5PSQ-102 ANALYSIS OF REPEATED EMERGENCY DEPARTMENT VISITS AND THEIR RELATIONSHIP TO MEDICATION

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Background and Importance Analysing the reasons of repeated Emergency Department (ED) visits could help establish a pharmacotherapeutic follow-up consultation, in order to reduce the number of re-consultations

Aim and Objectives Analyse the percentage of repeated visits to ED in relation to pharmaceutically-approved patients' medication or patients' medication that have received a thorough pharmacotherapy revision (approved/thoroughly checked patients).

Material and Methods An observational, retrospective study developed in a second-level hospital from September to December 2022. All patients approved and thoroughly checked by Pharmacy team from ED were included, meaning all those who appeared in at least one of Emergency Pharmacy Activity (EPA) forms. The main variable considered was the percentage of patients that came back to ED, counting $\geq$2 EPA registrations, compared to the total amount of approved/thoroughly checked patients in that period. Other variables considered were the percentage of patients coming back with the same issue, the main issues the repeat a visit, the percentage of repeated visits related to pharmacotherapy and the main pharmacotherapeutic related groups (ATC code). Data were acquired from the electronic clinical history. Data were statistically evaluated through a software descriptive frequency analysis.

Results During the study period, 673 patients were included. From them, 50.52% were women (median age: 72 years old). The number of patients that visited ED again was 11.44% (77/673). The total amount of repeated visits was 83. Several patients [46.75% (36/77)] came back due to same issue. The main issues to revisit were respiratory infection [11.68% (9/77)], unbalanced heart failure and urinary tract infection [both 10.38%(8/77)], and COPD flare-ups [7.8% (6/77)]. The repeated visits related to medication were 57.83% (48/83) of cases. The main pharmacotherapeutic groups related to the ED were: cardiovascular-system [35.41% (17/48)], anti-infective group [20.83% (10/48)] and respiratory-system [12.5%(6/48)].

Conclusion and Relevance From the approved/thoroughly checked patients that came to ED, 1/10 came back at least once and. In over half of the cases, repeated visits were related to medication, and specifically to issues where cardiovascular or anti-infectious medication were involved. To learn about the repeated visits to ED and how they are related to pharmacotherapy could help select patients who could benefit from an outpatient pharmacotherapeutic appointment after being discharged, aiming to reduce the amount of repeated ED visits related to medication.

REFERENCES AND/OR ACKNOWLEDGEMENTS

Conflict of Interest No conflict of interest.

5PSQ-103 VANCOMYCIN-INDUCED RENAL TOXICITY THROUGH THERAPEUTIC DRUG MONITORING IN DAILY PRACTICE

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Background and Importance Vancomycin is used in the treatment of resistant gram-positive microorganism infections. Due to a narrow therapeutic range, its use is limited by its nephrotoxicity, which ranges from 5–43% according to the literature. Therefore, it's important to identify patients who may benefit from pharmacokinetic monitoring. The duration of treatment and a high minimum concentration of vancomycin are factors associated with nephrotoxicity.

Aim and Objectives To determine the incidence of nephrotoxicity associated with the use of vancomycin in monitored patients and identify factors related to its occurrence.

Material and Methods Retrospective, observational study in patients who underwent pharmacokinetic monitoring between 2022 and January 2023, in a third-level hospital. Demographic data and information related to antibiotic treatment were collected, including duration and indication, initial dose and frequency of administration, minimum steady-state concentration of vancomycin, and renal function data: baseline creatinine, creatinine at the start of antibiotic treatment, and at two days to assess the development of Acute Kidney Injury (AKI), defined by the Kidney Disease: Improving Global Outcomes (KDIGO) guidelines as an increase in creatinine by 0.3mg/dL compared to the initial value after two consecutive days of treatment.

These data were analysed with Jamovi software.

Results 93 patients, 71% men, mean age 62 (18–92).

8.6% of the patients met the criteria for AKI secondary to vancomycin.

Factors associated with nephrotoxicity age equal to or greater than 65 years (p=0,04), being female (p=<0,001) and having a BMI equal to or greater than 30kg/m2 (p=0,03).

There was no observed higher incidence of nephrotoxicity based on the use of high doses or the location of the infection.

Conclusion and Relevance In our study, we observed an advanced age, being female, a BMI over 30kg/m2 and a high minimum concentration of vancomycin as factors associated with nephrotoxicity. Given the incidence of AKI secondary to vancomycin treatment, it's important to recognise the factors associated with its occurrence in order to identify patients who may benefit from pharmacokinetic monitoring, thus optimising treatment and limiting nephrotoxicity.

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5PSQ-104 REAL-WORLD EVIDENCE: IS IBRUTINIB AS SAFE AS EVIDENCE TELLS?

