Conclusion and relevance The coefficient was >0 , which suggests a positive correlation, but it was also very close to 0, which indicates that the correlation was very weak. Usually, asthmatic patients know the TAI as many pneumologists use it as a tool to calculate adherence, and therefore they know they are expected to get 50/50 in the test. However, the dispensing records are an objective method to measure adherence of patients and although it is not a substitute for the TAI, it should be complementary. When a patient with poor adherence is detected, pharmacists can play an important role with motivational interviews.

REFERENCES AND/OR ACKNOWLEDGEMENTS

Conflict of interest No conflict of interest

5PSQ-186 MAIN POTENTIAL INTERACTIONS DETECTED IN THE OUTPATIENT CONSULTATION

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10.1136/ejhp-pharm-2021-eahpconf.305

Background and importance In recent years, new oral treatments for cancer and hepatitis C have been authorised. These treatments have in common that they present a high risk of clinically relevant drug–drug interactions (DDIs). Polypharmacy and the use of complementary and alternative medicines (CAM) are increasingly common.

Aim and objectives To determine the prevalence and type of DDIs between selected drugs dispensed in the outpatient pharmacy service and drugs or CAM that patients take on a regular basis.

Material and methods A retrospective observational study was conducted. Inclusion criteria were patients treated with drugs with a high risk of clinically relevant DDIs for hepatitis C and oncohaematological malignancies between April 2018 and December 2019. Exclusion criteria were patients with other pathologies or treatments not considered ‘high risk’. Variables studied were: demographics (age, sex), reconciled drugs, type of DDI and pharmaceutical recommendations (PR). Data were obtained from the medical history, prescription chart and patient interview at the time of the first dispensing act. For the analysis of DDIs, the Lexi-comp interaction database and About Herbs, Botanicals and Other Products were used.

Results 130 patients (59% men), median age 62 years (range 25–87), were included. Diagnosis was oncohaematologic malignancy in 84% of patients and hepatitis C in 16%. Median number of drugs and CAM reconciled per patient was 6 (range 0–17). Drugs dispensed in the outpatient clinic were: 17% capecitabine, 14% temozolomide, 14% dabrafenib/trametinib, 11% glecaprevir/pibrentasvir, 8% imatinib and 32% others. DDIs were detected in 45% of patients: 29% type X (avoid combination), 29% type D (consider treatment modification) and 42% type C (monitor). The therapeutic groups that patients took on a regular basis involved the following: 25% antipyretic analgesics (metamizole), 22% proton pump inhibitors, 10% HMG-CoA reductase inhibitors, 8% oral anti-diabetics and 34% others. DDIs with CAM were detected in 6% of patients. PRs were accepted, implemented in all cases and recorded in the patient’s medical history: discontinuation

of treatment (26%), switch to therapeutic equivalent (24%), analytical monitoring (27%) and clinical follow-up (23%). In all CAM cases with DDIs, it was recommended to stop the medicinal plant.

Conclusion and relevance A high prevalence of moderate/severe interactions was observed in patients treated with oral antineoplastic and antiviral agents. This highlights the importance of continued pharmaceutical care and patient interview.

REFERENCES AND/OR ACKNOWLEDGEMENTS

Conflict of interest No conflict of interest

5PSQ-187 ALTERNATIVE TREATMENT TO ORAL IVERMECTIN IN *STRONGYLOIDES STERCORALIS* HYPERINFECTION IN THE SETTING OF SMALL BOWEL OBSTRUCTION AND PARALYTIC ILEUS

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10.1136/ejhp-pharm-2021-eahpconf.306

Background and importance Gastrointestinal complications, including small bowel obstruction and paralytic ileus, are associated with *Strongyloides stercoralis* hyperinfection syndrome, decreasing oral bioavailability. Ivermectin is the firstline agent for the treatment of strongyloidiasis as well as *S stercoralis* hyperinfection. In Europe, ivermectin is available in oral and parenteral formulations but the European Medicines Agency (EMA) has approved only the oral formulation for human use.

Aim and objectives The aim of the study was to describe alternatives to oral ivermectin when enteral absorption is compromised, regarding a recent case in our hospital.

Material and methods A bibliographic search was made using databases such as MEDLINE (Pubmed) and Micromedex. A specific search for official regulatory documents concerning human and veterinary medical products, from the websites of the EMA, was carried out. Therapeutic options found were assessed by the multidisciplinary infectious diseases team, including a clinical pharmacist.

Results Rectal and parenteral administration of ivermectin were the two therapeutic alternatives found to the oral route. Subcutaneous ivermectin is approved in Europe for veterinary use; its use in humans may be a therapeutic option but this requires an investigational new drug exemption from the EMA. After approval, subcutaneous ivermectin was started at a dose of 200 µg/kg/day. The rectal route was also assessed. Compounding pharmacists prepared enemas of ivermectin (12 mg/30 mL) from the tablets marketed for human use, which were administered every 12 hours. A progressive decrease in the parasite load was observed. *S stercoralis* was no longer detected in stools after 14 days of treatment, and on sputum gram stain after 25 days. The patient continued on therapy until a second negative sputum on day 33. Despite the resolution of the *S stercoralis* infection, the patient died due to multiple complications, including sepsis caused by translocation through the intestinal mucosa of gram negative bacteria into the bloodstream together with the larvae.

Conclusion and relevance The lack of treatment alternatives to oral ivermectin implies the use of off-label therapies. Subcutaneous ivermectin, available for veterinary use, and rectal ivermectin, compounded from marketed tablets, could be valid