part of the SOPs. Data were obtained from medical charts and included demographic characteristics, concomitant medication and laboratory results of liver function (at admission and after about 5 and 10 days of hospitalisation).

Results 30 patients received remdesivir during the observation period, and in addition 11 patients without remdesivir were included as controls. Median time from symptom onset to hospitalisation was 4 days for the remdesivir group and 10 days for patients not treated with remdesivir. Remdesivir was prescribed in 17/30 patients (56%) without any other pharmacotoxically relevant medication. 13 patients (43%) received remdesivir together with ceftriaxone. There was no evidence of liver dysfunction, defined as alanine transaminase (ALT) values above 2.5 times the upper limit of normal, in patients with remdesivir with or without concomitant ceftriaxone. 3 patients (50% total) who received ceftriaxone without remdesivir had evidence of liver enzyme dysfunction. Only 1 patient received a P-gp inhibitor (carvedilol, 25 mg) together with remdesivir; however, no effect on ALT levels was observed.

Conclusion and relevance In this small sample retrospective study there was no evidence of clinically relevant liver toxicity with remdesivir, with or without other drugs that would impact liver enzyme function, such as ceftriaxone. Interactions with potent Cyp3A4 or P-gp inhibitors appear to be rare in a real-life clinical environment.

REFERENCES AND/OR ACKNOWLEDGEMENTS

No conflict of interest.

Conflict of interest No conflict of interest

5PSQ-128 CLINICAL INTERVENTIONS IN THE AREA OF INPATIENT PRESCRIPTIONS PERFORMED BY A HOSPITAL PHARMACY RESIDENT

R Serrano Gimenez, I Castañeda Macias, M Florido Francisco, I García Giménez*. *Juan Ramon Jimenez University Hospital, Hospital Pharmacy, Huelva, Spain*

10.1136/ejhpharm-2022-eahp.334

Background and importance Pharmaceutical validation of inpatient treatments is a fundamental activity in the clinical practice of the hospital pharmacist. Thanks to this, many prescription errors are detected, promoting patient safety.

Aim and objectives To describe the interventions performed by a hospital pharmacy resident in the area of pharmaceutical validation, supervised by consultant pharmacists, and to evaluate their degree of acceptance.

Material and methods Prospective interventional study conducted during September 2021. Adult inpatients, whose hospital treatment was reviewed, were included. Demographic (sex and age), clinical (clinical judgement (CJ) and inpatient clinical service) and pharmacotherapeutic (number of chronic medicines and polymedication (≥6 drugs)) variables were collected. Interventions were reported to the clinician via electronic prescribing software. They were classified as: Activity (reconciliation on admission/information to the clinician), Adequacy (detection of prescribing error/therapy reconciliation error), Change (therapeutic exchange), Initiation (usual treatment not prescribed/need for additional treatment), Modification Dosage Form (DF) or Posology, Suspension (duplicity/unnecessary medication/allergy). Patient lists and data were collected through medical records and electronic prescribing software, and processed using Excel 2020.

Results Interventions were performed in 56 patients. 63.2% male; median age 73 years (IQR 61–80). The most frequent CJ were: heart failure (10.7%), COVID-19 (7.1%), liver dysfunction (7.1%). Services with most interventions: Internal Medicine (25.8%), General/Vascular Surgery (19.4%), Digestive (11.3%). Median number of chronic medicines: 8 (IQR 5–12). Polymedication in 71.4%. 62 interventions were performed (12.9% were 'not evaluable', reasons: discharge/death). Of the evaluable interventions, 77.8% were accepted. The percentages were: duplicity (30.9%), modification DF/posology (23.8%), usual treatment not prescribed (7.1%), therapeutic exchange (7.1%), discontinue medication due to allergy (7.1%), therapy reconciliation error (4.8%), reconciliation on admission (4.8%), information (4.8%), additional treatment (4.8%), prescribing error (2.4%), unnecessary medication (2.4%). Of the accepted interventions, 11.9% were related to high-risk medicines according to the Institute for the Safe Use of Medicines[1–2] (nonsteroidal anti-inflammatory drugs (NSAIDs), beta-blockers, heparin, immunosuppressants). Of the not-accepted interventions, 50.0% corresponded to errors in home treatment reconciliation.

