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.

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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,