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P32 TO EVALUATE PROPHYLACTIC POSACONAZOLE PRESCRIBING IN CHILDREN UNDER 12 YEARS WITH PRIMARY IMMUNODEFICIENCY

Mairi Watson*, Helen Young, Sinead Greener. *Newcastle Upon-Tyne Hospitals*

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Aim Current prescribing in our trust, in the absence of a guideline and licensing for prophylactic posaconazole in children under 12 years, is based on a paper by Boonsathorn et al. 2018 [1] The purpose of this audit is to evaluate the extent to which prescribing and monitoring of prophylactic oral posaconazole prescribed within our paediatric inpatient population is in line with published recommendations.[1] Targets were 100% of patients were dosed as recommended[1]; 100% of trough concentrations for posaconazole were taken within 5–10 days after initial administration; and if trough concentrations are not in range (>0.7 mg/L) was corrective action taken.

Method Patients between the ages of 2 months to 12 years with primary immunodeficiency recorded on their health record as being initiated on prophylactic posaconazole in the last 2 years were identified. Where patients met the inclusion criteria; age, weight, posaconazole formulation, date of initiation of posaconazole, trough concentration, date of trough concentration and dose adjustments were collected. Data was collated and analysed using MS Excel. Caldicott Guardian approval (ID: 9378) was granted by our trust and was added to the clinical effectiveness register (ID: 13451).

Results 23 patients were included with the mean age of 3.7 years. 84% of patients were dosed as recommended by Boonsathorn et al. 52% of all patients got a trough concentration taken within the 5–10 days and 75% of those patients had a trough concentration of >0.7 mg/L. 25% of patients had concentrations taken in 5–10 days that were <0.7 mg/L and doses were increased. These increased doses were not as recommended.[1] 33% of patients had concentrations taken in 5–10 days that greatly exceeded 0.7 mg/L and had dose reductions.

Conclusion The majority of the patients were dosed as recommended and had a trough concentration >0.7 mg/L. Recommendations could be translated into a guideline to include; advising trough concentrations are taken 5–10 days of initial administration to get an accurate picture of the posaconazole concentration. To include recommendations of dose adjustments following <0.7 mg/L trough concentrations to get consistent optimal prescribing. There was no maximum trough concentration for prescribers to adhere so the addition of a maximum trough concentration and recommendations of dose reductions would improve the clinical safety of prescribing prophylactic posaconazole. Limitations of this audit included the limited number of patients that fitted the criteria and results cannot be generalised for all oral formulations as only one patient was prescribed tablets.

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P33 PATIENT/PARENT ACCEPTABILITY OF DIFFERENT FORMS OF ORAL HYDROCORTISONE IN CONGENITAL ADRENAL HYPERPLASIA

Jennifer Duncan*, Louise Bracken, Gabrielle Seddon, Amy Hill, Amy Nuttall, Ellie Clarke, Pauline Blundell, Sarah Madine, Andrea Gill. *Alder Hey Children's NHS Foundation Trust*

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Aim Hydrocortisone is used in Congenital Adrenal Hyperplasia (CAH) as a long-term replacement therapy. Accurate dosing, patient acceptability, and ease of administration of the available dosage forms are vital as treatment is life-long.[1] Prior to the introduction of a licensed immediate-release formulation the use of a variety of unlicensed oral hydrocortisone preparations was widespread. This project aimed to explore patient/parent acceptability of oral hydrocortisone preparations in the real-world setting. This included assessment of preferences and the reasons for discontinuation if more than one formulation had been used.

Method This clinical audit was registered within the Trust. Two e-surveys were developed by a multi-disciplinary team (MDT) using Microsoft Forms, one for parents of children <8 years and the other for parents and children ≥8 years. With permission, both e-surveys included the validated Pediatric Oral Medicines Acceptability Questionnaire for caregivers (POMAQ-C) and the POMAQ-P was optional for patients ≥8 years old.[2] Most questions utilised the Likert rating scale, with 5 being positive and 1 being negative. The form was piloted with one family, then parents were contacted by the clinical team and if happy to take part, a member of the project team contacted them with the survey link details. Inclusion criteria: Patients with CAH aged 6 months to 17 years (inclusive) taking an oral form of hydrocortisone. Exclusion criteria: non-UK residents, non-English speaking, non-classical CAH patients, and/or not taking an oral form of hydrocortisone.

Results 33 eligible patients were identified. The results below represent the findings from the first 8 families. Patients were aged between 1 to 17 (mean 7.7) years. Three (37.5%) were taking hydrocortisone tablets, one (12.5%) was taking Alkindi® granules, and four (50%) hydrocortisone liquid. The mean score for parent-rated overall acceptability of tablets, granules, and liquid preparations was 4.3, 4, and 4.75, respectively. Parent-rated mean acceptability score for their child was 4.67, 3, and 5, respectively for the different types of formulations. One patient had moved from liquid hydrocortisone to tablets due to problems obtaining prescriptions and transporting/refrigerating the product when not at home. Another had moved from granules to liquid as the parent found it 'difficult to give to a baby' and reported issues obtaining a prescription.

Conclusion Assessment of the acceptability of medicines for children in a real-world setting is possible and allows for parents/carers and patients to provide practical feedback on available treatment options. To date, parental feedback received indicates a slight preference for liquids over tablet and granule hydrocortisone formulations, although data is currently limited.

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