over-controlled (lower HbA1c levels) and inadequately controlled (higher HbA1c levels).

Modifications to antidiabetic treatment at discharge were documented including the drugs involved and the type of modification applied (treatment or dose initiation/increase, discontinuation/reduction).

Results This study includes 300 patients with a 33%prevalence of DM at the AGU (107 patients). From the diabetic patients, 90%(n=96) had an updated mean value of HbA1c of 7.4 ±1.5%. Among these 96 patients, 46%achieved appropriate control, 41%were over-controlled and 13%were inadequately controlled. Thus, 52 patients(54%) had an inadequate disease control either excessive or insufficient.

From these 52 patients with inadequate control, 75%had guideline-based antidiabetic treatment modifications. The main drug groups involved were insulins(46%), biguanides(27%), and DPP-4 inhibitors(13%). The treatment modifications applied were 75%discontinuation/reduction and 25%initiation/increase.

Conclusion and Relevance Approximately one-third of AGU patients have diabetes and, in most the cases, an updated HbA1c values were available.

On hospital admission, over half of the patients did not follow ADA recommendations for metabolic control, leading to over-control. Most patients with inadequate control had discharge changes ADA recommendations based. Main modification were discontinuation or dose reduction in antidiabetic treatment.

REFERENCES AND/OR ACKNOWLEDGEMENTS

Conflict of Interest No conflict of interest.

4CPS-122 ANALYSIS OF THE USE AND EFFECTIVENESS OF FIDAXOMICIN IN CLOSTRIDIOIDES DIFFICILE INFECTION

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Background and Importance Clostridioides difficile infection (CDI) is the main cause of infectious diarrhoea in the hospital setting.

Aim and Objectives The aim of this study is to analyse the use and effectiveness of fidaxomicin in CDI.

Material and Methods An observational, descriptive and retrospective study was conducted in patients treated with fidaxomicin between April 2018-August 2023. Variables, collected through the electronic medical record, were: sex, age, patient location, immunosuppression, severity and type of episode, previous antibiotic treatment, indication, dose and duration, time to clinical cure (days between fidaxomicin started and diarrhoea resolution) and recurrence (presence of diarrhoea or positive toxin in stool within 4 weeks after treatment). Effectiveness was assessed by clinical cure rate, recurrence rate and overall cure rate (absence of stool-positive toxin and diarrhoea within 4 weeks after treatment). Outpatients were excluded from the clinical cure analysis. Continuous variables are expressed as median and interquartile range while categorical variables as frequency and percentage.

Results A total of 37 patients were included, 17 (46%) male, aged 73 [62–80] years, 25 (67.6%) were inpatients and 14 (37.8%) immunocompromised. Most of them were severe cases with high risk of recurrence (20 (54.1%)).

Most patients received fidaxomicin during the first (13 (35.1%)) or higher (16 (40,5%)) recurrence episode and only 8 (21.6%) during the first CDI episode. Previously, 28 (75,7%) patients had received oral vancomycin and 22 (59.5%) metronidazole. Vancomycin refractoriness (35 (94.6%)) was the main indication. The dose used in all cases was 200mg/12h for 10 days [10–15].

The effectiveness analysis was conducted in 35 patients (2 died during the study period) (table 1).

Abstract 4CPS-122 Table 1 Effectiveness analysis

	All patients (n=35)	First Episode CDI (n=8)	Recurrence CDI (n=27)
Clinical Cure (days)	5 [3–6]	5 [3–6]	5 [3–6,8]
Recurrence Rate (N(%))	12(34,3)	2(25)	10(37)
Days to Recurrence (days)	14 [13,3–16,8]	18,5 [17,2–19,8]	14 [12,3–14,8]
Overall Cure Rate (N(%))	23(65,7)	6(75)	17(63)

Conclusion and Relevance In this study, fidaxomicin has been shown to be effective in resolving CDI diarrhoea , although with a less favourable clinical cure, recurrence and overall cure rate than obtained in pivotal trials. Due to the small sample size further research is needed to support the results obtained here.

REFERENCES AND/OR ACKNOWLEDGEMENTS

Conflict of Interest No conflict of interest.

4CPS-123 SARGRAMOSTIM AND LIPOSOMAL AMPHOTERICIN B FOR THE TREATMENT OF CHRONIC VISCERAL LEISHMANIASIS IN HIV CO-INFECTED PATIENT: A CASE REPORT

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Background and Importance In Spain, leishmaniasis is caused by *Leishmania infantum*, whose main reservoirs are dogs or small mammals, transmitted through the bite of dipterian insects of the genus *Phlebotomus*. *Leishmania* infection causes disease ranging from localised cutaneous to visceral leishmaniasis (VL), the most severe form, affecting frequently to profoundly immunocompromised individuals, such as late-stage HIV-infected patients, with high rates of treatment failure, relapses, and mortality.

Liposomal amphotericin B (LAB) is the VL treatment of choice, with an induction regimen followed by maintenance (3–5mg/kg/monthly). Published data[1] suggests that sargramostim, a recombinant human granulocyte-macrophage colony-stimulating factor, has potential as co-adjuvant treatment to LAB in VL-HIV to augment immune responses and clinical control.

Aim and Objectives To report a case of VL-HIV co-infection successfully treated with monthly LAB and sargramostim for 12 weeks.