

Introduction and Objectives Previous studies have shown that overall asthma care can vary greatly between practises. In this study we evaluate the recorded asthma prevalence and characterize asthma control and risk profiles of real-life asthma patients from 210 practises managed within UK primary care.

Methods Electronic practise data was extracted from patients with asthma from 210 practises across the UK. Patients included in the analysis were ≥ 18 years, had clinician-diagnosed asthma (defined as a diagnostic Read code compatible with the UK Quality and Outcomes Framework [QoF] for asthma) and were receiving current asthma therapy (≥ 1 asthma prescriptions within the last 2 years). Eligible patients were sent asthma management questionnaires to capture patient-reported outcomes. Pooled practise and patient data were used to characterize patients in terms of their control status (as classified by the Global INitiative for Asthma [GINA] and Royal College of Physician three questions [RCP3]) and risk status (stratified according to exacerbation frequency [Read code defined acute exacerbations and number of courses of acute oral steroids in previous 12 months], with high risk defined as ≥ 2 exacerbations annually).

Results From 210 practises across the UK there was an asthma prevalence of 5.9%, comprising 80280 adult patients and comparing to a UK QoF-assessed prevalence of 5.8%. The percentage of patients per practise with uncontrolled asthma (Median [IQR]) was 18.8% (9.1, 26.7) while the percentage per practise with no recorded RCP3 data was 18.9 (12.4, 45.9). 3.2% (n=2594) of the patients were classified as being high risk.

Conclusions A high proportion of patients managed in routine UK primary care have sub-optimal asthma control. More patients at BTS management stages 4 and 5 have uncontrolled asthma and suffer from a greater number of exacerbations. RCP3 recording varies between practises, and can be poorly recorded.

P278 REASONS PROFFERED FOR NON-ATTENDANCE AT A DIFFICULT ASTHMA CLINIC

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Background Our weekly difficult asthma clinic consistently has a higher 'did not attend' (DNA) rate compared to the general respiratory clinics (32.6% v 23.7%). There is some evidence that DNA rates are particularly high for primary care asthma reviews¹. Demand for our weekly difficult asthma clinic appointments is increasing such that routine appointments are at a premium. To explore reasons for non-attendance, our asthma specialist nurses attempted to interview patients that DNA over the telephone within a week of their scheduled appointment. The cause for non-attendance was ascertained in a non-confrontational manner and asthma control gauged.

Aim To determine reasons preferred for non-attendance at a difficult asthma clinic and to ascertain whether these differed between new and follow-up patients.

Methods Review of database generated from contacting patients that DNA asthma clinic between April 2011 and March 2012.

Results There were a total of 153 missed appointments. We attempted to contact the patient following their missed appointment in 101 cases and were able to successfully complete a telephone interview in 51 cases. Of the DNA appointments, 8 were new-patient appointments and 43 were follow-up.

See Table 1. Reasons for non-attendance.

Conclusions Forgetfulness ('wrong day' and 'forgot') was the commonest reason for non-attendance amongst both new and follow-up patients. This is in keeping with work done in the general outpatient population.² One in 5 patients claimed not to have received their appointment. Attempts to telephone patients a week prior to their scheduled appointment may help to reduce DNA rates and/or make more appointments available to patients that need them.

References

- van Baar et al, Understanding reasons for asthma outpatient (non)-attendance and exploring the role of telephone and e-consulting in facilitating access to care: exploratory qualitative study *Qual Saf Health Care* 2006; 15:191-195
- Pal et al, Why do outpatients fail to keep their clinic appointments? Results from a survey and recommended remedial actions. *Int J Clin Pract.* 1998 Sep; 52(6):436-7.

Abstract P278 Table 1

Reason	Overall (n=51)	New (n=8)	Follow-up (n=43)
Didn't receive	10 (19.6%)	2 (25%)	8 (18.1%)
Forgot	12 (23.5%)	1 (12.5%)	11 (25.6%)
Wrong day	12 (23.5%)	3 (37.5%)	9 (20.9%)
Unwell	5 (9.8%)	0	5 (11.6%)
Family problems	2 (3.9%)	1 (12.5%)	1 (2.3%)
Pt says cancelled appointment	5 (9.8%)	1 (12.5%)	4 (9.3%)
No data	2 (3.9%)	0	2 (4.7%)
Inpatient	2(3.9%)	0	2 (4.7%)
Moved out of area	1(2.0%)	0	1 (2.3%)

P279 EVALUATION OF TREATMENT WITH FIXED DOSE COMBINATIONS IN ASTHMA PATIENTS IN PRIMARY CARE IN SWEDEN BY USING MANNITOL CHALLENGE TEST

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Background The mannitol challenge test is an indirect bronchial challenge test suitable for use in a primary-care setting. The test is most often used to diagnose asthma. In this pilot study the test was used to evaluate the effectiveness of ongoing treatment with ICS/LABA combination therapy in patients with asthma.

Objectives To explore the prevalence of optimal treated asthma patients in primary care in Sweden. The hypothesis was that not all patients are optimal treated.

Methods Male and female subjects, age 18-65 years with asthma, who were treated with a fixed dose combination (budesonide/formoterol or fluticasone/salmeterol) were included in the study. The subjects performed a mannitol challenge test (direct fall) followed by an inhalation of a β_2 -agonist. A new spirometry (reversibility test) was performed 15 minutes later. The main explorative end-point was positive or negative response of mannitol challenge test and/or a reversibility of $\geq 15\%$.

Results The preliminary result of this pilot study (100 subjects) shows that an unexpected, surprisingly high proportion of the asthma patients had a positive response, either as a direct fall of FEV₁ $\geq 15\%$ in the mannitol challenge test and/or a reversibility of $\geq 15\%$.

Conclusion The result of this study indicates that a large proportion of asthma patients in primary care, who are currently treated with fixed dose combination therapy, may not be optimally treated. Further research is needed to support these findings and to understand the reasons.

P280 REDUCING NON-ATTENDANCE AT A DIFFICULT ASTHMA CLINIC – ARE PHONE CALLS FUTILE?

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Background Missed outpatient appointment cost NHS hospitals in the region of £600 million per year.¹ There is some evidence that