Results The best compromise found was a 10% amitriptyline cream made in Versatile with urea at 2% as an emollient agent. This cream retains its diffusion properties, its organoleptic characteristics but also its physicochemical and microbiological stability for more than 6 months (stability data are still ongoing) in a PVC/ALU packaging.

81 patients were included (February–November 2020). For 49 patients (60.5%), the cream was effective. The etiologies for which the cream seems to be the most effective are post-chemotherapy pain (64% efficiency with taxane-based chemotherapy, 70% efficiency with platinum-based chemotherapy).

Conclusion and relevance The development of this topical has allowed neuropathic patients to gain relief. These data are very encouraging and will be confirmed through the implementation of a clinical trial.

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Conflict of interest No conflict of interest

4CPS-034 DEPRESCRIBING ORAL IRON IN ELDERLY PATIENTS: EXPERIENCE FROM A NURSING HOME ASSOCIATED WITH A THIRD LEVEL HOSPITAL

J Ibanez-Caturla, P Pacheco*, T Alonso-Domínguez, MA Carvajal-Sánchez, L Fructuoso-González, P Torrano-Belmonte, M Hernández-Sánchez, JA Gutiérrez Sánchez, S Clavijos-Bautista, C Fernández-Zamora, MA Meroño-Saura. *Hospital Morales Meseguer, Pharmacy Service, Murcia, Spain*

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Background and importance Oral iron is prescribed to elderly patients as the treatment for episodes of iron deficiency anaemia. Inadequate follow-up and chronic prescription in patients who no longer benefit from it is common.

Aim and objectives To identify potentially inappropriate prescriptions (PIP) for oral iron (OI) in institutionalised elderly patients, as well as describing the deprescribing process in consensus with the centre's medical team.

Material and methods Demographic (age, sex), clinical (pathologies), analytical (haemoglobin, ferritin and serum iron) and pharmacological variables (dosage, possible adverse reactions) were collected from all patients undergoing oral iron treatment at the centre under our care. The Selene medical record and the Mira electronic prescription were used for data collection.

Chronically prescribed treatments without evidence of iron deficiency anaemia and non-iron deficiency analytical profile in elderly patients (Hb >12 g/dL, ferritin >100 ng/mL) were ruled as cut-off points for PIP. Data weres collected prior to and 3 months after the intervention.

Results Out of the 129 institutionalised patients, a total of 27 patients (21%) followed a chronic treatment with different presentations of OI (10 iron lactate, 17 sulfate). With a median age of 88 years, the majority (74%) were women. 56% of the patients in treatment had chronic constipation, possibly exacerbated by OI.

Of the 27 patients with OI, 16 PIPs (59%) were found. 12 patients (75%) had high iron reserve values (ferritin and haemoglobin) and 4 patients followed a chronic prescription without adequate analytical testing.

We proposed to the medical team to study the possibility of suspending OI treatment in those 12 patients with high iron reserve values, as well as assessing those 4 patients without previous blood tests, and to reevaluate after 3 months. The pharmaceutical deprescribing recommendation was accepted in 10 patients (63%).

Three months after the withdrawal, 4 patients had normal values of iron reserve tests, 3 were deceased, 2 had no analytical data, and 1 patient restarted a 3-month course of OI treatment.

Conclusion and relevance Oral iron treatments are prone to inadequate chronic prescription; these drugs commonly cause gastrointestinal adverse effects. Deprescribing efforts by pharmacists in a nursing home as part of a multidisciplinary team is a effective way of optimising treatment in polymedicated, elderly patients.

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4CPS-035 PHARMACIST-LED MEDICATION RECONCILIATION AT DISCHARGE SHALL NOT BE SUFFICIENT TO REDUCE UNPLANNED HEALTHCARE UTILISATION: HEAR THE PATIENT EXPERIENCE!

[1]F Laval*, [2]R Lhermitte, [3]L Alix, [4]D Somme, [2]B Marie-Dit-Dinard, [1]V Gicquel, [1]A Bacle, [1]B Hue, [5]E Bajeux. *[1]CHU Rennes – Hôpital de Ponchaillou, Service de Pharmacie, Rennes, France; [2]CH de Fougeres, Service de Pharmacie, Rennes, France; [3]CHU Rennes – Hôpital de Ponchaillou, Service de Médecine Interne, Rennes, France; [4]CHU Rennes – Hôpital de Ponchaillou, Service de Gériatrie Aiguë, Rennes, France; [5]CHU Rennes – Hôpital de Ponchaillou, Service d'Épidémiologie et de Santé Publique, Rennes, France*

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Background and importance Older patients often experience adverse drug events (ADEs) after discharge that may lead to unplanned readmission. Pharmacist-led medication reconciliation at discharge (MRD) is known to reduce medication errors that lead to ADE but results on healthcare utilisation are controversial.

Aim and objectives The main aim of this study was to evaluate the MRD's effect provided to patients aged over 65 years on their unplanned rehospitalisation for ADE within 30 days. A secondary objective was to assess the impact of the pharmacist's presence on patient experience and knowledge about their treatment.

Material and methods An observational, multicentre prospective study, in medical and rehabilitation wards in 5 hospitals in Brittany, France. Included patients were aged 65 years and over who received MR at admission (MRA). A pharmacist-led MRD was the intervention. The primary endpoint was the proportion of patients experiencing death, unplanned rehospitalisation and/or visit to an emergency department within 30 days after discharge. Secondary endpoints encompassed the patient's experience of discharge and knowledge about their medication changes.

Results Patients who received MRA and MRD did not have significantly fewer deaths, unplanned rehospitalisations and/or emergency visits related to ADE or other (p=0.960) 30 days after discharge than patients receiving MRA alone.

The discharge from hospital seemed well organised for these patients (p=0.003) and they reported more frequently