Materials and Methods We retrospectively analysed the data of patients treated at our centre from April 2022 to August 2023. A total of 15 patients (11 men, four women) receiving empiric or targeted linezolid therapy guided by TDM were included. Blood samples were centrifuged immediately after being collected, and serum linezolid levels were measured within 24 hours. Trough levels were evaluated when using an intermittent dosing regimen, while blood was taken at random times after reaching the steady state when a continuous infusion was applied.

Results Dose adjustments were performed in 11 patients based on TDM results. Optimal linezolid exposure was only achieved when higher doses (1800–2400 mg/24h) were administered by continuous infusion. This regimen, which was subsequently introduced into routine care, led to linezolid overexposure in a single patient. Dose reduction with clinical improvement was accomplished in three patients. Serum linezolid levels showed no correlation with kidney function, age, or gender.

Conclusion and Relevance Optimal linezolid exposure often cannot be achieved with standard dosing regimens in critically ill patients after high-risk cardiovascular surgery. Higher doses and continuous infusion regimes may be required in this population. TDM is an important tool for guiding therapy.

NP-012 IMPROVING THE CLINICAL PHARMACIST HANDOVER PROCESS USING AN ADAPTED ISBAR COMMUNICATION TOOL WHEN TRANSFERRING PATIENTS FROM CORK UNIVERSITY MATERNITY HOSPITAL (CUMH) TO AN INTENSIVE CARE UNIT (ICU) WITHIN CORK UNIVERSITY HOSPITAL (CUH)

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Introduction Clinical handover has been identified, both nationally and internationally, as a high-risk step in a patient's hospital journey. Barriers such as poor communication can contribute to variations in practice.[1]

The use of different electronic healthcare records between CUMH and the ICU in CUH can lead to timely and ineffective handover. In order to ensure clinical handover of critical patients from CUMH to CUH is not jeopardised, an ISBAR tool was adapted to standardise the patient handover process between clinical pharmacists.

Aims

- To implement a communication handover tool for pharmacists, to optimise patient safety and reduce risk of error or miscommunication between electronic healthcare records, when critically unwell patients are transferred from CUMH to the CUH ICU.
- To determine the benefit of this tool by assessing pharmacist responses.

Method The National Clinical Guideline ISBAR communication tool[2] was adapted for pharmacist use in CUMH for safer transfer of obstetrics and gynaecology patients and their identified requirements.

To evaluate the benefit of the tool, a survey questionnaire was distributed to ICU pharmacists for feedback.

Conclusion At time of abstract submission, the ISBAR tool was newly implemented. Feedback from users was limited but positive.

Since implementation in January 2023, the ISBAR tool was completed for 100% of patients transferring to ICU.

Pharmacist feedback reported satisfaction with the communication method, usability of the tool, accuracy and efficiency of the handover.

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Conflict of Interest No conflict of interest.

1ISG-001 ANALYSIS OF THE USE OF ORAL ONCOLOGY TARGETED THERAPIES IN A REGION OF SPAIN

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Background and Importance Individualised treatments are the most important oncology pharmacotherapeutic innovation nowadays. The high cost of such treatments may hinder their incorporation into clinical practice.

Aim and Objectives To analyse the impact of the incorporation of oral oncology targeted therapies (OOTT) into routine clinical practice in a region.

Material and Methods Retrospective, descriptive study of the uptake and economic impact of OOTT between 2012 and 2022.

Analysis of incorporation and economic impact included OOTT for six molecular targets, which were dispensed in Hospital Pharmacy Services. ALK/ROS1 mutations were analysed together because the indication of OOTT could not be identified.

Regional consumption registers were used as a source of data.

Results Available OOTT options increased by 500%, with 18 authorised drugs at the end of the study. In 2012–2013, only ALK/ROS1 and EGFR drugs were available. BRAF and MEK drugs were added in 2014 and BRCA drugs in 2015.

The percentage of treatments used (greater than 10%) by mutation are shown in table 1.

