remaining patients, median basal VL was 1135 IU/mL (3.34–65400), final VL was undetectable in 46.1% and in those who did not negatively affect the median final VL was 215 IU/mL (34.5–6690). Mean reduction in VL was 90.4±17.9% (18–100). There was a 64.1% reduction in GF (mean reduction of 25.6±21.2% and 36.7±22.0% over >65 years).

Metabolic toxicity, according to the CTCAE classification (V.4.0), hypokalaemia (grade 1 in 10.2% patients, grades 2 and 3 in 33.3%, grade 4 in 5.1% and the rest were not altered) and hypophosphataemia (grade 1 in 10.2%, grades 2 and 3 in 33.3% and grade 4 in 2.5%) were studied. In addition, hypomagnesaemia (grade 1 in 12.8%) and hypocalcaemia (grade 2 in 28.2% and grade 3 in 33.3%) were also observed. 41.0% of patients died during or immediately after treatment with foscarnet. Their average age was 61±14.4 (27–82) years and 81.2% presented haematological pathologies.

Conclusion and relevance Despite the high mortality observed, foscarnet effectively reduced viraemia due to CMV infection, with a high rate of viral negativisation. Further studies are needed to extend the toxicity data and improve the quality of care.

REFERENCES AND/OR ACKNOWLEDGEMENTS

Conflict of interest No conflict of interest

5PSQ-147 IMMUNOGLOBULIN SHORTAGE: PRACTICE MODIFICATIONS AND CLINICAL OUTCOMES IN A REFERENCE CENTRE

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Background and importance An enlargement of the number of indications for intravenous immunoglobulins (IVIg) in recent years has resulted in an increase in the consumption of these products. A lack of raw material has led to shortages of IVIg.[1]

Aim and objectives The objective of this work was to evaluate the impact of this situation on patient management in one French university centre, considering practice modifications and clinical outcomes.

Material and methods All patients treated with IVIg for chronic inflammatory demyelinating polyneuropathy, multifocal motor neuropathy, Guillain–Barré syndrome and myasthenia gravis were included, from October 2017 to October 2018. The analysis of practices was carried out between 2016 and 2019.

Results Of 155 patients, 72% had a modification of IVIg treatment, including 51% who had a delay in treatment, 28% a decrease in dose and 21% experienced an interruption in IVIg treatment. About 29% of patients for whom IVIg treatment was stopped were switched to other treatments, mainly plasma exchange. 58 patients presented one deterioration of their clinical score after prescription changes, including 31 patients who had a moderate or a clinically significant deterioration. For 17 patients, clinical deterioration was directly related to the IVIg shortage.

Concerning practice modifications, we noted a substantial but not significant decrease in the median dose for myasthenia gravis and a significant increase in the delay between treatments for chronic inflammatory demyelinating polyneuropathy and multifocal motor neuropathy (p=0.011 and p=0.018).

Conclusion and relevance Our study showed a rather important number of IVIg prescription changes related to IVIG shortages during the study period. These changes had a negative impact on the clinical status of some patients. The interest of this study is essential because of the fragility of the post coronavirus disease period related to a lack of plasma from which blood products derive.

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5PSQ-148 IMPROVING SAFETY IN THE VACCINE CIRCUIT

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Background and importance In our healthcare district, vaccine electronic prescriptions are not usual. Nurses use immunisation schedules as a prescription and there is no pharmacist validation. The electronic prescription and the pharmacist validation could help us to detect and avoid potential medication errors, improving patient safety.

Aim and objectives To describe the vaccine prescription, validation and dispensation circuit; and to analyse the discrepancies detected after implementation of this procedure.

Material and methods In January 2018, the pharmacy department, in collaboration with the preventive medicine service, developed a procedure for the safe use of vaccines: medical prescription, pharmaceutical validation, dispensing and administration. Vaccine prescription protocols were agreed with the preventive medicine physician and mandatory electronic prescription was established. Since then, the preventive medicine physician prescribes every vaccine through the electronic prescription programme (EPP). The pharmacist validates every prescription: indication, dose and immunisation schedule. If the pharmacist detects any discrepancy, the preventive medicine physician is contacted to resolve it before vaccines are dispensed. Lastly, the nurse administrates the vaccine and registers the batch and expiration date in the electronic medical record, guaranteeing drug traceability.

Results Between July 2019 and September 2020, 1084 vaccines were prescribed and 27 discrepancies were found. 4 of them (14.82%) were justified because the patients needed an accelerated vaccine regimen, but 23 of them (85.18%) were not justified: 3 discrepancies (13.04%) were prescription errors (the wrong vaccine was prescribed), 7 (30.43%) were dosage errors, 8 (34.78%) were errors in the immunisation schedule, in 2 cases (8,66%) no more doses were needed and 3 (13.04%) had a registration error of the last vaccine administration in the electronic medical record. In all cases, a potential medication error was avoided.