Background and Importance Optimisation of antibiotic (ATB) administration is vital for improving infection treatment effectiveness. An ATB stewardship programme can help clinicians rationalise ATB prescribing. There is no simple and effective tool. Last year we conducted an adherence audit with the local guidelines (LG).
Aim and Objectives This study aimed to review the adherence of clinicians to LG in terms of ATB prescribing and administration.
Material and Methods Single-centre prospective audit for prescribed ATB treatment in at least 50 inpatients admitted to the university hospital with ATB initiation within the first 48 hours of admission. Adherence to LG for ATB was assessed using the adopted audit tool.[1] The patient selection was generated from the hospital's electronic prescribing system based on emergency department admission and subsequent hospitalisation and ATC code for ATB prescribed within 48 hours. Adherence was assessed as full compliance with LG. Partial adherence was attributed when minor deviation from LG occurred. Nonadherence was defined as an incorrect choice of ATB.
Results During the audited period, there were 1,842 new admissions and ATB were initiated within 48 hours in 478 inpatients (26%). A total of 74 patients with 117 ATB agents were audited and 77 indications for newly prescribed ATB therapy were found. For 46 indications (59.7%) ATB was given in an indication that is included in available LG. The overall adherence to ATB LG was observed in 33 indications (i.e. 71.7% of 46). Partial adherence was found in 11 indications (23.9%). Non-adherence was shown in two indications (4.3%). These involved ATB for surgical prophylaxis. Out of 117 ATB, there was 72% adherence with LG. Incorrect administration of ATB were the most common reasons for partial adherence (21%).
Conclusion and Relevance We found that adherence in 72% of prescribed ATB agents with recommended practices is considered a satisfactory outcome. The audit results were presented to management and shall be repeated in future.

REFERENCES AND/OR ACKNOWLEDGEMENTS

1. *Hood G, et al. Measuring appropriate antibiotic prescribing in acute hospitals: development of a national audit tool through a delphi consensus. Antibiotics (Basel).* 2019 Apr 29;**8**(2):49.

This study was supported by Charles University grant SVV 260 665.
Conflict of Interest No conflict of interest.

5PSQ-076 EFFICACY AND SAFETY OF NIVOLUMAB MONOTHERAPY VS NIVOLUMAB PLUS IPILIMUMAB IN RENAL CELL CARCINOMA IN CLINICAL PRACTICE

MD Zambrano Croche, A Rojas Albarrán*, Á Gil García, M Gragera Gómez, H Velázquez Vázquez. *University Hospital Complex of Badajoz, Pharmacy Department, Badajoz, Spain*

10.1136/ejhpharm-2024-eahp.410

Background and Importance Nivolumab is indicated for advanced renal cell carcinoma (RCC) both as monotherapy (second-line) and in combination with ipilimumab (first-line). It is not known the benefit to add ipilimumab to nivolumab, also it must been taken the possible worse security profile.
Aim and Objectives The aim of this study is to determine the efficacy and security of nivolumab plus ipilimumab vs nivolumab monotherapy in the clinical practice.
Material and Methods This is a descriptive, observational and retrospective study (January 2016 to September 2023) of 30 patients treated with nivolumab or nivolumab plus ipilimumab in a third-level hospital. The data were obtained from the electronic medical records of the patients and the FarmaTools Management programme. Data were processed by Microsoft Excel and SPSS software.
Results In this study 30 patients were included in total, 11 treated with dual therapy and 19 with monotherapy. Patient demographics and disease characteristics are described in table 1. Median progression-free survival was 4.9 months (95% CI: 0–10.8) for nivolumab and 10.7 months (95% CI: 0–26.5) for the combination therapy. However, when we compared the two treatments using the log-rank test, the p-value was 0.799. The median overall survival was 43.4 months (95% CI: 0–97.4) for nivolumab, but it was not reached for the combination treatment. The most prevalent adverse reactions in the monotherapy vs dual therapy group, respectively, were hepatic (5.3% vs 45.5%), endocrine (36.8 vs 63.6) and skin (57.9 vs 36.4). It should be noted that one patient with the combination therapy had myositis, myocarditis, and hepatitis. This patient ultimately died.

Abstract 5PSQ-076 Table 1

Characteristic	Nivolumab plus Ipilimumab (n=11)	Nivolumab (n=19)
Age, median (range), years	62 (44–74)	57 (37–83)
Male	6 (54.5)	16 (84.2)
Histology		
Clear cell RCR	10 (90.9)	13 (68.4)
Papillary RCR	0 (0)	3 (15.8)
Not specified	1 (9.1)	3 (15.8)
ECOG (*Eastern Cooperative Oncology Group*) performance status		
0	5 (45.5)	11 (57.9)
1	5 (45.5)	3 (15.8)
Not specified	1 (9.1)	5 (26.3)
Lung metastases	8 (72.7)	16 (84.2)
Liver metastases	2 (18.2)	6 (31.6)

NOTE: Data are No. (%).

Conclusion and Relevance No differences were observed in efficacy, but there were differences in safety. However, our study is limited since it involves few patients.

REFERENCES AND/OR ACKNOWLEDGEMENTS

Conflict of Interest No conflict of interest.

5PSQ-077 ADEQUATE NUTRITIONAL THERAPY IN CRITICAL PATIENTS WITH CORONAVIRUS DISEASE (COVID-19)

S Arnaiz Diez, M Ubeira Iglesias, L Izquierdo Acosta, O Álamo González, MP Espinosa Gomez, MDLÁ Machín Morón, E Briones Cuesta, I Gutierrez Fernández, Z Rodriguez Fernandez*, M Guemes García. *Burgos University Hospital, Pharmacy, Burgos, Spain*

10.1136/ejhpharm-2024-eahp.411

Background and Importance The critical patient is by definition a patient at nutritional risk for presenting a hypermetabolic state which leads to a rapid process of malnutrition. Nutrometabolic treatment in this type of patient is a fundamental part of a better clinical evolution.
Aim and Objectives To describe how the parenteral nutrition prescription was adapted to the nutrition guidelines in patients with COVID-19 disease in critical care units (ICU).
Material and Methods Retrospective observational study of patients with total parenteral nutrition (TPN) in critical care units between March and May 2020.

