during November-December 2021 were included. Patients who hadn´t taken both presentations for at least 4 months and patients impossible to locate were excluded. Those who gave their verbal consent underwent a telephone survey. Variables collected: sex, age, drug indication, treatment duration, self-administration, pain measured with VAS(Visual Analogue Scale) with both presentations, presence of administration site reactions with both presentations, satisfaction with pen change measured from 0 to 10 (0 minimum-10 maximum), 300mg pen discontinuation and reason. Qualitative variables were expressed as frequency and percentage and quantitative ones as mean and standard deviation. Statistical analysis was performed with Excel (v.12.0).

Results Total number of patients with 300mg pen presentation:33. Included: 24 (72.2%). Women:9(42.9%). Age:49 (13.9). Patients with psoriasis:19(79.2%), psoriatic arthritis 4 (16.7%) and spondyloarthritis 1(4.2%). Treatment duration (months) 38.7(22.6). Patients who self-administered medication: 23(95.8%). VAS with 150mg presentation 1.8(1.2) and with 300mg presentation 2.2(1.9). Regarding the 150mg presentation, 2(8.3%) patients reported having bruises at the injection site and regarding the 300mg presentation, 3(12.5%) reported having suffered swelling that reverted spontaneously. Two(8.3%) had to discontinue the 300mg presentation due to severe pain during administration. Regarding change satisfaction, 1(4.1%) referred to the change as indifferent, 2(8.3%) as not satisfactory and 21(87.5%) as satisfactory, with the average satisfaction being 8.0(2.2).

Conclusion and Relevance

- Changing from 150mg to 300mg secukinumab pen presentation was considered satisfactory for 87.5% of patients.
- Two patients suffered greater pain during administration, leading to a return to the previous presentation.
- It would be advisable to carry out additional follow-up in order to detect possible reactions at the administration site or greater pain after the change of presentation.

REFERENCES AND/OR ACKNOWLEDGEMENTS

Conflict of Interest No conflict of interest

5PSQ-078 ANALYSIS OF CASIRIVIMAB AND IMDEVIMAB USE IN OUTPATIENTS WITH COVID-19

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Background and Importance At height of COVID-19 pandemic surge of delta variant, monoclonal antibodies became a vital treatment option for SARS-COV-2 positive outpatients at high risk of severe disease progression. Casirivimab and imdevimab (C/I) were used under EMA emergency use authorisation (EUA) and there was paucity of real-world data on safety and effectiveness.

Aim and Objectives The study aimed to describe drug safety, self-reported symptom burden and vaccination status in SARS-COV-2 positive outpatients within 90 days post-C/I infusion.

Material and Methods Prospective multicentric survey of SARS-CoV-2 positive outpatients with mild symptoms at high-risk of severe COVID-19 progression (defined criteria under EUA authorisation for C/I ambulatory administration) was conducted from September 2021 till January 2022 in three teaching hospitals. The data collected using electronic medical records comprised: patient details, vaccination status, date of SARS-COV-2 positive test, indication, adverse drug reaction to infusion, hospitalisation. Structured telephone questionnaire with symptom scoring adapted from BLAZE-1 trial was used on D (day) 0, D+7, D+29 and D+90 post- C/I infusion. Data were analysed using MS Excel. Ethics committee approval was obtained.

Results Within studied period 404 out of 471 patients were included (median age 66 years; 57.4% females). Excluded patients included prophylactic C/I, not consented or dropped out. 396 patients had the first COVID-19 episode. The most frequent indications included age over 65 years (55.5%), hypertension (56.8%), diabetes mellitus II (19.4%). C/I infusion was administered with a mean of 2.3 days (range 0–11 days) since virus positivity. 62.4% patients had complete vaccination (2 or 3 doses Comirnaty, 1 dose Janssen vaccine) prior C/I infusion. Adverse events were reported by 11.6% of patients, most commonly chills, fever, diarrhea. Subjective worsening of symptoms after C/I infusion was reported by 3.4% subjects by D+7. 11.6% patients observed no difference in symptom score between D0 and D+7. Altogether 85%; 92% and 93.6% patients reported improvement in symptom burden score by D+7, D+29 and D+90 respectively.

Conclusion and Relevance We describe real-life outpatient utilisation of C/I in terms of patient characteristics, self-reported symptom burden and adverse events. Therapeutic value of C/I timely administration is evident in high-risk patients with completed vaccination.

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Conflict of Interest No conflict of interest

5PSQ-079 FONDAPARINUX IN AN INFANT WITH SUSPECTED HEPARIN-INDUCED THROMBOCYTOPENIA. A CASE REPORT

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Background and Importance A 3-month-old infant (3kg) was admitted in the paediatric intensive care unit for extracorporeal membrane oxygenation (ECMO) after a pulmonary lobectomy.

Anticoagulant treatment was performed with unfractionated heparin (UFH).

During treatment with UFH, the patient had a sustained decrease in platelet count (>50% of basal) and inferior cava deep venous thrombosis (DVT). Once ECMO was finished, anticoagulant treatment was modified to enoxaparin.

Due to persistent thrombocytopenia and DVT, heparin-induced thrombocytopenia was suspected. Anticoagulant was replaced to fondaparinux, whose recommended dose in paediatrics is 0.1mg/kg/day.

