2009 and 2010 was unavailable as it was not stored electronically.

Results 385 patients were referred for MDT review from 2005 to 2008 (n = 167) and 2011 to 2013 (n = 218). Usual Interstitial Pneumonia (UIP) was the pre-MDT diagnosis in 144 (37%) cases. Post-MDT 71 (49%) individuals had their diagnosis altered, leading to a change of treatment in 37 (52%) cases. A further 3 patients were referred for biopsy. One individual died pre-MDT and therefore was not discussed.

Of the 68 cases referred with no diagnosis multidisciplinary consensus was reached in 60 (88%) cases. The remaining 172 were referred with a range of aetiologies.

Conclusion Our findings support ARS/ERS consensus guidelines[1] which strongly advise the implementation of multidisciplinary discussion in the care of the individual with interstitial lung disease.

REFERENCES

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S13 SOLE USE OF FORCED VITAL CAPACITY AS PER NATIONAL INSTITUTE OF HEALTH AND CARE EXCELLENCE CRITERIA DISADVANTAGE 2 IN 5 PEOPLE WITH IDIOPATHIC PULMONARY FIBROSIS

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Introduction Pirfenidone has undergone NICE approval and is recommended for patients with IPF if the FVC is 50–80% 1. We hypothesised that the NICE guidance would disadvantage a significant cohort of IPF patients who have moderate reduction in transfer factor despite preserved FVC.

Methods We retrospectively reassessed the eligibility of fifty IPF patients on the named patient programme using the NICE guidance. Electronic CT and clinical reports were analysed for the presence of coexisting emphysema.

Results Of fifty patients we identified that 20/50 (40%) would not have been prescribed pirfenidone as per the NICE criteria. The average FVC was significantly higher in the 20 patients that did not meet the NICE criteria compared to those that did (97.6 ± 16.24% vs. 65.48 ± 8.56% ($p < 0.001$) respectively. In contrast there was no difference in transfer factor between the two groups (42.35 ± 14.66% vs. 44.74 ± 12.29%) respectively.

The frequency of emphysema was statistically different between those that met the NICE criteria and those that did not (3 vs. 8 $p = 0.0409$). Of those patients that had an FVC greater than 80%, 12/20 (60%) had no emphysema visible on CT imaging and 2 (10%), 4 (20%) and 2 (10%) had evidence of mild, moderate and severe emphysema respectively. However, the average transfer factor was not significantly different between those with or without emphysema (35.75% vs. 46.75% respectively).

Conclusion This retrospective data demonstrates that the sole use of FVC in the NICE criteria for treating IPF disadvantages 40% of patients who demonstrate a significant reduction in transfer factor despite FVC greater than 80%. In this study this reduced transfer factor and preserved FVC can only be attributed to the presence of coexisting emphysema in 8/20 (40%) of patients. 60% of patients had IPF alone with FVC greater than 80% despite an average transfer factor of 47%, which was not statistically different to those with coexisting emphysema. We would therefore advocate the use of both FVC and DLCO when assessing patient suitability for pirfenidone treatment for IPF. The use of FVC alone excludes a substantial cohort of IPF patients who have preserved FVC, reduced DLCO with or without coexisting emphysema.

S14 FVC AS A SURROGATE MARKER FOR DEATH AND HOSPITALISATION IN IPF, SARCOID AND BRONCHIECTASIS CLINICAL TRIALS

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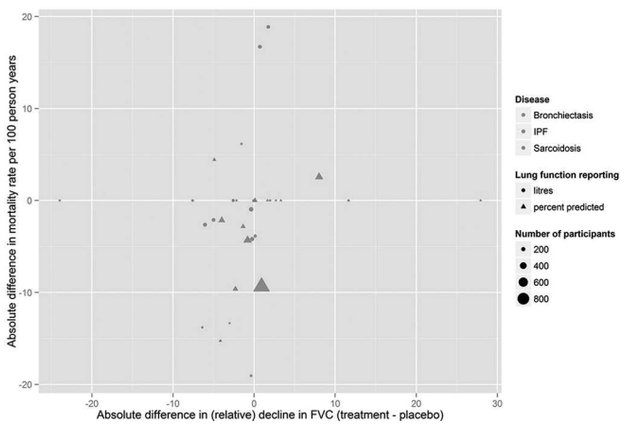
Introduction & Objectives Decline in Forced Vital Capacity (FVC) is predictive of mortality in IPF and is commonly used as an end-point in IPF clinical trials. FVC has not, however, been formally validated as a surrogate end-point for death or hospitalisation, making it difficult to interpret the clinical importance of differences in decline in FVC, and its use controversial. Change in FVC has also been used in other chronic lung diseases as a clinical trial end-point. The aim of this project was to determine if FVC is a surrogate end-point for mortality and/or hospitalisation in IPF, sarcoidosis and bronchiectasis trials. We also aimed to comment on the reporting of FVC in chronic lung disease trials.

Methods A systematic review was conducted. MEDLINE, EMBASE, LILACS and CENTRAL (1990-present) were searched on 25/03/2013. Reference lists and relevant journals (Jan-Apr 2013) were hand-searched, and experts in the field contacted to identify further studies. Only randomised controlled trials of drug interventions in adult participants with IPF, sarcoidosis and bronchiectasis were considered.

Results 42 studies were identified, 37 of which were included in linear regression analysis. All studies reported mortality, and 17 studies reported hospitalisation. No association was found between difference in annual decline in FVC and annual mortality or hospitalisation rate (see graph). It was frequently difficult to combine results across studies due to variation in measures reported, or due to insufficient detail in reports. 32 studies reported change in FVC: 24 studies reported absolute changes (e.g. 7.2% decline from 67.6% to 60.4%), 4 reported relative change (e.g. 7.1% decline from 70.7% to 65.7%), and one study reported both. Clarification of change type from authors was required for 16 studies.



Abstract S14 Figure 1.