and previous biological treatments. The effectiveness variables are affected body surface area (BSA) and psoriasis area severity index (PASI) AND 90% PASI clearance (PASI90) collected at baseline, and next visits with dermatologist. The main tools used: Diraya© for the clinical history, Modulab© for laboratory values and Excel© for anonymised data recording. The information was collected according to data minimisation policy, article 5.1 of data protection.

Results 49 patients (29 men) included with a mean age of 50.9 years. The main biologic pre-treatments were etanercept (31), adalimumab (11), secukinumab (9) and ustekinumab (9). Averaged pre-treatment BSA (13,6 ± 10.27 SD) and PASI (9.7 ± 6.68 SD). Next dermatologist's control at 5 months 43 patients averaged BSA (3.9 ± 9.27 SD) and PASI (2.9 ± 4.17 SD). PASI90 was reached by 48.8% of patients. There were four treatment discontinuities during this period (1 due to lack of adherence, 1 due to primary failure, 1 due to secondary failure and 1 due to toxicity). At 10 months 25 patients averaged BSA (1.8 ± 3.28 SD), PASI (1.8 ± 3.30 SD), and PASI90 was reached by 72%. 3 treatment discontinuities in this period (1 due to gestational desire and 2 due to secondary failure). At 18 months 15 patients averaged BSA (0.9 ± 1.55 SD) and PASI (0.5 ± 0.91 SD). PASI 90 was reached by 73%. Patients not counted had not gone to dermatology control yet when our analysis were made.

Safety: One patient had to stop treatment due to strong diarrhoeas after each dose.

Conclusion and Relevance According to the results obtained, it is possible to evaluate guselkumab as an effective and safe alternative in the treatment of moderate to severe psoriasis resistant to conventional treatments.

REFERENCES AND/OR ACKNOWLEDGEMENTS

Conflict of Interest No conflict of interest

4CPS-136 STANDARD FIRST DAY OF LIFE CENTRAL PARENTERAL NUTRITION, EXPERIENCE IN REAL CLINICAL PRACTICE

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Background and Importance Standard parenteral nutrition (PN) solutions should generally be used over individualised PN solutions in the majority of paediatric and newborn patients, including very-low-birth-weight premature infants,[1] starting as soon as possible and within 8h at the latest.[2] In 2021 our Paediatric and Pharmacy Departments designed a standard central PN (CPN) to have ready to use, in order to meet the nutritional needs of most newborn patients in their first day of life.

Aim and Objectives Evaluate the use of the standard first day of life CPN and describe clinical data of patients and the time frame for its start.

Material and Methods Observational, retrospective and longitudinal study conducted between March 2022 and September 2022 in a tertiary hospital. A database was designed to record all prepared CPN, their use and data of patients who received them.

Results 55 CPN were prepared and 32 (58.2%) were administered. 31 newborn required PN and 100% received the standard first day of life CPN, 18 (58.1%) patients were female, the mean gestational age was 28.5 weeks, the mean weight was 1138.2g and 12 (38.7%) were multiple pregnancies. The indication of PN was: 23 (74.2%) preterm infants born <32.0 weeks with birth weight <1500g, 4 (12.9%) preterm babies born >32.0 weeks with <1500g and 4 (12.9%) patients born <32.0 weeks with birth weight >1500g. The mean time to start CPN was 6:01h (range 1:13-22:54h), 26 (83.9%) babies initiated within 8h at the latest and 5 (16.1%) patients after 8h of life (3 due to a lack of central line, 1 lack of 2 ready to use CPN for twins and 1 delayed prescription). 30 patients (96.8%) started trophic feeding with breast milk (maternal or bank) within the first 24h of life.

Conclusion and Relevance Standard first day of life CPN ready to use has considerably reduced the time to start PN in newborn patients. However, CPN was initiated after 8h of life in 5 patients (mostly due to a lack of central line). Standard first day of life CPN met the nutritional requirements of all newborn requiring PN, not needing to produce individually tailored CPN in any case.

REFERENCES AND/OR ACKNOWLEDGEMENTS

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Conflict of Interest No conflict of interest

4CPS-137 EVALUATING THE POTENTIAL CLINICAL AND ECONOMIC IMPACT OF CHEMOTHERAPY PRESCRIBING BY PHARMACISTS AT A UNIVERSITY TEACHING HOSPITAL

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Background and Importance Chemotherapy prescribing errors represent a potentially serious risk of causing patient harm. Whilst pharmacist prescribing has a well-established role in many clinical settings worldwide and has been shown to be effective, there is a paucity of research on pharmacist prescribing chemotherapy.

Aim and Objectives Assess the potential clinical and economic impact of pharmacist prescribing versus medical prescribing of chemotherapy (including supportive medicines) at a university teaching hospital.

Quantify the error rate in pharmacist- and doctor-prescribed chemotherapy prescriptions.

Classify prescribing errors according to the Pharmaceutical Care Network Europe (PCNE) classification framework for drug-related problems (DRPs).

Assess the potential severity of prescribing errors made by the pharmacists and doctors using a validated tool and peer review panel.

Evaluate the time taken for the chemotherapy prescribing process by doctors and pharmacists and assign costs to these times. Estimate the cost of the provision of a pharmacist prescribing service in comparison to the doctor prescribing practice.