Aim and Objectives To show the need to redose fondaparinux in paediatrics, as registered presentations don't allow fractionation: they are single-dose pre-filled syringes based on two concentrations: 5mg/ml and 12.5mg/ml.

To verify the stability of the preparation through the study of the pharmacotherapeutic effect, indirectly measured by plasma levels of anti-Xa factor (antiXa).

Material and Methods Subcutaneous fondaparinux was started at a dose of 0.3mg/day (0.06mL).To facilitate administration, the preparation was initially diluted 1mg/mL in normal saline under sterile conditions. The dose was packaged in 1ml dead space free syringe with a purged needle. According to the datasheet, the preparation is stable for 24h at room temperature.

AntiXa was monitored 3 hours after administrations. The dose was adjusted according to Table1 until the target level (0.5mg/l) was reached.

Subsequently, as the dose increase allowed, the undiluted dose (0.4mg/0.08ml) was fractionated from commercial presentation. Stability of 7 days in the refrigerator was defined according to the risk matrix (low risk) of the Good Pharmaceutical Practices for the preparation of sterile drugs.

Results The dose was adjusted according to antiXa (Table2). The monitoring of antiX, necessary for the clinical follow-up, allowed us to obtain indirect data on the stability of the fractionated drug, maintaining correct levels throughout treatment, as shown in graph.

After fondaparinux initiation, the platelet count increased to normal values. Anticoagulation therapy was discontinued after three months, upon confirmation of DVT resolution.

Abstract 5PSQ-079 Table 1

TABLE I. Dose Adjustment of Fondaparinux

Level (mg/L)	Dose adjustment
< 0.3	Increase dose by 0,03 mg/kg
0.3 - 0.5	Increase dose by 0,01 mg/kg
0.5 - 1	**No change**
1 - 1.2	Decrease dose by 0,01 mg/kg
> 1.2	Decrease dose by 0,03 mg/kg

TABLE II. Dose Adjustment of Fondaparinux in our Patient

Day*	Dose (mg)	Fxa (U/mL)**	Dose adjustment
1 - 2	**0,3**	0,38	↑ 0.01 mg/kg
3 - 4	0,35	0,32	↑ 0.01 mg/kg
5 - 8	0,38	0,44	↑ 0.01 mg/kg
9 - 40	**0,4**	**0,5**	**No change**
41	0,4	0,4	↑ 0.01 mg/kg
42 - 78	**0,5**	**0,54**	**No change**

*Day of treatment with Fondaparinux
**Plasmatic levels 3h post-administration of Fondaparinux

Conclusion and Relevance Individualised dosing of fondaparinux by dilution or fractionation has allowed DVT treatment, using a commercial presentation unsuitable for paediatric s.

We verify stability of the fractionated dose with the therapeutic effect.

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

5PSQ-083 FOUR YEARS OF A PHARMACEUTICAL CARE PROGRAMME IN PATIENTS UNDERGOING CARDIAC SURGERY

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Background and Importance The preoperative setting is an area with high risk for medication errors with potentially severe consequences. Pharmaceutical care programmes(PCP) can help to achieve an adequate preoperative pharmacological management, to ensure patients reach surgery in optimal pharmacological conditions. Adequate coordination with other specialists such as surgeons and anaesthetists is paramount to guarantee patient safety.

Aim and Objectives To evaluate the impact of a PCP in patients undergoing cardiac surgery in preventing medication errors after 4 years of implementation.

Material and Methods Retrospective, observational, descriptive study. Time of study: July 2018-July 2022. All patients scheduled for cardiac surgery were interviewed by a clinical pharmacist 24-72h before the surgery. Interviews were conducted by phone. During the interview, patients' complete medication list, including over the counter medicines and herbal products, was collected and instructions for adequate preoperative medication management according to current guidelines and anaesthetist instructions were reinforced.

Avoided medication errors were categorised according to Overhage-classification and their severity was analysed according to NCC-MERP.

Savings were calculated by multiplying the probability of adverse event occurrence with the error(NCC-MERP≥F:high risk of admission or prolonged hospital stay) by avoided cost (6.745€ according to Ministry of Health, Consumer and Social Welfare).

Results During the time of study, 1020 pharmacist preoperative interviews were performed. Mean age was 66.8(sd:12.6) years and 65.8% of the interviewed patients were males.

41.8% of patients were taking at least one drug that needed to be discontinued before surgery. The most frequent were angiotensin-converting enzyme inhibitors, angiotensin-II receptors blockers and diuretics(23.6%), anticoagulants and antiplatelet treatment(22.2%) and hypoglycaemic treatment (11.4%). 43.5% of patients needed heparin bridge therapy.

A total of 807 pharmacy interventions were conducted with 94.2% of acceptance rate: 533 requirements to discontinue drugs before surgery(70.1%), 81 dose error(10.7%), 49 drug omission(6.4%), 32 associated with duration, frequency or indication(4.2%).

673 serious errors were avoided, 236(31.1%) of these errors could have resulted in permanent harm(G/H), 277 (36.4%) in temporary harm(E/F) and 160(21.1%) monitoring patients to confirm no harm(D).

Potential medication errors avoided an estimated cost of 992.130€ .