Conclusion and relevance The data obtained demonstrate that clinical interventions performed by the hospital pharmacy resident have a high degree of acceptance, increasing the quality and safety of healthcare and avoiding medication errors.

REFERENCES AND/OR ACKNOWLEDGEMENTS

1. High-risk medicines in hospitals. ISMP, 2012. http://www.ismp-espana.org/ficheros/Medicamentos%20alto%20riesgo%202012.pdf
2. High-risk medicines in chronically ill patients. ISMP, 2014. http://www.ismp-espana.org/ficheros/Relaci%C3%B3n%20medicamentos%20alto%20riesgo%20en%20cronicos.pdf

Conflict of interest No conflict of interest

5PSQ-130 DOSE BANDING OF INTRAVENOUS 5-FLUOROURACIL, OXALIPLATIN, PACLITAXEL AND GEMCITABIN: EVALUATION OF EFFICIENCY AND SAFETY SUBSEQUENT TO AN IMPLEMENTATION PROGRAMME

F Bustelo*, MF Fernández, R Olivera, S Boullosa, C Barca, I Proupin, B Franco, L González, S Castro, C Crespo. *University Hospital Complex of Pontevedra, Pharmacy Department, Pontevedra, Spain*

10.1136/ejhpharm-2022-eahp.335

Background and importance Dose banding (DB) is a strategy used to optimise the individualisation of antineoplastic treatments in order to reduce dose errors and achieve the highest efficiency.

Aim and objectives The aim of this work was to implement a DB system and analyse its impact on the efficiency and safety of patients treated with 5-fluorouracil (5-FU) elastomeric pumps and oxaliplatin, paclitaxel and gemcitabin solutions.

Material and methods Retrospective 5-month study, including 147 patients treated with antineoplastic agents (44 with 5-FU, 28 oxaliplatin, 36 paclitaxel and 39 gemcitabin). 5-FU was prepared in an elastomeric pump (Autofuser UFSC-2); the remaining drugs were prepared for infusion with NaCl 0,9% in a Freeflex plastic container.

Patients were divided into two groups for each drug, depending on the theoretical calculated doses adjusted to their body surface area (BSA): P1 higher-doses, P2 lower-doses. Dose-range was established with a ±5% variability.

In order to measure the efficiency, the number of elaborations, expired preparations and percentage of saved vials were noted.

Safety was determined comparing leucocyte (5-FU) and neutrophil levels (oxaliplatin, paclitaxel and gemcitabine) the day before the treatment and preceding the next dose.

Statistical association was investigated by applying Student's t-test, and Wilcoxon and Shapiro–Wilks tests. Non-statistical significance was considered a favourable outcome.

Results Six 5-FU, oxaliplatin and paclitaxel doses were standardised covering 93.6%, 100% and 72% of patients, respectively, and seven gemcitabin doses covering 97.5%.

A total of 1527 preparations were elaborated (412 5-FU, 312 oxaliplatin, 431 paclitaxel and 372 gemcitabin) and the percentages of expired preparations were 6.3%, 15.6%, 4.4% and 11.8%, respectively. The efficient use of vials allowed a significant saving: 23.4% for 5-FU vials, 32.2% for oxaliplatin, 52.6% paclitaxel and 22.2% gemcitabin.

There were no statistical differences between leucocyte/neutrophil levels measured before and after the treatment in either group (5-FU: p=0.99/p=0.57; oxaliplatin: p= 0.71/p=0.57; paclitaxel: p=0.90/p=0.26; gemcitabin: p= 0.32/p=1).

Conclusion and relevance The implementation of the project turned out to be simple and satisfactory. The process proved to be efficient after the stock adjustment (oxaliplatin and gemcitabine). The DB did not compromise safety of patients in terms of haematological toxicity. Thus, DB represents a cost-effective technique that might be taken into account.

REFERENCES AND/OR ACKNOWLEDGEMENTS

Conflict of interest No conflict of interest

5PSQ-131 PARENTERAL NUTRITION IN ACUTE PANCREATITIS: A REVIEW OF APPROPRIATENESS

C Sebastián*, G Garreta, N Meca, F Salazar, M Rodrigo, J Nicolas-Pico. *Hospital Mútua Terrassa, Hospital Pharmacy, Terrassa, Spain*

10.1136/ejhpharm-2022-eahp.336

Background and importance According to nutritional recommendations in patients with pancreatitis, adequate nutrition from the beginning has a high impact on the pathology, since these are patients at risk of malnutrition.