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Background and Importance Ibrutinib is a Bruton tyrosine-kinase inhibitor used in first and subsequent lines of treatment of chronic lymphocythic leukaemia (CLL). Ibrutinib has demonstrated its efficacy and safety in many studies published to date. There is also experience available about this topic in real- world practice. However, the safety's evidence is different between both scenarios. Because the use of ibrutinib may vary among different countries and hospitals in the same country, we question whether safety's information in our patients is according to real-world evidence.
Aim and Objectives To analyse the safety profile of ibrutinib in CLL all-lines of treatment, and the management of its toxicity.
Secondary endpoints to determine ibrutinib's type responses.
Material and Methods Observational, descriptive, single-centre, retrospective and longitudinal study. Inclusion criteria: patients CLL diagnosed who started single-agent ibrutinib treatment from January 2016 to December 2022, aged ≥18 years-old. Patients treated in clinical trials and compassionate use contexts, were excluded. Quantitative variables will be described with means or medians (ranges); qualitative variables with absolute and relative frequencies.
Results Sixty patients were included, 35% received ibrutinib in first-line setting. 642 adverse events (AEs) were described, average: 10,7 (2–32) AEs/patient. Most common AEs of any grade were haematological toxicity (18,1%) mainly anaemia and neutropenia, and infections (15.9%). As special interest EAs, it was found arterial hypertension (3.7%), atrial fibrillation (1.2%) and heart failure (0.8%). Most frequent grade ≥3 AEs were: infections (27%) especially respiratory infections, haematological toxicity (16%) and arterial hypertension (13%). Five patients died during ibrutinib treatment. Temporary interruptions occurred in 68% patients, mostly because AEs (69%) and surgical procedures/diagnostics tests. 27% of patients needed dose reductions for toxicity management. Any patient required a second reduction for its management. Main reasons for treatment end were AEs (32%), disease progression (19%) and death (19%). Treatment response was evaluated in 51 patients: complete response (56%), partial response (20%) and stable disease progression (7%).
Conclusion and Relevance Despite the elevated number of AEs detected, none of special of interest. not previously described have been found. Safety profile shown by ibrutinib in our treated population is comparable to that described in previous published studies. Surprisingly, complete response frequency detected is higher than reported in other studies.

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

5PSQ-105 PATTERNS OF USE AND APPROPRIATENESS OF ANTICOAGULATION IN ATRIAL FIBRILLATION: AN OBSERVATIONAL STUDY AMONG GERIATRIC INPATIENTS

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Background and Importance Atrial fibrillation (AF) is a common arrhythmia, affecting nearly half of all geriatric patients. AF poses a significant ischemic stroke risk, making effective anticoagulation essential. Direct oral anticoagulants (DOACs) have emerged as effective stroke-prevention agents, yet underutilisation remains a concern, especially in geriatric patients. To improve pharmacotherapy, including anticoagulation, a clinical pharmacy program was implemented on the geriatric units.
Aim and Objectives On that background, we sought to characterise anticoagulant utilisation patterns and inappropriateness among geriatric AF inpatients.
Material and Methods An observational study was performed at the acute geriatric units of an academic hospital. The first 90 AF patients for 2020, 2021 and 2022, who received at least one oral anticoagulant, were included. Anticoagulant use at discharge and therapy appropriateness were assessed. Determinants for underdosing were evaluated using multivariable logistic regression. Temporal associations for appropriateness (yes or no) and anticoagulant class (Vitamin K antagonist (VKA) vs. DOAC) were assessed using Fisher's exact analysis.
Results Mean age was 86.5 (±5.3) years with median CHA_2DS_2-VASc score 5 [4–6]. At discharge, 256 (94.8%) patients used a DOAC, 9 (3.3%) used a VKA, 1 (0.4%) a DOAC-antiplatelet combination, and in 4 (1.5%) anticoagulant use was discontinued. Apixaban was most commonly prescribed (40.7%) and a majority of patients (64.4%) received a reduced DOAC dose. Thirty-nine (14.4%) patients received inappropriate therapy and for 23/39 (59.0%) no deviation rationale was documented. The year '2022' (odds ratio 0.104; 95% confidence interval, 0.012–0.878) was the only determinant for underdosing. There was no temporal association regarding appropriateness (P=0.533) or anticoagulant class (P=0.479).
Conclusion and Relevance A majority received anticoagulation at discharge, mostly reduced DOAC doses. Only a minority was managed inappropriately. The reassuring findings over the 3-year period might be explained by the success of the clinical pharmacy programme. In conclusion, on a background of said pharmacy services, most AF patients were treated according to current guidelines. However, deviation from clinical guidelines still occurred consistently, frequently without a documented rationale and largely explained by underdosing in the context of a high bleeding risk. Accordingly, more trial data on the most appropriate anticoagulation strategy are urgently needed in geriatric AF patients with (very) high bleeding risks.