4CPS-353 COLLABORATION BETWEEN HOSPITAL AND COMMUNITY PHARMACISTS ABOUT DISCHARGED PATIENTS: A PILOT STUDY

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Background and importance Clinical pharmacist services (CPS) are increasingly used in optimising patients' medications at hospital admission and during the hospital stay. However, some drug related problems (DRPs) are not always solvable in the hospital, but community pharmacists (CPs) and hospital pharmacists (HPs) may collaborate to follow-up and resolve these DRPs post discharge.

Aim and objectives To analyse the nature and type of DRPs referred by HPs to a CP for follow-up post discharge.

Material and methods The study was conducted on four acute hospital wards in Region Zealand, involving 11 HPs. The HPs conducted their usual CPS at admission and wrote a referral meant for the CP with information about DRPs to be followed up post discharge. Additionally, data were gathered on patient age, gender and number of medications, and analysed using descriptive statistics. The identified DRPs were classified according to the PCNE-DRP Basic Classification (V9.1). In addition, the referrals were analysed and categorised into themes.

Results The HPs made a total of 132 referrals in the period from October 2019 to March 2020. The majority of patients were ≥ 50 years old (88%) and took an average of 10 (0–23) medications. On average, 1 (1–8) DRP was identified per referral. The most used combination of the P, C and I codes where P1 (treatment effectiveness), C7 (patient related) and I2 (intervention on patient level). The ATC codes most often involved in the identified DRPs were R03, A02 and N02. Six themes were identified from the qualitative analysis 'counseling on medication use', 'non-adherence', 'medication discrepancies', 'dialogue with the general practitioner', 'referral to existing community pharmacy services' and 'other'.

Conclusion and relevance HPs identify various DRPs to be referred to the CP post discharge. The DRPs were related to the patient, especially to adherence and correct administration of devices meant for respiratory illnesses. Additionally, the HPs were aware of existing services that might be used to solve the DRPs post discharge. Under normal circumstances, these DRPs might not have been identified after discharge in the community pharmacy, which highlights the importance for more collaboration between HPs and CPs in care transitions

REFERENCES AND/OR ACKNOWLEDGEMENTS

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4CPS-354 EFFICACY AND SAFETY WITH ERENUMAB AND GALCANEZUMAB: OUR EXPERIENCE

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Background and importance Calcitonin gene related peptide (CGRP) receptor inhibitors are a new group of drugs that have been included for migraine pharmacotherapy and migraine prevention. Erenumab and galcanezumab have notable individual variance and we wanted to explore this effect and also their safety.

Aim and objectives To assess the efficacy and safety of the CGRP receptor inhibitors erenumab and galcanezumab.

Material and methods In this 6 month observational retrospective study (January to June 2020), based on patient interviews, we obtained demographic parameters, reduced monthly migraine days (RDMM), a response rate of 50% (TR50) and adverse effects during treatment. RDMM are calculated by subtracting the migraine days 4 weeks before starting the treatment from the monthly migraine days between weeks 9 and 12 of treatment. TR50 are patients who achieved at least a 50% reduction in monthly migraine days in comparison with their initial condition.

Results 31 patients were registered with a mean age of 43.9 years (± 12.1), 77.4% were women and 22.6% were men. 66.7% (n=22) of patients were treated with erenumab and 33.3% (n=9) with galcanezumab. The RDMM for erenumab was -10.5 days (-17.1; -3.9) and a TR50 of 81.8% (n=18). For galcanezumab, the RDMM was -5.5 days (-8.6; -0.8) and a TR50 of 33.3% (n=3). The most frequent adverse reactions to erenumab were constipation (31.8% (7)) and erythema at the injection site (9.1% (2)); for galcanezumab, it was erythema at the injection site (22.2% (2)).

Conclusion and relevance Despite the disparity between the sample sizes of both drugs, in our study erenumab showed greater reduction in migraine days in comparison with patients treated with galcanezumab. Both drugs were safe in all patients, showing mild adverse reactions that did not require intervention.

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4CPS-355 EVALUATION OF PATIENTS CONSULTING THE EMERGENCY DEPARTMENT FOR BRADYCARDIA RELATED TO MEDICATION

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Background and importance Drug related problems are one of the main causes requiring assistance by the emergency units (EU), with bradycardia being one of the most frequent presentations. However, information related to the frequency of revisits to the EU depending on treatment changes at discharge is scarce.

Aim and objectives To describe the treatments that cause visits to the EU for bradycardia and to identify the interventions carried out and the revisits to the EU 30 days after discharge.

Material and methods A retrospective observational study was carried out in patients who attended the EU of a tertiary hospital for drug related bradycardia from September 2018 to March 2020.

