airflow limitation (PAL)). There is no agreed definition of PAL in children, but pragmatically, most would define it as post steroid, post-bronchodilator FEV_1 percent predicted <80% or Z score less than −1.96, with normative data from appropriate reference populations despite optimal therapy. However, there is no agreement on the dose, duration or route of administration of steroids to determine the optimal spirometry that a child can achieve.

Hypothesis A single intramuscular dose of triamcinolone and acute bronchodilator are insufficient to determine optimal lung function and reliably diagnose PAL. The aim of this study was to determine whether forced expired volume in 1 second (FEV_1) 2–4 weeks after a single dose of triamcinolone and acute bronchodilator administration reflect the best obtained in the following year in patients with severe, therapy resistant asthma.

Patients and Methods 39 children age 5–16 received triamcinolone; the FEV_1 was measured before the treatment, after triamcinolone and during the 12-month period. The highest follow-up FEV_1 was compared with post-steroid post-post-bronchodilator FEV_1.

Results In the year following the 1st dose of triamcinolone 25 (64%) of 39 patients exceeded their immediate post-steroid trial target lung function by >9% predicted. 13 out of 39 patients (33.3%) achieved FEV_1 of >80% predicted at the 1st follow-up. If the diagnosis of PAL had been made just on the steroid trial, 16 patients would have been wrongly given this label; only 10 children were ultimately diagnosed with PAL. 13 of 39 patients received multiple (2–4) doses in 4 weeks intervals and only in 9 of them only the data was analysable. In this small group, the median and interquartile range of FEV_1 were significantly higher (75 vs 68 and 38.75 vs 17) following the 3rd dose of triamcinolone than after the 1st.

Conclusion Reliance on a single dose of triamcinolone plus acute administration of ß-2 agonist will lead to an overdiagnosis of PAL in children with severe asthma.

ILD: from bench to bedside and back again

P84 BTS NATIONAL INTERSTITIAL LUNG DISEASES (ILD) SURVEY 2010–2011

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Aim The aim of this survey was to capture the current "state of play" with regard to ILD services, with an emphasis on idiopathic pulmonary fibrosis (IPF), in the UK.

Methods The BTS Specialist Advisory Group emailed a survey to 260 clinicians. Respondents were advised to collect data prospectively for 1 month (late 2010/early 2011) before completing it.

Results 120 responses were obtained, (England-96, Scotland-16, Wales-6, Northern Ireland-2), total catchment population 37.3 million, number of full-time consultants 3 (1–15). *50% of centres had a "lead" ILD consultant, 57% ran an ILD clinic and, of those centres currently without an ILD clinic, 70% anticipated setting one up in the next 5 years. For patients with all types of ILD the estimated number of new patients seen at clinic each month was 6 (1–75). *The percentage of new patients with IPF (options "<25%", "25–50%", "50–75%" or ">75%") was estimated at 18%, 36%, 27% and 18% respectively. For all ILD patients, the number of return patients seen at clinic in a month was 25 (1–300). *Only 5% of respondents were "very confident" about these figures (based on audit/registry) with 62% expressing "low confidence". HRCT reporting was performed by "Pulmonary radiologists"/"Pulmonary radiologists with a specific ILD interest" in 48% and 36% respectively. 47% of centres did not have an ILD-multidisciplinary meeting (MDM), and for those that did, 32% held them monthly. Access to an ILD Specialist Nurse, ambulatory oxygen, pulmonary rehabilitation, palliative care and smoking cessation were 26% 93%, 81%, 93% and 97% respectively. 64% had not recruited into IPF clinical trials and 68% had no registry/database[n1]. "Triple" therapy continued to be prescribed "frequently", prednisolone (55%), azathioprine (49%), N-acetylcysteine (45%). The reported preferred model of care for ILD patients was "local" (51%), "network" (45%) and "centre" (4%). *Median/range.

Conclusions There is a wide variation in current practice, with almost half of all respondents not holding a MDM, despite BTS/ERS/ATS guidelines. Our survey has implications for the delivery of ILD care in the UK and should support the BTS in developing Quality of Care standards.

P85 MORTALITY TRENDS IN ASBESTOSIS, EXTRINSIC ALLERGIC ALVEOLITIS AND SARCOIDOSIS IN ENGLAND AND WALES

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Background To ascertain the trends in mortality from Asbestosis, Extrinsic Allergic Alveolitis (EAA) and sarcoidosis in England and Wales, we analysed mortality data from the Office of National Statistics.

Methods We calculated age and stratum specific mortality rates between 1968 and 2008 and applied these to the 2008 population demographics to generate the standardised number of expected deaths per annum. Poisson regression was used to calculate annual mortality rate ratios.

Results From 1968 to 2008 there were 1958 registered deaths from Asbestosis, 878 deaths from EAA and 3544 deaths from sarcoidosis. The Asbestosis mortality rate increased from 0.04 (95% CI 0.03 to 0.05) in the 1968 to 1972 calendar period to 0.12 (95% CI 0.10 to 0.13) in the 2005 to 2008 period while the mortality from EAA increased marginally from 0.04 (95% CI 0.03 to 0.05) in the 1968 to 1972 calendar period to 0.08 (95% CI 0.07 to 0.09) in the 2005 to 2008 period. Mortality from sarcoidosis has increased by approximately 9% a year.

Discussion Our findings show that the mortality from Asbestosis continues to rise in the UK. Overall mortality rates from EAA have remained stable throughout the same period but they were higher in males and in older people. There was a slight increase in mortality from sarcoidosis over the study period which was greater in women.

P86 THE ASSESSMENT OF HEALTH RELATED QUALITY OF LIFE IN SARCOIDOSIS WITH THE KING'S SARCOIDOSIS QUESTIONNAIRE (KSQ)

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Introduction The King's Sarcoidosis Questionnaire (KSQ) is a recently developed and validated sarcoidosis specific health related quality of life (HRQOL) tool comprising of 5 modules: general HRQOL (10 items), lung (6 items), medication/side-effects (3 items), skin (4 items), and eye (7 items). We set out to evaluate HRQOL in a large group of patients with wide ranging sarcoidosis and determine the factors that influence it.