

and 35 different antibiotics, respectively, was recorded in the general hospital clinics versus 25 in the independent clinic. Ampicillin/sulbactam, meropenem and piperacillin/tazobactam (with minor differences observed) were more often used in the general hospital, while meropenem, piperacillin/tazobactam and clindamycin were used most in the independent one. Despite the differences, the relative contribution of different antibiotics to total consumption was comparable for piperacillin/tazobactam, meropenem and ceftriaxone in all cases. Variables in the choice of regimen were mainly patient age, LOS and antibiogram. Average LOS was 10 days versus 25 days between hospitals. More than 90% of admissions in the general hospital (vs 5%) were emergency admissions.

Conclusion and relevance Only small differences in antimicrobial regimens were observed within each hospital, whereas between hospitals they varied significantly. Variables related to the general hospital environment, such as the increased probability of multiresistant pathogens (suggesting concomitant administration of two or more antibiotics) and the intensive care profile may adequately explain the observed variations. Such variables should always be considered in antibiotic stewardship programmes and/or other initiatives.

REFERENCES AND/OR ACKNOWLEDGEMENTS

Conflict of interest No conflict of interest

4CPS-248 APPROPRIATENESS OF THE *CLOSTRIDIUM DIFFICILE* INFECTION PRESCRIPTION PRIOR TO THE IMPLEMENTATION OF A PROTOCOL FOR ITS MANAGEMENT

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Background and importance *Clostridium difficile* disease (CDD) is the main cause of nosocomial diarrhoea.

Aim and objectives To evaluate the adequacy of treatment of CDD prior to implementation of the checklist for the diagnosis and treatment of CDD.

Material and methods This was a retrospective observational study of CDD cases in a tertiary hospital during 2019. The adequacy of treatment of positive cases was evaluated according to the checklist, considering variables for vulnerability (cancer patients, neutropenic, transplant recipients, inflammatory bowel disease or prolonged antibiotic treatment), severity (according to leucocytosis, renal function or presence of hypotension, shock or ileus), risk of recurrence (age, CDD the previous year, positive toxin or persistence of diarrhoea on the fifth day) and their treatment.

Results There were 126 cases of CDD in 100 patients, with a median age of 76 years (1–96) and 59% were women. The adequacy of the protocol was checked in 103 cases and the rest were incomplete:

- First non-severe episode/non-vulnerable patient (protocol: metronidazole → vancomycin): one case was not appropriate because it was treated with fidaxomicin before vancomycin.

- First non-severe episode/vulnerable patient (protocol: vancomycin → fidaxomicin): five cases were not adequate because they were not treated with vancomycin initially.
- First severe episode/non-vulnerable patient (protocol: vancomycin → fidaxomicin): seven cases were not appropriate because they were not treated with vancomycin initially.
- First severe episode/vulnerable patient (protocol: vancomycin → fidaxomicin → vancomycin+bezlotoxumab): one was not adequate because they were not treated with vancomycin initially.
- Fulminant (protocol: vancomycin+metronidazole IV): two cases were not appropriate as they were not initially treated with vancomycin+metronidazole IV.
- First episode and mild recurrence (protocol: vancomycin): six cases were not adequate. All should have been treated initially with vancomycin.
- First severe episode or recurrence (protocol: vancomycin or fidaxomicin±bezlotoxumab, depending on previous treatment): in four cases the treatment received was not appropriate because vancomycin is not indicated without continuing a downward pattern.

The treatment received was not appropriate in 26 (25.2%) cases.

Conclusion and relevance The percentage of patients whose treatment did not follow the protocol was considerable (26.5%). An increase in protocol deviations was observed in more complex treatments as the severity and/or vulnerability of the patient increased. Although oral metronidazole should be reserved only for the first mild episode in non-vulnerable patients, overuse was observed in all cases.

REFERENCES AND/OR ACKNOWLEDGEMENTS

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4CPS-249 SECOND GENERATION β-LACTAM/β-LACTAMASE INHIBITOR COMBINATIONS: CEFTAZIDIME–AVIBACTAM AND CEFTOLOZANE–TAZOBACTAM EXPERIENCE OF USE

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Background and importance Ceftazidime–avibactam and ceftolozane–tazobactam are two second generation cephalosporin/β-lactamase inhibitor combinations. The antimicrobial spectrum of activity includes multidrug resistant gram negative bacteria, including *Pseudomonas aeruginosa*. Ceftazidime–avibactam is also active against carbapenem resistant Enterobacteriaceae that produce *Klebsiella pneumoniae* carbapenemases. Both drugs are approved for treatment of complicated intra-abdominal infections (cIAIs), complicated urinary tract infections (cUTIs), community acquired pneumonia (CAP) and ventilator associated bacterial pneumonia (VABP).