generated more oscillation in plasma levels. For qualitative variables, absolute and relative frequencies were obtained, and for quantitative variables, the median (IQR) were used. For hypothesis contrast, Fisher's exact test or the Mann-Whitney U test was performed according to the type of variable.

Results 45 patients were included, 23 received voriconazole and 22 isavuconazole. Median age was 62 years (56–67) for those receiving voriconazole versus 63 years (54–68) for those receiving isavuconazole ($p=0.91$). 34.8% ($n=8$) of patients treated with voriconazole achieved concentrations of tacrolimus >20 ng/mL (toxic concentration) within 10 days from the start of the combination compared with 14.3% ($n=3$) of patients treated with isavuconazole ($p=0.1685$). The median standard deviation of plasma concentrations was 3.76 ng/mL (2.89–4.5) with voriconazole versus 3.17 ng/mL (1.4–5) with isavuconazole ($p=0.272$). The proportion of patients who temporarily discontinued tacrolimus treatment due to high level concentrations and associated toxicity was 18.2% ($n=4$) with isavuconazole versus 34.8% ($n=8$) with voriconazole ($p=0.318$).

Regarding tolerance to treatment, 28.57% of patients treated with isavuconazole had side effects associated with azole, compared with 82.6% of those treated with voriconazole ($p<0.005$). Treatment had to be suspended due to these side effects in 47.82% ($n=11$) of patients treated with voriconazole and in no patient treated with isavuconazole ($p<0.005$).

Conclusion and relevance Treatment with isavuconazole resulted in fewer tacrolimus poisonings, although the difference was not statistically significant. In addition, treatment with isavuconazole was found to be safer, had fewer side effects and did not require antifungal discontinuation.

REFERENCES AND/OR ACKNOWLEDGEMENTS

Conflict of interest No conflict of interest

5PSQ-143 DRUG RESISTANT TUBERCULOSIS IN A HIGH COMPLEXITY SPECIALISED UNIT: EPIDEMIOLOGY, TREATMENT AND MAIN ADVERSE REACTIONS

M Ayllón*, C Sobrino, C Bilbao, M García-Trevijano, M Escario, AB Arancón, C Jimenez, J Álvarez, A Herrero. *Hospital La Paz, Hospital Pharmacy, Madrid, Spain*

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Background and importance Inadequate therapeutic regimens and lack of adherence due to adverse effects of antituberculosis drugs have made resistance to these drugs a major public health problem. A better understanding of these issues may lead to better outcomes.

Aim and objectives To describe the population with drug resistant tuberculosis, the most used treatments, their adverse drug reactions (ADR) and their efficacy.

Material and methods A descriptive, observational, retrospective study was carried out. All patients cared for in our hospital that finished their treatments for drug resistant *Mycobacterium tuberculosis* between 2015 and 2019 were included.

Results 13 patients were analysed (62% men, mean age 43 (SD 14.8) years). Patients came from the following places: 46% Eastern Europe, 38% Latin America, 8% Western Europe and 8% Asia. Nine patients were diagnosed with multidrug resistant tuberculosis, 2 with polyresistant tuberculosis and 2 with extensive drug resistant tuberculosis. The therapies

included 6–9 different antituberculosis drugs. The most commonly used were linezolid and moxifloxacin (13/13), followed by amikacin and clofazimine (12/13). Other prescribed drugs were cycloserine (10/13), prothionamide (10/13), pyrazinamide (5/13), ethambutol (5/13), isoniazid (3/13), bedaquiline (2/13), meropenem/clavulanate (2/13), streptomycin (1/13), rifampicin (1/13) and rifabutin (1/13).

All patients had some ADR. The most frequent ADR were neurological (10), gastrointestinal (9), ototoxicity (5) and hepatitis (4). Cycloserine caused ADR (psychological, dizziness) in 70% of patients; amikacin (ototoxicity), ethambutol (cutaneous, neurological) and pyrazinamide (hyperuricaemia, arthralgia) in 40%; clofazimine (cutaneous, gastrointestinal), linezolid (neurological, aplasia) and prothionamide (gastrointestinal, hormonal) in 30%; moxifloxacin (fasciitis, nausea) in 8%. All patients reached seroconversion after 1.9 (SD 0.77) months from the beginning of treatment.

Conclusion and relevance Most of the patients diagnosed with drug resistant tuberculosis came from Eastern Europe and Latin America. Moxifloxacin and linezolid were the most used drugs. Cycloserine was the most toxic treatment. Despite the high frequency of ADR reported, all treatments were effective.

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5PSQ-144 PHARMACOTHERAPY OPTIMISATION IN PATIENTS OVER 50 YEARS OF AGE WITH HIV INFECTION: FIRST STEPS

¹B De La Calle Riaguas*, ¹P Gómez Espinosa, ¹FJ Juliá Luna, ²MDP Briceño Casado, ³M Domínguez Cantero. ¹Hospital Nuestra Señora Del Prado, Hospital Pharmacy, Talavera De La Reina-Toledo, Spain; ²Hospital Nuestra Señora Del Prado, Hospital Pharmacy, Talavera De La Reina, Spain; ³Hospital Universitario Puerto Real, Hospital Pharmacy, Puerto Real. Cádiz, Spain

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Background and importance HIV infection causes premature aging. As a result, there is an increase in comorbidities and therapeutic burden in these patients earlier than in the rest of the population.

Aim and objectives To evaluate the prevalence of pluripathology, polypharmacy and pharmacotherapeutic complexity in HIV patients aged over 50 years and to determine the need for optimisation of non-antiretroviral therapy.

Material and methods A cross sectional observational study was conducted (November 2019 – September 2020) in HIV patients aged over 50 years. Electronic prescription programme and clinical history were used to collect the following data: sex, age, comorbidities, antiretroviral therapy (ART) and concomitant medication. Pluripathology was defined as three or more comorbidities, and polypharmacy as six or more prescribed drugs. Pharmacotherapy complexity was determined by calculating: anticholinergic burden and the drugs involved, using the anticholinergic burden calculator programme; and relevant interactions between non-ART/ART medication (potential interaction/not coadminister), using the University of Liverpool and Lexicomp databases. Pharmaceutical interventions (PI) were performed based on criteria for optimisation of non-antiretroviral therapy from a guide for pharmacological deprescription in HIV patients, published by the Spanish AIDS Study Group (GESIDA).