ceftazidime 2 g every 8 hours was initiated. Two weeks later, PE was confirmed by growth of *P. aeruginosa* resistant to carbapenems in the pleural fluid and treatment was escalated to IV ceftolozane/tazobactam 2 g/1 g every 8 hours.

After subsequent microbiological control, *P. aeruginosa* resistant to ceftolozane/tazobactam and ceftazidime-avibactam (minimum inhibitory concentration (MIC) >250 µg/mL) was observed and, therefore, IV ciprofloxacin 400 mg/12 hours and IV amikacin 15 mg/kg/24 hours were initiated. Nebulised colistin 5 million units (MIU)/8 hours was added. IpC was added due to the persistence of extensively drug-resistant (XDR) *P. aeruginosa* in the pleural fluid. The decision was based on a case report in which IpC was used for MDR *Acinetobacter baumannii* PE, with positive results; 0.5 MIU of colistimethate sodium were diluted in 50 mL 0.9% physiological saline and instilled through the pleural drains every 12 hours (clamped for 2 hours).

The patient presented episodes of desaturation and sweating associated with the administration of IpC, forcing the suspension of IpC after 9 days of treatment. Finally, she died in the context of infectious disease as a consequence of refractory hypoxaemia.

Conclusion and relevance The persistence of XDR *P. aeruginosa* in our patient motivated the search for alternatives and IpC was choosen on the basis of a single case. However, the efficacy could not be determined due to its poor tolerance. Despite the limited amount of published data, the administration of intrapleural antibiotics may constitute a therapeutic option.

REFERENCES AND/OR ACKNOWLEDGEMENTS

Conflict of interest No conflict of interest

4CPS-039 EFFECTIVENESS OF ERENUMAB AND GALCANEZUMAB IN THE TREATMENT OF MIGRAINE

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Background and importance Migraine is a neurological disorder characterised by episodic and recurrent seizures. Erenumab and galcanezumab are two monoclonal antibodies (MA) indicated for the prophylaxis of migraine in adults. They are recently marketed drugs, so it was necessary to determine their effectiveness.

Aim and objectives This study analysed the effectiveness of these MA in a series of patients in a third-level hospital.

Material and methods Retrospective observational study. Study period: January 2020–April 2021.

To start treatment, patients must be diagnosed with chronic or episodic migraine, having at least 8 migraine days per month and after having failed three or more previous treatments, one of them being botulinum toxin in the case of chronic migraine. This treatment is dispensed in the outpatient consultation service of the Hospital Pharmacy after a clinical interview in which all variables are recorded. To evaluate the effectiveness, we analysed the number of days with migraine attacks per month and the consumption of concomitant-related medication.

Results 53 patients (49 women, 4 men). Median age: 50 (range 21–77) years.

Diagnosis: chronic migraine: 41 patients; episodic migraine: 12 patients.

Treatment: erenumab 140 mg: 46 patients; erenumab 70 mg: 5 patients; galcanezumab 120 mg: 2 patients.

Received doses: galcanezumab: 6 doses: 2 patients; erenumab: 12 or more doses: 10 patients; 6–11 doses: 27 patients; 3–5 doses: 11 patients; fewer than 3 doses: 3 patients.

The median number of monthly episodes suffered pre-treatment was 20 (9–30). After 3 months, the median was 9 (1–30): 45% of episodes. After 6 months: 7 (0–28): 35% of episodes. After 12 months: 13 (4–28): 65% of episodes. 4 patients suspended treatment due to lack of effect.

The rest of the antimigraine drugs consumed prior to the use of MA, at the beginning, after 3 months and after 6 months of treatment were:

Beta-blockers: 22.22%, 1.85%, 0%, 0%.

Calcium antagonists: 20.37%; 1.85%, 0%, 0%.

Antiepileptics: 38.89%; 1.85%,1.96%, 0%.

Nonsteroidal anti-inflammatory drugs (NSAIDs): 25.92%; 29.63%, 45.09%; 16.21%.

Triptans: 38.88%; 62.96%, 50.98%, 18.91%.

No interactions with MAs were identified.

Conclusion and relevance The use of subcutaneous MA reduced the median of seizures per month significantly at 3 and 6 months. Although a rebound is observed at 12 months, the result of this is difficult to assess due to the small number of patients (10). The consumption of other antimigraine drugs was also reduced.

REFERENCES AND/OR ACKNOWLEDGEMENTS

Conflict of interest No conflict of interest

4CPS-040 INTERINDIVIDUAL VARIABILITY OF LINEZOLID IN CRITICALLY ILL PATIENTS

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Background and importance A high variability in linezolid plasma concentrations (Cp) has been observed when administered at the standard dosage recommended in the technical data sheet (600 mg/12 hours), which is directly related to the effectiveness of the treatment and the appearance of haematological toxicity.

Aim and objectives The main objective was to describe the Cp values of linezolid obtained in critically ill patients, as well as the recommendations made during pharmacokinetic monitoring.

Material and methods Retrospective observational study carried out in a third-level general hospital. Patients >18 years old admitted to the critical care units between September 2019 and May 2021,in which at least one Cp determination of linezolid was performed, were analysed. Demographic, clinical, therapeutic and pharmacokinetic monitoring-related variables were collected. Cp determination of linezolid was analysed by homogeneous enzyme immunoassay (IndikoTM Plus kit). The target therapeutic interval of linezolid was established between 2 and 8 µg/mL and statistical analysis was performed using R software.

