P236 ALLERGY SERVICES AT A TERTIARY REFERRAL CENTRE: A 1-YEAR RETROSPECTIVE REVIEW OF ALL REFERRALS

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Introduction A retrospective review was performed of all new referrals attending the Allergy Dept at Guys and St Thomas' NHS Foundation Trust (GSTT) over 12 months. The purpose was to establish the prevalence of non-allergic and allergic disease, determine the value of the investigations requested and ascertain the correlation between initial and final diagnoses.

Method All 1702 new patient referrals made to the allergy clinic between 1/01/2006 and 1/01/2007 were reviewed. Information collated included patient demographics, referral source, referral reason, working diagnosis, investigations requested, frequency of abnormal blood test findings, final diagnosis, and outcome after attending first appointment.

Results The age at presentation was 38±17 (Mean±SD). The female to male ratio was 3:1; the most common source of referral was primary care (84%); 54% of the working diagnoses after first consultation were allergic conditions, the commonest being food allergy; the final diagnosis was predominantly a non-allergic condition (65%), the commonest being idiopathic urticaria. Skin prick testing (65%) and full blood count (18%) were the commonest investigations requested with abnormal results recorded in 59% and 38%, respectively. 54% of the patients were discharged at first appointment and 26% were followed-up allergy out-patient appointments. The rest were referred to another speciality (5%) or to specialist services within the department (drug challenge (5%), dietician (4%), immunotherapy (4%), and food challenge (1%)). Diagnostic concordance data between referral sources and allergy specialists revealed that Emergency Department, Primary Care and Dermatology referrals were associated with a lower diagnostic agreement, (40%, 52% and 59%) respectively as compared to referrals from ENT and Immunology resulting in 86% diagnostic concordance. Overall there was a 57.5% and 92% agreement between the working and final allergic and non-allergic diagnoses respectively.

Conclusion The majority of new patient referrals seen in this Allergy Centre year did not have a final diagnosis of allergy. The diagnostic agreement between certain referral sources & allergy specialists was low providing a focus for targeting allergy educational resources. Training programmes should endeavour to produce specialists competent in the diagnosis and management of both allergic and non-allergic conditions which may share similar modes of presentation.

Clinical challenges in diagnosing and managing respiratory infection

P237 THE UTILITY OF THE NOTTINGHAM HEALTH PROFILE IN EXACERBATIONS OF NON-CYSTIC FIBROSIS BRONCHIECTASIS

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Aim The aim of this study was to assess the utility of a generic health status questionnaire, the Nottingham Health Profile (NHP) in non-cystic fibrosis bronchiectasis.

Methods The NHP is a generic health status measure that contains 6 scales: energy (3 items), pain (8 items), emotional reactions (9 items), sleep (5 items), social isolation (5 items) and physical mobility (8 items). In addition the NHP also has a total score including 24 items called the NHP-D. High scores on the questionnaire indicate worse health status. Patients with an exacerbation of bronchiectasis requiring 2 weeks' intravenous antibiotic therapy completed the NHP at the start of the exacerbation and then 1 week following completion of treatment. In addition, they completed the Leicester Cough Questionnaire, a cough severity score, previously validated for use in bronchiectasis. The LCQ assesses three components: physical, psychological and social. The total score ranges from 3 to 21 with a lower score indicating a more severe cough. The change scores and effect size (ES) of the NHP and LCQ were measured. The ES is based on the ratio of difference between the mean measure at baseline and at follow-up (related to the SD for baseline scores) and the thresholds are: 0.2 for a small group change, 0.5 for a moderate group change, and 0.8 for a large group change.

Results 44 patients completed the study. Abstract P237 Table 1 shows the change in the components of the NHP and the LCQ at the start and end treatment of the exacerbation. The change score and effect size in the NHP included: Energy Level: −18.18 and −0.56; Pain Scale: −4.26 and −0.14; Emotional Reaction:−7.58 and −0.29; Sleep Scale:−18.2 and −0.56; Social Isolation: −5.45 and −0.21; Physical Mobility: −9.94 and −0.34; NHP-D: −2.27 and −0.43. The change score and effect size for the LCQ included: Physical: 1.28 and 1.32; Psychological: 1.61 and 1.11; Social: 1.62 and 1.09; Total: 4.51 and 1.25.

Abstract P237 Table 1

n	44		
NHP	**Mean (SD)**	**LCQ**	**Mean (SD)**
Energy level: Start	68.9 (32.5)	Physical: Start	3.7 (1.0)
Energy level: End	50.8 (41.0)	Physical: End	5.0 (1.1)
p	0.004		<0.001
Pain scale: Start	19.6 (29.8)	Psychological: Start	4.1 (1.5)
Pain scale: End	15.3 (26.4)	Psychological: End	5.7 (1.2)
p	0.268		<0.001
Emotional reactions: Start	26.5 (25.8)	Social: Start	4.0 (1.5)
Emotional reactions: End	18.9 (27.6)	Social: End	5.6 (1.2)
p	0.014		<0.001
Sleep scale: Start	40.9 (32.6)		
Sleep scale: End	22.7 (30.1)		
p	<0.001		
Social isolation: Start	14.1 (25.7)		
Social Isolation: End	8.6 (18.5)		
p	0.096		
Physical mobility: Start	38.4 (28.8)		
Physical mobility: End	28.4 (26.5)		
p	0.008		
NHP D: Start	7.0 (5.3)		
NHP D: End	4.8 (4.6)		
p	<0.001		

Conclusion The NHP was responsive to change in acute exacerbations of bronchiectasis but further validation studies are needed.