known whether faster dissolving formulations of paracetamol granulate result in improved exposure.

Aim and objectives Our objective was to determine the pharmacokinetics (PK) of two different formulations of oral paracetamol in old, frail adults.

Material and methods Geriatric inpatients aged 80 years or older were eligible for inclusion if they received 1000 mg of paracetamol as a tablet or a granulate formulation at 8am, 2pm and 8pm. Samples were collected at trough levels (T0) and at +0.5 (T0.5), +1 (T1), +2 (T2), +4 (T4), +5 (T5) and +6 hours (T6). PK parameters were evaluated for both paracetamol formulations.

Results 36 patients were included, with a mean age ($\pm$ SD) of 86.78 ($\pm$ 4.20) years. Most of the patients ($n=26/36$, 72%) received the tablet; 10 patients (28%) were prescribed the granulate formulation. Seven (21%) patients achieved an average plasma concentration (C_{ss}) above the analgesic target of 10 mg/L. Median C_{ss} (IQR) for the tablet group was 7.76 (6.31–9.08) mg/L and 9.27 (4.94–11.03) mg/L for the granulate group. T_{max} was 50.5 (31.50–92.50) min and 42.50 (33.75–106.75) min for the tablet and granulate formulation, respectively ($p=1.00$). C_{max} for tablet users was 15.95 (12.38–21.19) mg/L and 15.59 (10.80–21.77) mg/L for the granulate users ($p=0.698$).

Conclusion and relevance Large interindividual differences in PK parameters were found in a very old patient sample. Absorption parameters such as T_{max} and C_{max} were not significantly different between the tablet and granulate formulation. A trend for a higher C_{ss} was observed for patients in the granulate group.

REFERENCES AND/OR ACKNOWLEDGEMENTS

Conflict of interest No conflict of interest

5PSQ-182 ANTICHOLINERGIC BURDEN IN PATIENTS ADMITTED TO A PSYCHIATRIC HOSPITAL

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Background and importance The effect of taking drugs with the capacity to develop anticholinergic adverse effects, both peripheral (urinary retention, constipation, etc) and central (cognitive/functional disorders), is cumulative and may be different depending on the measurement scale used. In the psychiatric population, this effect may be greater due to the type of medication used.

Aim and objectives To analyse the prevalence and risk of anticholinergic burden (AB) in hospitalised psychiatric patients through the use of different calculation scales, and comparison between them to determine the most indicated in our psychiatric sample. To establish the most prescribed antipsychotic medications, and to determine if there are differences between the short stay unit (CSU) and the long/medium stay ward (LSW).

Material and methods A cross sectional study was conducted in psychiatric patients admitted in the last month. Variables collected were: demographic (age, sex), hospitalisation unit, number of drugs with AB and their anticholinergic risk according to the following scales: anticholinergic drug scale (ADS), anticholinergic risk scale (ARS), drug burden index

(DBI), anticholinergic cognitive burden scale (ACB), Chew's scale (Chew), anticholinergic activity scale (AAS), anticholinergic load scale (ALS), clinician rated anticholinergic scale (CrAS) and Duran's scale (Duran). The variables were obtained from the electronic medical records, and the AB and risk (no risk/low/medium/high) were calculated according to the aforementioned scales, using the AB calculator tool.

Results 67 patients (63% women) were treated with drugs with anticholinergic effects; mean age was 42.9 years. All patients had been prescribed some drug with AB (average number 5). Average number of drugs with AB in the CSU was 3.8 compared with 5.5 in the LSW ($p<0.05$). The AB on each scale was: 4.3 (high) with ACB; 3.7 (medium) with Chew; 2.3 (medium) with CrAS; 3.3 (medium) with AAS; 2.3 (medium) with ARS; 2.7 (high) with Duran; 2.9 (high) with DBI; 5.3 (high) with ADS; and 1.8 (medium) with ALS. The most prescribed drugs with anticholinergic activity were: benzodiazepines (88.1%), olanzapine (46.3%), antidepressants (41.8%) and quetiapine (37.3%).

Conclusion and relevance The number of psychiatric patients treated with drugs with anticholinergic effects was very high (100%), and statistically higher in the LSW than in the CSU. Studies are needed to determine which of these scales is the most useful to apply in our population. The drugs with anticholinergic activity most prescribed were, by far, benzodiazepines. Withdrawing (progressively), replacing pharmacological treatment (if it cannot be suspended) or reducing the dose (minimum effective dose) would be valid strategies to reduce the anticholinergic burden.

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Conflict of interest No conflict of interest

5PSQ-183 CONCOMITANT USE OF ACETYLCHOLINESTERASE INHIBITORS AND DRUGS WITH ANTICHOLINERGIC PROPERTIES AT ADMISSION BY EMERGENCY DEPARTMENT

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Background and importance Evidence suggests that pharmacological inefficacy and even worsening of conditions in elderly people with dementia may be due to the concurrent use of acetylcholinesterase inhibitors (AChEI) and drugs with anticholinergic properties (DAP).

Aim and objectives To assess the concomitant use of DAP and AChEI at admission to the emergency department (ED).

Material and methods A retrospective observational study was conducted in elderly patients treated with AChEI and DAP at admission to the ED from March to May 2019. Analysed variables were: gender, age, type of AChEI, number of other concomitant prescribed drugs and which of them were DAP, symptoms related to cognitive impairment and discharge destiny. Anticholinergic risk assessment was determined using the consensus scale of Durán *et al*, which classifies different drugs based on their anticholinergic potential (1 mild/2 severe). Statistical analysis was performed by IBM SPSS statistics software