The most prescribed antibiotics were piperacillin/tazobactam (22), ceftriaxone (16), cotrimoxazole (15), amoxicillin/clavulanate (8) and metronidazole (5).

The sources of infection were respiratory (26.2%), urinary (21.3%), intra-abdominal (21.3%), skin and soft tissue (9.8%), catheter-associated (6.6%) and unclear (14.8%).

Recommendations were made to continue treatment (67.8%), discontinue for excessive duration (10.3%), de-escalate (9.2%), discontinue for unnecessary antimicrobial (8.0%) and escalate (4.6%).

The acceptance rate was 98.8%.

**Conclusion and relevance** The recommendations made by the ASP team were almost entirely accepted by the responsible clinician. Advice from a multidisciplinary team of experts in the field benefits these patients in optimising their antimicrobial therapy.

**REFERENCES AND/OR ACKNOWLEDGEMENTS**

Conflict of interest No conflict of interest

---

**CHARACTERISATION OF A COMPOUNDED VORICONAZOLE SOLUTION FOR NEBULISATION AND DESCRIPTION OF ITS USE IN THE CLINICAL SETTING**


Vall d’Hebron University Hospital, Clinical Pharmacy, Barcelona, Spain

10.1136/ehjpharm-2022-eahp.399

**Background and importance** Voriconazole is the primary treatment for invasive pulmonary aspergillosis. Antifungal nebulisation has advantages, but there are no commercial antifungal pharmaceutical presentations for nebulisation.

**Aim and objectives** To physicochemically characterise a compounded voriconazole solution for nebulisation and to describe its use in a cohort of patients.

**Material and methods** Voriconazole solution for nebulisation was prepared in the Pharmacy Department. Accord, Kern and Normon vials were used.

Clinical data from patients treated with nebulised voriconazole in our hospital were retrospectively collected.

Voriconazole concentration in plasma was determined using high-performance liquid chromatography.

**Results** Voriconazole vials containing 200 mg of powder for solution for infusion were diluted with sterile water for injection (19 mL). The solutions were adequate for nebulisation (pH 4.97, 7 and 5; osmolarity 359, 503 and 313 mOsm/kg, respectively). Syringes containing 40 mg/4 mL were dispensed.

Ten patients received nebulised voriconazole, 9 adults and 1 child; median age was 35 years (minimum 5 and maximum 69 years), all men. Five patients had cystic fibrosis and 8 had undergone lung transplantation (LT) 7 (0–84) months ago. 6 patients had respiratory distress and 2 were colonised. Treatment was started on the hospital floor (5), intensive care unit (3) or outpatient department (2).

Fungi detected were *Aspergillus spp* (5) (*A. flavus* (4)), *Scedosporium spp* (4) and *Purpureocillium spp* (1).

Treatment was started due to lack of response to systemic treatment (4), toxicity (4), avoiding drug-drug interactions (2), post-LT prophylaxis (1) and booster oral voriconazole effect (1).

Doses (40 mg for adults, 10 mg for children) were administered every 12–24 hours (2–3 days in the case of colonisation) during a median of 130 (26–911) days.

Three patients died, 3 fungal infections resolved, 2 had colonisation without exacerbations, there was one case of voriconazole resistance and the patient using voriconazole as prophylaxis had a successful evolution.

No adverse events were reported, only mild pruritus in a patient with a history of allergy (treatment withdrawal was not required).

There were 11 voriconazole plasma measurements for 6 patients. Voriconazole was only detected in 2 patients receiving oral voriconazole.

**Conclusion and relevance** The characteristics of the compounded voriconazole solution are adequate for nebulisation.

Compounded voriconazole solution is well tolerated and it is not absorbed into the systemic circulation.

Nebulised voriconazole could be an interesting therapeutic option to treat pulmonary infections and/or colonisations.

**REFERENCES AND/OR ACKNOWLEDGEMENTS**

Conflict of interest No conflict of interest

---

**DURABILITY OF ORAL DUAL ANTIRETROVIRAL THERAPY IN HIV PATIENTS**

1. L Perez Cordon*, 1A Sanchez Ulayar, 2S Marin Rubio, 1V Aguilara Jimenez, 1L Campins Bernadas, 1J Delgado Rodriguez, 1M Billich Obsols, 1R Merino Mendez, 1T Gurerra Roig, 1D Lopez Faixo, 1Hospital de Mataro, Pharmacy, Mataro, Spain; 2Hospital Germans Trias i Pujol, Pharmacy, Badalona, Spain

10.1136/ehjpharm-2022-eahp.400

**Background and importance** Dual antiretroviral therapy (DAT) is currently used as initial treatment in naïve patients or as a maintenance therapy in those who are virologically suppressed. The simplification of antiretroviral regimens is associated with a reduction in treatment toxicities and costs and an adherence improvement. However, there are a lack of studies reporting data on DAT effectiveness beyond clinical trials.

**Aim and objectives** To assess the durability and reasons for discontinuation of DAT in HIV-infected patients.

**Material and methods** This was a retrospective, cohort study. Adult HIV-infected patients who started a treatment with DAT between 2015 and 2019 in a general hospital were included. Sociodemographic data, HIV-1 RNA copies at baseline and treatment data (DAT combination, previous treatment, time to discontinuation and reason for discontinuation) were collected from clinical records. Treatment durability was assessed using the Kaplan-Meier analysis up to 48 weeks.

**Results** Fifty-one patients were included: 31 patients were male, mean age was 49±11 years. Mean time from HIV diagnosis was 16.2±9.1 years, 20 patients had a previous classification Centers for Disease Control and Prevention (CDC) stage C and 15 had a history of intravenous drug use. Thirty-six patients were previously treated with a three-drug regimen, 8 with a DAT, 5 with an antiretroviral monotherapy and 2 were treatment-naïve. Thirty-seven patients were virologically suppressed at baseline. DAT combinations were: integrase inhibitor (INI) plus nucleoside reverse transcriptase inhibitor (NRTI) or non-nucleoside reverse transcriptase inhibitors (NNRTI) (n=29), boosted protease inhibitor (PI/b) plus NRTI or NNRTI (n=15) and INI plus PI/b (n=7). Thirty-nine patients maintained DAT at 48 weeks and mean treatment