

Methods A prospective observational cohort study of patients admitted with an acute exacerbation of COPD (AECOPD) was performed. Patients were >40 years of age, with spirometry confirmed COPD, admitted to one of 12 UK centres between 2009–2012.

Hazard ratios for mortality and cardiovascular events at 1 year follow up, based upon the presence of either sinus tachycardia or new onset AF at the initial hospital admission were calculated through Cox proportional hazard regression analysis following correction for influential covariates. Logistic regression was performed to calculate odds ratios (OR) identifying predictor variables of both sinus tachycardia and AF.

Results 1343 patients were included in our study. New onset AF was recorded in 155 patients (12%) of patients. Mean (IQR) age was 72(63–79). Mean (95%CI) FEV1% predicted and MRC dyspnoea score were 46 (34–67) and 4 (3–5) respectively. Hazard Ratios (95%CI) for new onset AF and tachycardia are displayed in table 1.

Factors predicting new onset AF included; history of IHD (OR 4.8; 95%CI 2.95–7.80), increasing age (OR 1.03; 95% CI 1.01–1.07) and worsening MRC dyspnoea score (OR 1.74; 95%CI 1.31–2.29). Prior beta blocker use was not significant (OR 0.68; 95%CI 0.35–1.28).

For sinus tachycardia >120bpm, there were significant relationships for MRC dyspnoea score (OR 1.73; 95%CI 1.43–2.09), respiratory acidosis (OR 1.80; 95%CI 1.20–2.70) and aminophylline treatment (OR 1.53; 95%CI 1.06–2.20). Prior beta blocker use was protective (OR 0.68; 95% CI 0.47–0.97).

Conclusions The presence of tachycardia and new onset AF in patients admitted with AECOPD are associated with a deleterious effect on short and long term mortality. For sinus tachycardia risk was greatest around the time of exacerbation, however new onset AF also heralds more significant 1 year mortality and risk of cardiac events.

Abstract P216 Table 1 Hazard Ratios for Mortality and Cardiovascular Events

Predictor	In hospital mortality	1 year mortality	Cardiovascular events (acute coronary syndrome, cardiac failure, serious arrhythmia)
HR > 100 (sinus)	1.43 (0.83-2.46)	1.31 (1.02-1.67)	1.06 (0.81-1.39)
HR > 110 (sinus)	1.87 (1.12-3.11)	1.33 (1.04-1.71)	1.14 (0.88-1.49)
HR > 120 (sinus)	2.25 (1.33-3.83)	1.37 (1.04-1.81)	1.23 (0.89-1.70)
New onset atrial fibrillation	2.14 (1.26-3.62)	1.60 (1.20-2.12)	1.44 (1.07-1.96)

P217 **CURRENT PRACTISE IN CONSIDERING EARLY LIFE FACTORS IN RESPIRATORY DISEASE: A BRITISH THORACIC SOCIETY SURVEY**

doi:10.1136/thoraxjnl-2012-202678.278

¹CE Bolton, ²A Bush, ³JR Hurst, ⁴S Kotecha, ⁵LP McGarvey, ⁶J Stocks, ⁷M Walshaw. ¹University of Nottingham, Nottingham, UK; ²Imperial College London, London, UK; ³University College London, London, UK; ⁴Cardiff University, Cardiff, UK; ⁵The Queen's University of Belfast, Belfast, UK; ⁶UCL Institute of Child Health, London, UK; ⁷Liverpool Heart and Chest Hospital, Liverpool, UK

Background Despite an 8% UK preterm birth rate and the improved survival of very preterm infants into adulthood, we hypothesised that the longer term impact of early life factors on respiratory health and disease is not routinely considered by respiratory specialists. We surveyed BTS members to determine their practise.

Methods Using a survey link, an email was sent twice, 4 weeks apart, to clinically active BTS members, enquiring whether they

asked their patients about birth-weight, being born preterm, pregnancy and postnatal complications, and time in a neonatal unit; whether patients' knew this information, and also whether members believed their patients had airflow limitation due to prematurity or low birth-weight.

Results There was good geographical spread of the 123 replies (61% consultants, 21% doctors in training, 15% nursing profession, 2% GPs and 1% SAS doctors). 93% worked in the secondary care sector (55% in teaching hospitals), and only 13 dealt predominantly with children (12 in hospital, 1 community).

Results are summarised in the Table. Only a small minority (mainly hospital paediatricians) ask "most respiratory patients" about early life factors. In those who do ask, there is a wide variation in patient knowledge, this being greatest for children, in whom parental recall or use of the "red book" assisted. Although 47% thought some of their patients were born preterm or had a low birth-weight, 46% were unaware and 7% thought there were none.

Discussion Given evidence suggesting early life factors do impact on respiratory health, the survey suggests little current consideration is given to these in adult medicine. Limited retrospective recall may preclude accurate assessment. To develop a greater understanding of the potential impact of early life influences on chronic respiratory disease requires a new approach, for example accessing early medical records, recall by a living parent of the patient or via a pre-term registry. In tandem, training needs to address the gaps in history taking.

Abstract P217 Table 1

	"Do you ever ask patients you review about...."		
	Birth-weight?	Born Preterm?	Perinatal or pregnancy complications or time in Neonatal unit?
Most patients with respiratory disease	14%	20%	20%
Occasionally	27%	37%	38%
Selected patients – asthma, COPD, restrictive lung disease or combination	4%	8%	4%
Do not ask	55%	35%	38%

P218 **PREVALENCE OF BRONCHIECTASIS IN COPD PATIENTS IN A GENERAL RESPIRATORY CLINIC**

doi:10.1136/thoraxjnl-2012-202678.279

¹SE Brill, ¹S Sikka, ¹CE Miller, ²A Ghali, ²S Hare, ¹R Vancheeswaran. ¹Department of Thoracic Medicine, Barnet Hospital, London, United Kingdom; ²Department of Radiology, Barnet Hospital, London, United Kingdom

Introduction There is increasing recognition that radiological bronchiectasis is present in many patients with COPD. However, estimated prevalence varies from 4% (Agusti, Respir Res; 2010) to 50% (Patel, AJRCCM; 2004), with the prevalence in the UK general secondary care population unknown. We assessed this in patients from the respiratory clinic at our general hospital.

Methods COPD patients underwent chest CT as part of their clinical assessment. Patients were included if COPD was diagnosed based on spirometry and clinical assessment and excluded if there was clinical bronchiectasis. Scoring was by a simplified system based on Smith (Thorax, 1996) and returned a score of 0 (no bronchiectasis), 1 (0–50% of bronchi involved), or 2 (50–100% of bronchi involved) for each lobe, with a total score of 12 including the lingula; emphysema, interstitial lung disease (ILD), or other pathology was noted.