Results 92 patients were analysed, 67% men and 33% women, with a median age of 67 and 68 years and a mean body mass index (BMI) of 30±7.74 kg/m^2 and 30±6.98 kg/m^2, respectively. Linezolid was administered intravenously (IV), 86 started treatment with the standard dosage (600 mg/12 hours), 5 with an intensified regimen (600 mg/8 hours) and only 1 patient with a regimen below that recommended in the technical data sheet (600 mg/24 hours). After the first control: 34 patients (37%) Cp = 2–8 µg/mL, 37 (40%) Cp <2 µg/mL and 21 (23%) Cp >8 µg/mL. The median Cp at first control was 3.1 µg/mL, with a wide range of distribution (0.2 to 30 µg/mL). A modification of the dosage was recommended in 70% of the reports made and 47% achieved Cp within the therapeutic interval at the second control. A total of 2.4 determinations per patient were performed, recommending an individualised dosage in 60% of the reports. The recommended dosing was between 400 and 2400 mg/day, in intermittent infusion every 6, 8, 12 and 24 hours; and in 5 patients,1200–1800 mg/day by continuous infusion. A significant reduction in platelet count from baseline (>25%) was observed in 46% (42) patients and 22% (20) developed thrombocytopenia, with a platelet count below 100×10^3/µL.
Conclusion and relevance There is high variability in the Cp of linezolid obtained in the critically ill patients analysed in our study, with a low percentage of patients being within the established optimal therapeutic interval. In 60% of the pharmacokinetic reports, a modification of linezolid dosage was recommended.

REFERENCES AND/OR ACKNOWLEDGEMENTS
Conflict of interest No conflict of interest

4CPS-041 SACUBITRIL/VALSARTAN PRESCRIPTION PRACTICE IN PATIENTS WITH CHRONIC HEART FAILURE

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Background and importance Sacubitril/valsartan (SV) is a drug for chronic symptomatic heart failure (HF) with reduced left ejection fraction (LVEF). The PARADIGM-HF study demonstrated that SV was superior to standard treatment, reducing the absolute risk of cardiovascular death or hospitalisation for HF by 4.7%.
Aim and objectives The objectives of this study were to evaluate the adherence of clinicians to the recommendations of the Pharmacy and Therapeutics Committee (PTC) for the prescription of SV, as well as to estimate the number of patients who were readmitted due to decompensation of HF and the number who died from any cause.
Material and methods A prospective study that included patients treated with SV was carried out from February to August 2020. Variables considered were: sex, age, LVEF, N-terminal pro B-type natriuretic peptide (NT-proBNP), standard treatment, New York Heart Association (NYHA) classification and mortality and/or hospitalisations due to HF at 6 months.

Recommendations approved by the PTC for the prescription of SV were: LVEF ≤35%, NT-proBNP >400 pg/mL, NYHA class II-III and standard therapy (angiotensin-converting enzyme inhibitors or angiotensin II receptor blockers plus beta-blockers and mineralocorticoid antagonists).
Results A total of 54 patients were included (89% men) with a median age of 72 (32–87) years. 23 patients (43%) started treatment during their hospital admissions, while 31 (57%) received the drug before admission.

Overall adequation to the first prescription of SV was achieved in 5/23 patients (21.7%). Adequation for each individual item was as follows: LVEF ≤35% in 18 patients (74%), NT-proBNP >400 pg/mL in 23 (100%), NYHA II-III in 17 (74%) and just 8 patients were successfully treated with standard therapy.

72% (39/54) of patients continued treatment after being discharged from hospital and 64% (34/53) continued with this drug 6 months later. Four patients were readmitted once, and another four twice, as a consequence of decompensation of the HF during the 6 months of follow-up. Eight patients died during this period.
Conclusion and relevance Clinicians mostly adapt to the utilisation criteria established by the PTC except for the recommended standard treatment, and the percentage of readmissions due to decompensation of HF in our cohort of patients is higher when compared to the clinical trial.

REFERENCES AND/OR ACKNOWLEDGEMENTS
Conflict of interest No conflict of interest

4CPS-042 PHARMACOKINETIC MONITORING OF TACROLIMUS IN RENAL TRANSPLANT PATIENTS

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Background and importance Tacrolimus (TAC), a calcineurin inhibitor, is indicated in renal transplantation, and its monitoring is important due to its pharmacokinetic variability.
Aim and objectives To describe the demographic, clinical and pharmacokinetic characteristics of patients in immediate post-renal transplantation in treatment with TAC.
Material and methods Retrospective observational study carried out in a third-level general hospital.All patients with renal transplantation between September 2019 and September 2021 were included. The following variables were collected at immediate transplantation: demographic (sex, age), anthropometric (weight, height, body mass index (BMI)), monitoring-related (TAC concentration, ConTAC, corresponding to the first monitoring and at which optimal levels are reached, time relapsed from the start of TAC to the first level and the optimal level, number of determinations), clinical (creatinine(Cr) and renal clearance (ClCr) on the day of transplantation and day +7) and pharmacotherapeutics (antibody administered). Two protocols depending on the immunological risk were applied. Low-risk protocol (LR): basiliximab 20 mg on day 0 (day of transplantation) and on day +4, with immediate release TAC (single pre-transplant dose and maintenance dose). High-risk protocol (HR): thymoglobulin 1–1.5 mg/kg/day for 5–7 days and at the end, start with TAC. The target therapeutic interval of TAC in the first month post-renal transplant used was 10–15 ng/mL and the TAC dosage used was 0.15 mg/kg/day orally.The data collected were extracted from the GestLab and OrionClinic12 computer programs.
Results Thirty five patients were analysed, 57% men and 43% women with a mean age of 60±13 and 57±11years,