

of NTZ infusions. This has led us to search an optimal dosing strategy.

**Aim and Objectives** In this study, we explore the impact of extending the dosing interval of NTZ from every four weeks to every six weeks in RRMS patients.

**Material and Methods** A retrospective observational study was carried out in a general hospital from January 2023 to September 2023. RRMS patients who had been receiving Natalizumab every four weeks for at least one year and subsequently switched to a six-week dosing interval were included. Clinical data were collected and analysed including relapse rates, disability progression, and adverse events.

**Results** 11 RRMS patients were included. None of them had new focal neurological symptoms, as evidenced by stable MRI (Magnetic Resonance Imaging) findings and absence of clinical relapses. Importantly, no cases of PML or other serious adverse events were reported during the study period. One patient reported visual worsening in the left eye but this was attributed to other factors unrelated to the dosing interval change.

**Conclusion and Relevance** In this study, the extension of Natalizumab dosing interval in RRMS patients demonstrated promising results, including stable disease activity and an absence of PML cases.

The absence of PML cases in our cohort is particularly encouraging, suggesting that the risk of PML may not be significantly increased with this extended dosing regimen.

This dosing strategy may offer a balance between maintaining therapeutic efficacy and minimising potential safety concerns. However, more studies are needed to confirm these findings.

#### REFERENCES AND/OR ACKNOWLEDGEMENTS

**Conflict of Interest** No conflict of interest.

#### 4CPS-063 CLINICAL PHARMACIST IN THE MULTIDISCIPLINARY TEAM IN THE INTENSIVE CARE UNIT IMPROVE THE QUALITY OF MEDICINE THROUGHOUT THE PATIENT'S HOSPITAL STAY

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**Background and Importance** Medication errors during a hospital stay can endanger patient safety, prolong the patients hospital stay and even be fatal. The critically ill patients in the intensive care unit (ICU) are particularly vulnerable to errors in medication management, and each care transition increases the risk of medication discrepancies.

**Aim and Objectives** The aims of the study were 1) to develop a workflow for clinical pharmacist to become an integral part of the multidisciplinary ICU team, 2) to perform a pharmacist-led intervention to improve the documentation of medication lists, optimise medical treatment and avoid drug-related problems (DRPs).

**Material and Methods** A preintervention retrospective control cohort at the ICU (n=34) was used to assess the effect of pharmacist-led intervention. Clinical pharmacist registered medication information about the patients before admission to

ICU, quality score of the medication information in the admission records, medication information when patients were transferred in-hospital, and in the discharge summary. Additional in the pharmacist-led intervention (n=23) medication reconciliation and drug review were performed.

**Results** Clinical pharmacist found discrepancies in medication information and/or electronic prescribing for 55 different drugs (n=19 patients, 82%), in average 2.4 drugs per patient. Most common discrepancies were drugs missing (n=25, 45%), important information about poor compliance were missing (n=12, 22%) and drugs no longer in use were listed in medication information and/or electronic prescription (n=10, 18%).

Most of the patients (n=20, 87%) had DRPs or potentially DRPs, in total 85 DRPs. Most commonly DRPs included drugs needed monitoring (n= 16, 19%) and drugs were found unnecessary for patient (n=15, 18%). The ATC group N including central nervous agents like anxiolytics, hypnotics and sedatives, antipsychotics and antidepressants were commonly related to the DRPs or potentially DRPs (n=26, 31%).

The average quality score of medication information in discharge summary were higher in the intervention group (n=18, score: 11.5) compared to the control group (n=31, score: 8.3). Maximum score is 21.

**Conclusion and Relevance** In an ICU multidisciplinary team, clinical pharmacist should be integral part to increase patient safety. The clinical pharmacist contributed to less medication errors and DRPs and improved documentation of the medication lists throughout the hospital stay.

#### REFERENCES AND/OR ACKNOWLEDGEMENTS

**Conflict of Interest** No conflict of interest.

#### 4CPS-064 REVIEW OF USE OF IMMUNOGLOBULINS IN TERTIARY HOSPITAL

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**Background and Importance** Human immunoglobulins (HI) are essential for treatment of primary immunodeficiency (PI). They are also used for other conditions, some of which do not have very high evidence or have therapeutic alternatives other than HI. Given the current shortage of HI, careful consideration of its indications and administration is warranted.

**Aim and Objectives** I)To describe the use of HI of an adult population treated in a tertiary university hospital (767 beds), which is a reference hospital for PI and other minority pathologies. II)To identify those indications for which the use of HI has a low level of evidence according to the national guidelines.

**Material and Methods**

**Observational retrospective study** No intervention. All patients who received HI during 1/1–31/12, 2022 were included. Data was obtained from electronic medical records.

**Results** A total of 104786g of HI were administered to 432 patients (52.3% women). Median age and weight were 60.0