Data from the Electronic Medical Record and the TPN prescription were recorded: age, sex, weight, days of admission to the ICU, TPN indication, duration of TPN therapy, co-administration of Enteral Nutrition (EN) (if applicable), total energy intake and daily prescribed protein and complications from TPN.

Energy and protein requirements were calculated based on the ASPEN 'Guidelines for the Provision and Assessment of Nutrition Support Therapy in the Adult Critically Ill Patient' and the hospital's COVID-19 Nutrition Protocol: 11–14 Kcal/Kg/day for obese patients and 25 Kcal/Kg/day for non-obese patients. 1.5g/Kg/day of protein was calculated for all patients.

The agreement with the guidelines was accepted if the percentage of total energy and protein requirements was within 80–120%.
Results Thirteen patients with TPN were identified (table 1).

Abstract 5PSQ-077 Table 1

Sex	10 men, 3 women
Median age	60 years (50-79)
Median weight	85.5 Kg (109-72)
Reason for starting TPN	7 NE intolerance, 4 paralytic ileus, 1 pancreatitis, 1 ischemic colitis
Reason for ending TPN	13 good tolerance to NE
Complementary EN	8 patients
Complications due to TPN	5 patients suffered catheter bacteremia

Median number of days in the critical unit was 38 days (12–73). Median number of days with TPN was 13 (2–53). Median percentage of days with TPN (compared to the total days spent in the critical care unit) was 36.8% (7.1–72.6). Median calculated energy requirements were 1,800 Kcal/day (1150–2137), and median protein requirements per day were 130.5 grams of protein (105–163.5). A total of 28 prescriptions were recorded. Median total Kcal prescribed per day was 1,827 Kcal (1035–2475), and median protein intake was 100 grams (57–147.5). 18 (64.3%) total daily Kcal prescriptions and 9 (32%) of the protein prescriptions were adapted to the guidelines.
Conclusion and Relevance We found low adaptation of the prescriptions to the guidelines in relation to grams of protein (kidney involvement could be responsible), although the total energy requirements were adapted. The high rate of catheter bacteraemia was striking.

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

5PSQ-078 HYPOPHOSPHATEMIA AFTER FERRIC CARBOXYMALTOSE ADMINISTRATION IN A COHORT OF ELDERLY PATIENTS WITH HIP FRACTURE

[1]H Genestal Vicente, [1]P Lalueza-Broto*, [1]C Raventos-Aymar, [1]JC Juarez-Gimenez, [1]AG Arevalo-Bernabe, [1]MQ Gorgas-Torner, [2]N Rial-Lorenzo, [2]I Sanz-Perez, [2]J Mestre-Torres, [2]M Urquizu-Padilla. *[1]Vall Hebron University Hospital Campus, Pharmacy Department, Barcelona, Spain; [2]Vall Hebron University Hospital Campus, Internal Medicine Department-Orthogeriatric Unit, Barcelona, Spain*

10.1136/ejhpharm-2024-eahp.412

Background and Importance Hypophosphatemia after intravenous ferric carboxymaltose (FCM) is a well-documented adverse reaction. However, there is scant evidence about its prevalence among elderly patients with hip fracture, a complex polymedicated pluripathologic population exposed to these formulations in perioperative care.
Aim and Objectives The aim of this study was to identify the incidence of hypophosphatemia in patients over 65 years old treated with FCM in the context of hip surgery.
Material and Methods Observational retrospective study including all patients admitted to the Orthogeriatric Unit of a tertiary hospital from June 2023 to August 2023 for hip fracture and treated with FCM. Analytical treatment-related data were collected from electronic medical records. For descriptive analysis, categorical variables are presented as counts and percentages. Continuous variables as medians and interquartile range.
Results 65 patients were included (51/65[78.5%] women, 88 ±7 years old), with a median hospital stay of 13 days. The total doses used were 500 mg (69.2% of patients), 1 g (24.6%) or higher. On the gathered data are shown elevated parathormone and low cholecalciferol levels, and an altered glomerular filtration rate. Of the patients included, 28 had both pre- and post-iron administration phosphate levels measured. Among them, 21 (75%) experienced a phosphate level reduction with a mean change of -36.4[19.1–51.4]% from their initial levels to the second measurement, mirroring the overall trend shown in the table 1. Within this group, 5 out of 28 patients (17.9%) had initial phosphate levels below 2.5 mg/dL. After iron administration, this increased up to 12 (42.9%). None of them showed any relevant clinical signs associated.

Abstract 5PSQ-078 Table 1

Variable	N	Median[P25-P75]
Before iron administration:		
Phosphate (mg/dL)	45	3.5[2.8–4.1]
Hemoglobin (g/dL)	46	10.3[9.1–11.4]
Parathormone (pg/mL)	35	86.4[59.2–103.5]
Cholecalciferol (ng/mL)	37	23.2[13.6–33.9]
Glomerular filtration rate (ml/min/1.73 m2)	46	56[32–77.8]
After iron administration:		
Days between iron administration and phosphate determination	42	6.5[3.0–9.8]
Phosphate (mg/dL)	42	2.6[1.9–2.9]

Conclusion and Relevance Blood phosphate levels tend to decrease notably after FCM administration, suggesting a potential correlation. However, hyperparathyroidism and vitamin D deficiency are common in this population and may