

standard NHS tariffs. Immunomodulators were defined as thiopurines, methotrexate or prednisolone >20mg/day.

Results Between October 2008 and November 2010, 90 patients were tested with TSTB, of which 2 had a positive TSTB result and 5 borderline/indeterminate. From December 2010 until July 2012, 82 patients were tested with QFGIT, of which 3 had a positive result and 12 indeterminate/borderline (Table). 170 (99%) had normal CXR and a negative clinical assessment. 4 of 13 patients had two sequential indeterminate IGRA and also required assessment in TB clinic. The average price per patient was £60.66 for TSTB and £52.41 for QFGIT. 88% (152/172) have subsequently received treatment with either infliximab or adalimumab. No subjects have gone on to develop active tuberculosis.

Conclusion Using either platform, we find a comparable, low rate of LTBI in our IBD population. There appears to be a higher frequency of indeterminate results using QFGIT. This raises the average cost per patient, but overall, QFGIT remains more cost-effective than TSTB. Despite differing length of follow-up, the average time was sufficient in both, otherwise comparable, cohorts to detect likely development of active TB disease.

Abstract P57 Table 1 Characteristics of groups and results of screening assessment

	T Spot	Quantiferon
Number of subjects	90	82
Median Age [years], (range)	35 (17–70)	35 (17–76)
Risk Factors for TB	12%	16%
On immunomodulators	63/90 (70%)	66/82 (80%)
Pos IGRA	0	3
Neg IGRA	61	52
Borderline IGRA	1	2
Indeterminate IGRA	1	9
No immunomodulators	27/90 (30%)	16/82 (20%)
Pos IGRA	2	0
Neg IGRA	22	15
Borderline IGRA	0	0
Indeterminate IGRA	3	1
Cost/assay	£60.00	£35.00
Cost/patient assessment	£66.13	£52.41
Median follow up	29 months	13 months

P58 AN AUDIT OF TREATMENT OUTCOMES FOR PATIENTS WITH TUBERCULOSIS DIAGNOSED AT AN INNER LONDON TEACHING HOSPITAL BETWEEN 2000 AND 2010

doi:10.1136/thoraxjnl-2012-202678.199

E Togun, S Stephens, O Sewo, FM Perrin, RD Barker. *Kings College Hospital, Kings Health Partners, London, United Kingdom*

Background The WHO has the ambition that 85% of patients starting treatment for TB achieve treatment success (cure or treatment complete).¹ There has been considerable anxiety that poor treatment completion rates would lead to increased transmission of tuberculosis and perhaps drive increased drug resistance. We have been monitoring treatment outcomes for patients registering at our hospital since the year 2000. Here we report outcomes and analyse risk factors for treatment interruption for patients with tuberculosis registering up until 2010.

Methods All patients diagnosed with tuberculosis at an inner London teaching hospital between 2000 and 2010 were included in the study. Outcomes were recorded, as defined by the requirements of the London TB Register. Follow-up of patients is predominantly nurse-led with little day-to-day involvement from doctors. Samples are sent to the National Mycobacterial Reference Laboratory

– Whitechapel, for culture and sensitivity testing with first line anti-tuberculous drugs. Sex, Age (Decade), HIV status, disease site (pulmonary or extra pulmonary) and resistance to any first line drug were evaluated to see whether they were associated with “lost to follow up”, as opposed to all other outcomes, using chi-square test for proportions.

Results One thousand two hundred and forty two patients were identified. Ten patients (1%) had MDRTB, 714 58% were male, 981 (79%) were born abroad, 160 (13%) aged 0–20 years, 679 (55%) 21–40 years, 279 22% (41–60), 124 10% > 60, 164 (13%) were known to be HIV, 596 (48%) had pulmonary disease 147 (18%) of 803 with positive cultures had any drug resistance. None of the variables assessed were significantly associated with being lost to follow up.

Discussion Our nurse led TB programme has resulted in outcomes that meet international standards. Less than 5% of patients interrupt treatment. The results would probably improve if we obtained treatment outcomes for those who transferred out. None of the variables examined should be used as indicators for enhanced supervision.

1. World Health Organization - Stop TB Partnership. The Stop TB Strategy, 2006.

P59 TREATMENT AND DRUG SURVEILLANCE OF LATENT TUBERCULOSIS INFECTIONS (LTBI) BY A TB PHARMACIST: A PILOT STUDY

doi:10.1136/thoraxjnl-2012-202678.200

YO Abunga, SO Brij, G Luwemba. *Peterborough City Hospital, Peterborough, United Kingdom*

Objectives To assess the safety and effectiveness of a pharmacist-led LTBI clinic.

Methods Patients identified by screening as having LTBI were seen by TB pharmacist at the weekly TB clinic. Initial interview included history of symptoms to exclude active TB. Baseline bloods were taken as well as a screen for blood borne viruses. Follow up appointments were scheduled at 2 weeks, one month and at the end of treatment. The TB pharmacist obtains written consent for therapy, dispenses medication and information leaflets regarding potential drug adverse effects. At follow-up appointments the pharmacist evaluates treatment adherence and potential adverse effects.

Results 62 latent TB patients were seen from 01/05/11 to 01/05/12. All patients were discussed at the TB-MDT. 51 (82%) patients were allocated to the pharmacist led clinic. The 11 (18%) patients seen by the Consultant Respiratory Physician had significant co-morbidities at initial interview, but subsequently were followed up by the pharmacist. Of the 51 patients, 50 started therapy and 1 patient did not attend the appointment. 9 (18%) patients reported adverse drug reaction. 46 (92%) patients successfully completed treatment, 3 (6%) patients did not complete therapy due to side effects and 1 (2%) patient was lost to follow up. The patient who did not attend subsequently developed active TB during the study period. Of the 9 adverse drug reactions reported, only 3 required treatment to be discontinued. No adverse drug reaction occurred due to drug interaction.

Conclusion A pharmacy-led clinic for LTBI is feasible and safe. Patients were happy to be seen by the pharmacist. Patients with poly-pharmacy benefited as they had a medication review to maximise therapy and reduce adverse drug reactions.

P60 HOW OFTEN DO PATIENTS WITH TUBERCULOSIS REQUIRE ENHANCED CASE MANAGEMENT?

doi:10.1136/thoraxjnl-2012-202678.201

A Gebril, C Bell, M Woodhead. *Central Manchester University Hospitals NHS Foundation Trust, Manchester, UK*