Abstract 1ISG-001 Table 1

Mutation	Beginning of the study	End of the study
ALK/ROS1	Crizotinib (100%)	Alectinib (44%), lorlatinib (26%), crizotinib (15%)
EGFR	Erlotinib (100%)	Osimertinib (84%), afatinib (7%), erlotinib (6%)
BRAF	Vemurafenib (72%), dabrafenib (28%)	Dabrafenib (54%), encorafenib (41%)
MEK	Trametinib (100%)	Trametinib (60%), binimetinib (38%)
BRCA	Olaparib (100%)	Niraparib (49%), olaparib (47%)

In 2012, EGFR drugs had the greatest impact on both treated patients (99.8%) and pharmaceutical expenditure

(100%). In 2022, BRCA drugs had the greatest impact on treated patients (34%), while the highest pharmaceutical expenditure (34%) was still on EGFR drugs.

By the end of the study, OOTT treatments had increased by 179% and pharmaceutical expenditure by 494%. Drug distribution by mutation was 34% BRCA, 28% EGFR, 15% ALK/ROS1, 13% BRAF, and 11% MEK. The economic impact was 108,138,186€ accumulated over the entire study period.

Conclusion and Relevance Targeted therapies have had a relevant impact in recent years, with new drugs and diagnostic techniques increasing the eligible population. Stringent evaluation and adequate selection of these drugs are necessary in order to optimise the incorporation of innovative therapies while guaranteeing the sustainability of the public healthcare system in Spain.

REFERENCES AND/OR ACKNOWLEDGEMENTS

Conflict of Interest No conflict of interest.

1ISG-002 PHARMACIST RISK STRATIFICATION: A CHARACTERISATION OF PATIENTS WITH LOW SOLUBLE UROKINASE PLASMINOGEN ACTIVATOR RECEPTOR WHO DIED WITHIN 90 DAYS OF HOSPITAL DISCHARGE

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Background and Importance Soluble urokinase plasminogen activator receptor (suPAR) is a marker of systemic chronic inflammation thought to reflect overall disease burden. suPAR has been suggested as a prognostic marker in clinical settings, since elevated suPAR levels are strongly associated with mortality. Researchers have suggested using a suPAR level <3 ng/mL for safe and early discharge from the emergency department (ED). However, a subset of patients with low suPAR dies within 90 days of hospital discharge, and the risk is significantly associated with an increased medication use.

Aim and Objectives The aim of the present study was to characterise patients with low suPAR (<3 ng/mL) who died within 90 days of hospital discharge by exploring factors other than suPAR that may explain this contradictory finding of mortality among patients with low suPAR.

Material and Methods This observational registry-based study included consecutively admitted medical patients to the ED at our hospital from November 2013 to March 2017. We used validated databases and national registries to describe patients' characteristics (age, medication use, diagnoses, frailty index).

Results Compared to patients with low suPAR who survived (n=15,122), those who died within 90 days (n=87) had higher age (75.4 years), medication use (7.0; 71.3% with polypharmacy), more blood tests outside reference intervals (5.0) (including C-reactive protein, neutrophils, albumin), and the most common diagnoses were chronic pulmonary disease (27.6%), cerebrovascular disease (18.4%), and dementia (11.5%). The most common medications were antithrombotic agents (44.8%), lipid modifying agents (plain) (39.1%), and other analgesics and antipyretics (33.3%).

Conclusion and Relevance Patients with low suPAR who died had other risk factors explaining their morbidity and mortality risk than what was reflected by their suPAR level. Using suPAR as a proxy for disease burden in clinical settings may be challenging in situations, where patients receive a high number of medications. We suggest including medication use, routine blood tests, and selected diagnosis codes in combination with suPAR when stratifying patients based on their risk of adverse clinical outcomes.

REFERENCES AND/OR ACKNOWLEDGEMENTS

Conflict of Interest No conflict of interest.

1ISG-003 ABSTRACT WITHDRAWN