(N = 27; p = 0.023). Significant increases in QoL (p = 0.002) were also found on the Juniper QoL. $FEV_1$ significantly improved with a mean score of 2.21 at baseline, increasing to 2.83 at one-year (p < 0.001). Multiple regressions showed that 25% of the variance in QoL was predicted by $FEV_1$; however, depression and $FEV_1$ combined explained 50.8% of the variance (p < 0.001).

**Conclusions** Multidisciplinary intervention led to effective improvement in well-being and lung function in patients with severe and difficult asthma. The improvements in QoL were predicted by both $FEV_1$ and depression. We recommend supporting patients' adaptation to life with severe asthma as an integrated function of the multidisciplinary approach. This approach can help minimise anxiety and depression symptoms, improve QoL and reduce the psychological impact upon physical symptoms.

**Abstract M5 Table 1. Changes in lung function and psychological well-being across a one-year period of multidisciplinary intervention.**

| | Baseline (Mean Score) | One-Year Assessment (Mean Score) | P Value * = significant |
|---|---|---|---|
| HADS Depression | 7.69 | 7.13 | .192 |
| HADS Anxiety | 8.97 | 7.56 | .023* |
| AQLQ (Juniper QoL) | 3.20 | 4.09 | .002* |
| $FEV_1$ | 2.21 | 2.83 | .000* |

## M6 LEVEL OF ASTHMA CONTROL IN PRIMARY CARE IN THE UK AS DETERMINED BY THE RCP 3 QUESTIONS

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**Introduction** From 2012, the Quality Outcomes Framework (QOF) in Asthma was amended to include an objective assessment of a patient's asthma control using the RCP 3 questions.

In the last month

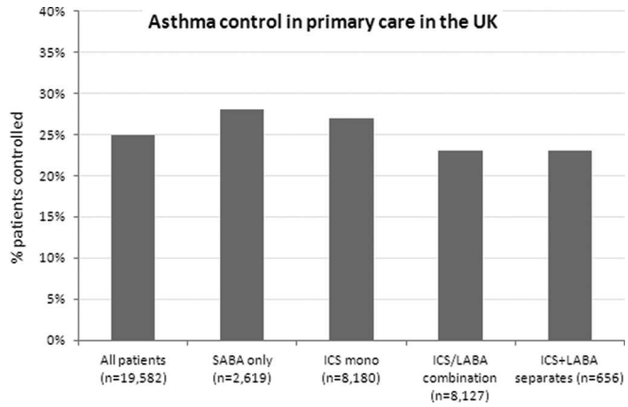
- Have you had difficulty sleeping because of your asthma symptoms (including cough)?
- Have you had your usual asthma symptoms during the day (cough, wheeze, chest tightness or breathlessness)?
- Has your asthma interfered with your usual activities (for example, housework, work/school, etc.)?

Controlled asthma is defined as answering 'no' to all 3 questions.

Cegedim Ltd, who own the InPS Vision prescribing software, have access to anonymised QOF data and have used 150 GP practices which are selected to provide UK-wide representation. This has enabled an analysis to determine real-world levels of asthma control in primary care in the UK.

**Methods** Asthma patients were identified according to QOF business rules. Patients who had provided responses to the RCP 3 questions (during the period March 2012–February 2013) were selected. A subset of those who had been on the same medication for the 12 months prior to that assessment were specified, defined as consistently prescribed the same medication at the time of assessment and 12 months prior.

**Results** A cohort of 19,582 asthma patients who had completed the RCP 3 question assessment during the study period with 12 months of consistent therapy was identified. One-quarter (25%) of patients were controlled (answered 'no' to all questions). For patients at BTS Step 1 (SABA only) and BTS Step 2 (ICS monotherapy), the proportion controlled was 28% and 27% respectively. For patients at BTS Step 3 and above (ICS and LABA in combination, including as separate inhalers) the proportion was 23% (see figure).




**Abstract M6 Figure 1.**

**Conclusions** Asthma control in primary care in the UK is poor with only 25% of asthmatics achieving control as defined by the RCP 3 questions; levels of control were consistent across BTS steps. Interventions to understand barriers and improve asthma control are warranted.

## M7 POOR CONTROL OF ASTHMA IN UYO, SOUTH-EASTERN NIGERIA

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**Background** The prevalence of asthma is increasing in the developing world. Asthma, management guidelines have been instituted to provide recommendations for the optimal control of asthma. This study evaluated the current level of asthma control as reported by the patients which may be a reflection of adherence to guidelines.

**Methods** Asthma patients referred to a respiratory diseases clinic were recruited for the study. The asthma control test (ACT) was administered on the patients. Data was also obtained for medication use and disease monitoring. A total ACT score of less than 20 signified poor control.

**Results** Seventy out of 78 patients completed the survey (89.7%). The average age of patients was 46 ± 18 years. The average ACT score was 14.4 ± 4.8 (mean ± SD). 82.9% of patients had poor control. 57.1% of patients who perceived their asthma to be well or totally controlled were objectively assessed to be poorly controlled. More than half of the patients used short acting 2 agonist (SABA) alone and only 20% used inhaled corticosteroids (ICS) for maintenance therapy. Thirty eight patients made unscheduled emergency room visits in the past 12 months and 68.8% could not use their inhaler devises well. Emergency room visits (OR 9.5) and poor inhaler technique (OR 18.9) was independent predictors of poor asthma control.

**Conclusion** The current level of asthma control among patients in Uyo is below guideline recommendations. Management of patients did not appear to follow guideline recommendations and patients tend to over-estimate their disease control.