visits, and therefore reducing SARS-CoV-2 transmissions. Otherwise, to maintain the sustainability of the implanted telepharmacy system, using the resources efficiently, it is necessary to apply patient stratifications tools, which allows access to this service to those patients who need it the most.

REFERENCES AND/OR ACKNOWLEDGEMENTS

Conflict of interest No conflict of interest

4CPS-317 IMMUNOSUPPRESSIVE TREATMENT MANAGEMENT IN A COHORT OF HOSPITALISED SOLID ORGAN RECIPIENTS AFFECTED BY COVID-19

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Background and importance Management of immunosuppression in recipients of solid organ transplantation (SOT) is challenging. Drugs used in COVID-19 involve drug–drug interactions (DDIs) with immunosuppressants.
Aim and objectives To describe DDIs in hospitalised SOT recipients (SOTr) and to analyse DDI management and their clinical impact.
Material and methods A retrospective single centre study was conducted in SOTr with COVID-19 hospitalised from 11 March to 25 April. Clinical data and pharmacotherapy were recorded from admission up to 28 days or discharge. Lexicomp was used to detect and categorise DDIs according to: risk level (X: avoid combination; D: consider therapy modification; C: monitor therapy; B: no action needed), reliability rating and severity. 46 patients were included: 33 (71.7%) men, aged 62.7 ±12.6 (mean±SD) years. They had received kidney (30; 56.2%), lung (13; 28.3%) or liver (3; 6.5%) transplants.
Results Immunosuppression at admission: tacrolimus (41; 89.1%), mycophenolate mofetil/mycophenolate sodium (28; 60.9%), prednisone (39; 84.8%), everolimus (7; 15.2%), sirolimus (7; 15.2%) and cyclosporine (1; 2.2%). 106 DDIs affecting 42 (91.3%) patients were detected (patients could have >1 DDI). DDIs were classified as confirmed (18; 39.1%) or potential (33; 71.7%). Immunosuppressants with DDIs: tacrolimus (65; 61.3%), everolimus (12; 11.3%), sirolimus (6; 5.7%), methylprednisolone (12; 11.3%), prednisone (10; 9.4%) and mycophenolate (1; 0.9%).

Drugs for COVID-19 with DDIs: lopinavir/ritonavir (45; 42.5%), azithromycin (32; 30.2%), tocilizumab (15; 14.2%), darunavir/cobicistat (10; 9.4%), and hydroxychloroquine (4; 3.8%). DDIs were risk X (6; 5.6%), risk D (42; 40.8%), risk C (57; 53.7%) and risk B (1; 0.9%). The reliability rate of DDIs was excellent (0.9%), good (52.8%) and fair (44.3%). Severity was low, moderate and major in 6.6%, 84.9% and 8.5% of cases, respectively.

Immunosuppression was withheld in 33 (71.7%) patients due to DDIs. 36 (87.7%) of 41 patients receiving tacrolimus had 65 DDIs; tacrolimus was withdrawn in 22 (61.1%), reduced in 18 (50%) and increased in 4 (11.1%) cases. Seven patients receiving everolimus had 12 DDIs and 4 patients with sirolimus had 6 DDIs; immunosuppressant was stopped in all cases. Tacrolimus levels were supratherapeutic (>10 ng/mL) in 8 (25%) patients at admission, 13 (43.3%; n=30) at 48 hours, 10 (31.3%, n=32) at 7 days and 2 at 14 days (17.7%, n=28). No graft rejection was detected. Mean creatinine serum concentration was 2.2 mg/dL at admission and 2.6 mg/dL 7 days later. Two cases of acute kidney failure were attributable to tacrolimus intoxication.
Conclusion and relevance DDIs were highly prevalent in hospitalised SOTr with COVID-19. Pharmaceutical care is critical to promptly detect and manage DDIs in SOTr.

REFERENCES AND/OR ACKNOWLEDGEMENTS

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4CPS-318 COMPOUNDING TACROLIMUS OPHTHALMIC OINTMENT 0.02% IN THE TREATMENT OF INFLAMMATORY AND AUTOIMMUNE OPHTHALMIC SYNDROMES: EFFECTIVENESS AND SAFETY ASSESSMENT

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Background and importance Inflammatory/autoimmune ophthalmic syndromes (IAOS) are often treated with corticosteroids in severe cases. However, in some cases, corticosteroids can be contraindicated, poorly tolerated or ineffective. This situation is common in paediatric patients who have a worse risk–benefit balance. Currently, evidence about using ophthalmic tacrolimus in IAOS is based in studies with monitoring duration reaching at most 4 weeks.
Aim and objectives To assess the effectiveness, tolerance and safety of compounded tacrolimus ophthalmic ointment 0.02% (CTOO) in the treatment of IAOS in paediatric and adult patients.
Material and methods We conducted observational retrospective research in paediatric and adult patients, recruited in our hospital with IAOS. Patients started treatment with CTOO once–twice/day+adjuvant therapy (AT) in January 2016 to April 2020, for 1 year at least. Effectiveness was assessed with hyperaemia grade (none, mild, moderate, severe) at 3, 6, 12 months, and grade of change noticed (GCN) at 1 and 12 months as a patient reported outcome. Tolerance/safety was determined at 1 week and 1 year. Every discontinuation was notified.
Results 30 patients (54 sick eyes) were recruited (27 women and 27 men). 32/54 were paediatric patients. The most common syndromes were vernal keratoconjunctivitis (18 eyes; 33.3%); atopic keratoconjunctivitis (14 eyes; 25.9%) and allergic conjunctivitis (8 eyes; 14.8%).

Hyperaemia was moderate–severe in 28 eyes (51.8%). It was reduced to 22.2% at 3 months, and to 9.3% at 12 months. No hyperaemia on day 0 was found in 21 eyes (38.9%) and which increased to 30 eyes (55.6%) at 3 months and to 41 (75.9%) at 12 months. After 1 month, 15 eyes (27.7%) had recovery of big or cleared grade, in 32 eyes (59.2%) recovery was mild–moderate and in 7 eyes (13.0%) no improvement was noticed. After a year, 15 eyes (27.7%) had reached the cleared grade. In contrast, 4 eyes had a deterioration after the treatment. Tolerance in the first week was: good (23 eyes; 42.6%), moderate (25 eyes; 46.3%) and poor in 6 eyes (11.1%) with no discontinuations. Tolerance at 1 year was good in 40 eyes (74.1%). However, in two eyes herpes virus infection was reported.