender, medical history) and clinical (weight, NOAC type and dose, diagnosis and renal function calculated with the MKP-EPI form) data were recorded in a chart, and dose adequacy was assessed and reviewed by two different investigators. The results were analysed using a multivariable logistic regression technique with a 95% significance level.

**Results** After excluding 3 patients due to incomplete data, 138 patients, 56% men, were recruited. From these, 40% of the patients were prescribed apixaban, 25% dabigatran and 34% rivaroxaban. The statistical analysis adjusted by sex and age showed that the risk of inadequacy was significant when using apixaban (p<0.001, OR 8.4) and dabigatran (p<0.006, OR 7.0). This could be explained by the fact that the most prevalent diagnosis was auricular fibrillation. In this indication, rivaroxaban is adjusted by creatinine clearance while apixaban is adjusted by weight, age and clearance, and dabigatran by age, concomitant treatment with verapamil and clearance. Lower doses were significantly inadequate compared with higher doses (apixaban 2.5 mg/12 hours (p<0.000), dabigatran 110 mg/12 hours (p<0.002) and rivaroxaban 15 mg/12 hours (p<0.036)). Rivaroxaban was the nearest to an adequate prescription.

**Conclusion and relevance** In conclusion, it seems that at least for auricular fibrillation, rivaroxaban constitutes the agent with the best adequacy, probably due to its simpler adjustment. Furthermore, with the three drugs, lower doses tended to be less adequate than higher doses, which raises the question of whether patients are under dosed. More training is needed to correctly prescribe this group of drugs.

**REFERENCES AND/OR ACKNOWLEDGEMENTS**

**Conflict of interest** No conflict of interest

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**5PSQ-128 WHICH ENOXAPARIN PREVENTIVE DOSAGE TO CHOOSE FOR OBESE PATIENTS IN ORTHOPAEDIC SURGERY?**

L Mariette-Laban*, J Jouglen, A Quenardel. Chu Purpan Toulouse, Pharmacie, Toulouse, France

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**Background and importance** In our orthopaedic surgery centre, prescribers seem to use different dosages of enoxaparin for the prevention of the thromboembolic risk for obese patients. Systematically, the dosage is adapted to renal function, but there are no guidelines for obese patients.

**Aim and objectives** The aim was to analyse the prescribing practices to create an internal protocol.

**Material and methods** This was a retrospective study from 1 January 2020 to 28 February 2020 of every enoxaparin prescription for a preventive dosage in orthopaedic surgery. We compared enoxaparin’s dosage with different criteria: sex, age, weight, body mass index (BMI), glomerular filtration flow, surgical and medical history, chronic treatment, surgical indication and prescribers.

**Results** We included 517 patients (table 1).

<table>
<thead>
<tr>
<th>Enoxaparin dose/day</th>
<th>No (%) of patients</th>
<th>Median BMI (kg/m²)</th>
<th>Median weight (kg)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2000 IU</td>
<td>20 (4)</td>
<td>20.5</td>
<td>50</td>
</tr>
<tr>
<td>4000 IU</td>
<td>462 (89)</td>
<td>24.7</td>
<td>71</td>
</tr>
<tr>
<td>6000 IU</td>
<td>21 (4)</td>
<td>31.3</td>
<td>90</td>
</tr>
<tr>
<td>8000 IU</td>
<td>14 (3)</td>
<td>37.5</td>
<td>110</td>
</tr>
</tbody>
</table>

Every patient with a dosage higher than 4000 IU (35/517) weighed >80 kg. Among them, 7 patients (19.4%) had a BMI >40 kg/m². These patients received 4000 IU of enoxaparin twice a day or 6000 IU in one administration. 20 of 517 patients were of low weight (<45 kg for women and <57 kg for men), and among them 6 (30%) received <4000 IU/day. Apart from renal function, no other criteria influenced the dose of enoxaparin. There was a disparity in dosages between prescribers. Of 19 prescribers, 7 (36.8%) occasionally, and 1 systematically, increased the dose of enoxaparin for weights >80 kg and BMI <40 kg/m². No thrombosis or haemorrhage occurred for dosages >4000 IU/day.

**Conclusion and relevance** European studies are based only on BMI or weight: increased dosage of enoxaparin for BMI higher than 40 kg/m² and more or less weight higher than 100 kg. The heterogeneity of prescriptions between prescribers and by prescribers highlights the lack of consensus. Adapting the dosage for a weight >80 kg does not seem appropriate because it includes non-obese patients with an increased risk of bleeding. Work in tandem with anaesthesiologists is underway to harmonise practices in our centre.

**REFERENCES AND/OR ACKNOWLEDGEMENTS**


**Conflict of interest** No conflict of interest

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**5PSQ-129 MANAGEMENT OF MULTIFACTORIAL ANAEMIA WITH SUBCUTANEOUS DARBEPOETIN WITH INITIAL MONTHLY DOSAGE, OMITTING INDUCTION ACCORDING TO THE TECHNICAL DATA SHEET, IN ELDERLY PATIENTS**

1. Villalobos Torres*, 2M Gonzalez Padilla, 3JC Del Rio Valencia. 1Hospital Alto Guadalquivir De Andújar, UGC Farmacia Hospitalaria, Jaén, Spain; 2Hospital Clínico Universitario Virgen De La Victoria, Servicio De Farmacia Hospitalaria, Málaga, Spain; 3Hospital Regional Universitario De Málaga, Farmacia Hospitalaria, Málaga, Spain

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**Background and importance** Multifactorial anaemia is a common disease in elderly patients, usually treated with darbe-epoetin in different dosages.

**Aim and objectives** To maintain normal haemoglobin (Hb) values (>12 g/dL in women and >13 g/dL in men according to...