Results 41 patients with a mean age of 81.2 years (range 55–96) undergoing treatment with negative inotropic drugs were

included. All patients treated with more than one drug were taking a beta-blocker. Four (30.8%) patients with dual therapy were taking flecainide concomitantly, four (30.8%) digoxin, three (23.1%) amiodarone and two (15.4%) diltiazem. 7.3% of the patients received the drug as a single dose, 9.8% started treatment the week before, 2.4% the month before and 12.2% in the last 3 months. Ten (24.4%) presented altered creatinine clearance and 17 (41.5%) had chronic renal failure.

In 14 (34.1%) patients one drug was suspended, in five (12.2%) two were suspended, in five (12.2%) the drug was changed, in seven (17.1%) the dose was decreased and in 10 (24.4%) treatment was not changed. Pacemakers were placed in 11 (26.8%) patients. 12 (29.3%) patients revisited the EU 30 days after discharge and 6 (50%) were admitted. Four (9.8%) patients consulted for an episode related to the previous one: 1 due to vasovagal syndrome after implantation of pacemaker without changes in treatment, 1 due to bradycardia after suspending bisoprolol but continuing with amiodarone and 2 due to AF after suspending any drug.

Conclusion and relevance Beta-blocker drugs were the main cause of pharmacological bradycardia, being used in most of the episodes as monotherapy and to treat atrial fibrillation. This group of patients presented with a high frequency of revisits at 30 days even after previous intervention. This is a potential group that could benefit from pharmacist follow-up after discharge.

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4CPS-356 COST MINIMISATION ANALYSIS OF THE USE OF NIVOLUMAB AND PEMBROLIZUMAB

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Background and importance Different studies have shown the equivalence of the dosage regimen for pembrolizumab adjusted to the patient's body weight (DPC: 2 mg/kg/3 week) and the fixed dose (DF: 200 mg/3 weeks), and the equivalence between nivolumab's DF (240 mg/2 weeks) and its DPC (3 mg/kg/2 weeks).

Aim and objectives To estimate the savings achieved by using DPC up to maximum doses of 200 mg for pembrolizumab, and 240 mg for nivolumab, in a medical oncology service of a third level hospital.

Material and methods A mathematical model was developed that included the cost of pembrolizumab/nivolumab (based on the laboratory's sales price), as well as the anthropometric characteristics of the patients, to estimate the economic impact using a cost minimisation analysis, on administration of DF versus DPC for oncological patients. All patients who received pembrolizumab for 2 years (2018–2020) and nivolumab for 3 years (2017–2020) were included in the study.

Results A total of 84 individuals were included:

- 65.5% (n=55) received nivolumab for the treatment of melanoma, (34.5%); non-small cell lung cancer (NSCLC) (23.6%); head-neck carcinoma (23.6%); and other types of carcinomas (18.2%).
- 34.5% (n=29) received pembrolizumab for the treatment of NSCLC (89.6%) and urothelial carcinoma (10.3%).

The mean number of cycles received was 14.1(2–72) for nivolumab and 11.5(2–32) for pembrolizumab.

During the study period, the use of nivolumab administered as DF would have cost a total of 3 515 760€ (1 171 920€/year; 63 923€/patient). However, the DPC would have cost 2 994 296€ (998 099€/year; 54 442€/patient), which means an annual saving of 173 821€. The total cost of treatment with pembrolizumab as DF for this study period was 2 374 956€ (1 187 478€/year; 81 895€/patient), while DPC would have had a total cost of 1 625 739€ (812 869€/year; 56 059€/patient), which means an annual saving of 374 608€.

Conclusion and relevance The introduction of immunotherapy in the oncological field has supposed an improvement in the survival of patients, but with a relevant economic impact. The search for strategies of this type can help optimise health resources without compromising the effectiveness of treatments. With the present study, we wanted to show one of these strategies that would allow a saving of 23% (548 429€/year) in the expenditure associated with pembrolizumab and nivolumab.

References and/or acknowledgements

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4CPS-357 CLINICAL CHARACTERISTICS AND MORTALITY OF COVID-19 IN A LONG TERM CARE FACILITY

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Background and importance Older patients living in long term care facilities (LTCFs) were the most vulnerable population during the pandemic caused by SARS-CoV2. It has been estimated that as many as half of all deaths from COVID-19 in Europe occurred in care homes.

Aim and objectives To describe a coordinated programme in response to a COVID-19 outbreak in an LTCF, the clinical and epidemiological characteristics, and the mortality rate.

Material and methods The study was performed from 20 March to 30 June 2020 in a single 264 bed LTCF in Spain. In response to the COVID-19 outbreak, we created a multi-disciplinary team to implement a coordinated programme to avoid high risk contagion with 12 interventions: (1) training on infection prevention and control, (2) screening of all staff members for symptoms, (3) communal activities and visit restrictions, (4) locating a clean room for equipment, (5) providing personal protective equipment, (6) resident cohorting, (7) assessment of all residents for symptoms and implementation of communication tools with families, (8) strengthening the workforce, (9) provision of equipment, materials and drugs with a minimum of supplies, (10) establishment of a consultation circuit with the local hospital, (11) compliance of protocols and (12) laboratory testing.