Abtsract P257 Table 1 Selected results

	Age	Febrile	Tachypnoea	Hypoxia (<94%)	Ddimer	Smoker	Abnormal CXR	Wells (High >6, 2–6 moderate)	Geneva (High >8 5–8 moderate)	PESI [Class 5 >126 Class 4: 106–126 Class 3: 88–105 Class 2: 66–85 Class 1 <65]
Deaths N=22										
Number (mean)	76.5	0/21	10/22 45%	14/22 63%	2/2 positive	9/22 42.8%	6/22 27%	4.7	2.9	146.9
Inpatient treatment N=20										
	Age	Febrile	Tachypnoea	Hypoxia (<94%)	Ddimer	Smoker	Abnormal CXR	Wells	Geneva	PESI
Number (mean)	68.6	3/20 15%	9/20 45%	9/20 45%	8/8 positive	7/20 35%	7/20 35%	5.3	3.1	105.8
Outpatient treatment N=18										
	Age	Febrile	Tachypnoea	Hypoxia (<94%)	Ddimer	Smoker	Abnormal CXR	Wells	Geneva	PESI
Number (mean)	60.4	1/18 5%	4/18 22%	3/18 17%	8/15 positive 53%	10/18 56%	4/18 22%	4.2	2.2	76.2

radiology and hypoxia. Managing PE as an outpatient potentially requires a combination of scoring systems in a prospective study.

P258 IS CHRONIC THROMBOEMBOLIC PULMONARY HYPERTENSION (CTEPH) UNDER DIAGNOSED IN THE UK?

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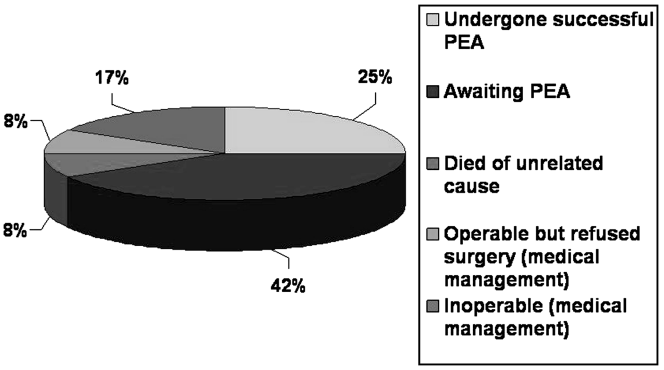
Introduction Chronic Thromboembolic Pulmonary Hypertension (CTEPH) is a rare but treatable condition. In selected cases Pulmonary Endarterectomy (PEA) surgery is potentially curative, with 80–85 procedures performed annually at a single national centre, Papworth Hospital. Previous studies suggest the disease may be under diagnosed.

Aim To identify whether developing a local Pulmonary Hypertension (PH) service improves the number of CTEPH cases diagnosed in a DGH setting.

Methods In 2005, a regional PH satellite service was set up at the Royal United Hospital (RUH), Bath, in conjunction with the Royal Free, London. The service aims to provide local access to PH-specific therapies at national standards of care. New cases of CTEPH are investigated with a number of investigations including right heart catheterisation and pulmonary angiography and then referred to Papworth Hospital's MDT to determine eligibility for surgery. This abstract examines the number of cases diagnosed in RUH's own catchment area following a rolling education programme targeting local physicians and radiologists.

Results Prior to 2007 no RUH patients had undergone PEA surgery. Since 2007, 12 patients have been diagnosed with CTEPH (7 male) with mean age 62.3 years (SD 12.1, range 37–72). Only 5 (41.7%) had a documented history of previous thromboembolic disease. Referrals were received from a variety of sources including respiratory, vascular, rheumatology, gastroenterology, primary care, ENT, stroke physician and cardiology. Four (33.3%) were referred as inpatients. At referral 33.3% were NYHA class II, 41.7% class III and 25.0% class IV. Mean pulmonary haemodynamics were: RA 10.9 mm Hg (6.4), mPAP 46.3 mm Hg (13.1), PCWP 13.2 mm Hg (4.4), CO 4.8 l/min (0.9), PVR 7.8WU (4.1). 8 have undergone or are awaiting surgery, 1 died of unrelated causes and 3 are being treated medically. (Abstract P258 Figure 1).



Abstract P258 Figure 1 Outcomes for patients with CTEPH diagnosed at RUH since 2007.

Conclusions Underdiagnosis of CTEPH may be exacerbated by patients presenting to a variety of specialties. The number of CTEPH cases diagnosed at the RUH has increased significantly since 2007, probably as a result of raised local awareness of the condition. It is therefore likely that this potentially curable condition is under diagnosed in areas with more limited access to PH specialist facilities.

P259 INCIDENTAL FINDINGS ON CT PULMONARY ANGIOGRAPHY: WHAT SHOULD WE BE LOOKING FOR?

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Introduction and Objectives The role of diagnostic imaging in pulmonary embolism (PE) is being increasingly undertaken by CT pulmonary angiography (CTPA) and there has been an explosion of usage in our trust in the last two years, which reflects a growing trend in clinical practice in the United Kingdom (UK). There has been an abundance of literature on how best to utilise CTPA with particular attention to optimisation of pulmonary artery opacification to aid diagnosis. An additional benefit of CTPA over other modalities for the diagnosis of PE that may be less widely appreciated is CTPAs ability to provide simultaneous information on other pathologies affecting the thorax and alternative diagnoses requiring further clinical management.

Methods To this cause a sample of 400 CTPAs were retrospectively reviewed in a 1001 bed acute teaching hospital in the UK, to identify