Aim and objectives To review the adequacy of individualised total parenteral nutrition (TPN) in patients admitted with a diagnosis of acute (AP) or exacerbated (rPAP) pancreatitis.

Material and methods Retrospective observational study including patients admitted from January 2020 to September 2021, all diagnosed with AP or rPAP.

The following variables were collected from the HCIS clinical history and Kabisoft TPN prescription program: age, sex, height, weight, diagnosis, initial TPN composition (lipids, carbohydrates, proteins), days from admission to initiation of TPN and reason for initiation.

Results A sample of 53 patients was obtained, 33 men, of whom 42 were diagnosed with BP (79.25%) and 10 with rPAP (18.87%) on admission.

The mean number of days to initiation of TPN was 3.30 (±1.90) days. The majority of patients, 48 of the total, started TPN due to contraindications to an oral diet.

Only 10 had a lipid intake ≥0.8 g/kg/day; the rest had less, with a mean of 0.6 (±0.23) g/kg/day. Protein intake was 1.1 (±0.23) and carbohydrates 2.8 (±0.55) g/kg/day.

Lipids accounted on average for 26.2% (±7.31) of the average caloric intake (ACT), protein 21.4% (±3.25) and carbohydrates 52.4% (±5.82). Twenty-eight of the TPNs had an ACT lower than the calculated requirements. The average non-protein kcal/g nitrogen (kcalNP/gN) was 94.8 (±19.20) and non-protein kcal/kg on average was 16.8 (±3.84).

Conclusion and relevance In line with the European Society for Clinical Nutrition and Metabolism (ESPEN) guidelines, protein, carbohydrate and lipid intake, and non-protein kcal/kg, were lower than recommended. Total TPN kilocalories were also lower than the calculated requirements of the patients. This may be due to the fact that energy needs change according to AP severity and stage. Also, there is risk of malnutrition and, consequently, refeeding syndrome.

However, the kcalNP/gN ratio was adequate, ensuring that protein was used for tissue formation. The caloric intake of carbohydrates with respect to ACT was adequate, being between the recommended 50%–70%.

More clinical nutrition interventions will be necessary, always integrated by a multidisciplinary team.

REFERENCES AND/OR ACKNOWLEDGEMENTS

1. ESPEN guideline on clinical nutrition in acute and chronic pancreatitis. *Clin Nutr* 2020;**39**:612–631.
2. ESPEN guidelines on parenteral nutrition: pancreas. *Clin Nutr* 2009;**28**:428–435.

Conflict of interest No conflict of interest

5PSQ-135 NEW SECURITY WARNINGS FOR TOFACITINIB: ANALYSIS OF PATIENTS AT RISK

MJ Lopez-Muñoz, A Alcala-Soto, M Vázquez-Real, MDV Sanchez Matamoros Piazza*, D Ruiz-Pérez, JF Sierra-Sánchez. *Hospital Universitario Jerez de La Frontera, Pharmacy Service, Jerez de La Frontera-Cádiz, Spain*

10.1136/ejhpharm-2022-eahp.337

Background and importance In July 2021, the European Medicines Agency (EMA) and the Spanish Agency for Medicines and Medical Products (AEMPS) notified healthcare professionals of a drug safety warning for tofacitinib that showed new recommendations for its use in relation to an increased risk of major adverse cardiovascular events and malignances with use of tofacitinib relative to tumour necrosis factor alpha (TNFα) inhibitors: "Tofacitinib should not be used in patients older than 65 years of age, people who are current or past smokers, or individuals with other cardiovascular (such as diabetes or coronary artery disease) or malignancy risk factors unless there are no suitable treatment alternatives".

Aim and objectives The objective of this study was to identify patients at increased risk of major adverse cardiovascular events and malignances who are being treated with tofacitinib in order to communicate this fact to healthcare professionals.

Material and methods Retrospective study of patients under treatment with tofacitinib from January to September 2021. The following factors were considered as risk factors: aged 65 years or more, cardiovascular risk factors, and current malignances. Data were recollected from the patients' clinical history and local prescription program. We prepared a personalised report that included a summary of the drug safety warning and the patients under treatment that were