the first 6 months were 11.0 ± 7.5 and 11.0 (6.0–13.5) days respectively for hospitalised patients and mean ± S.D. 1.2 ± 4.2 days for all patients. One patient was admitted to the Intensive Care Unit, for 5 days. Eighteen patients had IPF-related Accident and Emergency department visits, 3 had an IPF-related day-case and 67 outpatient clinic visits, with a mean of 2.1 ± 2.0 outpatient clinic visits per patient in the first 6 months of the observation period.

Conclusion IPF is a terminal disease associated with significant morbidity and mortality. This is reflected in the high level of resource use and frequent accessing of health care services by this severely ill cohort of patients. Whether resource use has been positively impacted by the introduction of pirfenidone is unknown but merits prospective assessment.

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P197 PHYSICAL INACTIVITY IN SARCOIDOSIS

S Vasudevan, M Maddocks, S Chamberlain, A Spinou, C Wood, C Jolley, SS Birring; *King's College London, London, United Kingdom*

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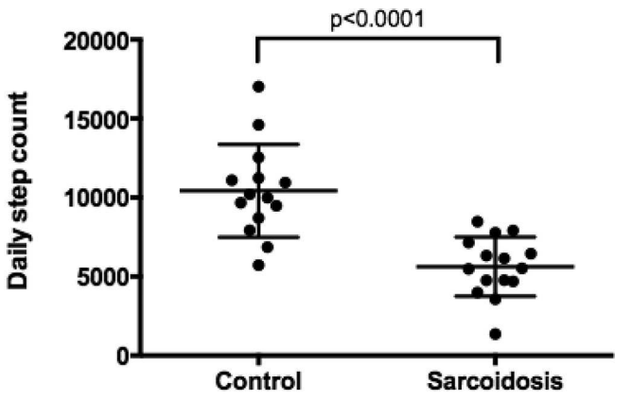
Introduction Sarcoidosis is associated with dyspnoea, arthralgia, fatigue and poor health status. Little is known about physical activity in sarcoidosis. This study aimed to: 1) objectively measure physical activity in patients with pulmonary sarcoidosis; 2) investigate the relationship between physical activity and fatigue, exercise capacity, health status and lung function.

Methods 15 pulmonary sarcoidosis patients (mean age: 52.7 years; 4 males) and 14 healthy controls (mean age: 46.5 years; 4 males) were recruited. Physical activity was assessed objectively over one week, using a validated tri-axial accelerometer- ActivPal™, and subjectively with the International Physical Activity Questionnaire (IPAQ). All participants also underwent pulmonary function tests, 6MWT and completed the Fatigue Assessment Scale (FAS), MRC Dyspnoea Scale and the King's Sarcoidosis QOL Questionnaire (KSQ).

Results Compared to controls, patients had lower mean ± SD daily step count (5624 ± 1875 steps vs. 10429 ± 2942 steps, $p < 0.01$, figure 1) and time spent stepping (1.18 ± 0.35 hr.day^{-1} vs. 1.97 ± 0.46 hr.day^{-1}; $p < 0.01$). There was also a trend to reduced bouts of activity in sarcoidosis patients compared with controls, (sit-stand transitions: 49 ± 15 vs. 61 ± 20; $p = 0.08$). Exercise capacity was significantly reduced in patients compared to controls (6MWT distance: 375 ± 59 m vs. 487 ± 92 m; $p < 0.01$). There was a significant association between daily step counts, and 6MWT distance, of patients ($r = 0.63$, $p = 0.01$). Physical activity (overall) reported subjectively was not significantly different between groups (Overall IPAQ median score: 2153 vs. 3230 MET.min.week-1; $p = 0.32$). However, 87% of patients reported doing no vigorous physical activity compared to 50% in controls (vigorous activity IPAQ; $p < 0.01$). There were no significant correlations between daily step count and fatigue, dyspnoea, health status, lung function and self reported physical activity (IPAQ).

Conclusion Physical activity is significantly reduced in sarcoidosis compared to healthy subjects. Objective measures of physical activity assess a unique dimension of health in the patient's own environment that is not captured by existing clinical tools and should be further investigated.



Abstract P197 Figure 1. Mean (SD) daily step count assessed with ActivPal.

P198 ESTABLISHING THE PALLIATIVE AND SUPPORTIVE CARE NEEDS OF PATIENTS WITH IDIOPATHIC PULMONARY FIBROSIS AND NON SPECIFIC INTERSTITIAL PNEUMONIA

[1]J Wall, [2]V Crosby, [2]A Hussain, [2]A Wilcock, [1]G Saini, [1]R Braybrooke, [1]G Jenkins; *[1]Nottingham Respiratory Research Unit, University of Nottingham, Nottingham, England; [2]Nottingham University Teaching Hospitals NHS Trust, Nottingham, England*

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Background Idiopathic Pulmonary Fibrosis (IPF) and Non Specific Interstitial Pneumonia (NSIP) are Idiopathic Interstitial Lung Diseases (ILD) without a known cure. IPF is progressive and fatal. Management of Idiopathic ILD must address patients' palliative and supportive care needs. The Sheffield Profile for Assessment and Referral to Care (SPARC©) questionnaire is a health needs assessment tool covering common biological, psychological and social needs. Local use of SPARC led to service refinements for thoracic cancer patients.

We now explore SPARC in patients with Idiopathic ILD to identify patients' perceptions of disease burden.

Methods Patients within 18 months of an Idiopathic ILD diagnosis, identified through specialist clinics, were invited to complete a SPARC questionnaire as part of an ongoing multicentre clinical study. Patients were excluded if concerns existed regarding ability to consent.

SPARC questionnaires included 45 questions: four (concerning personal, communication and information issues) required "yes/ no" responses. 41 questions related to symptoms and issues which were rated by patients as to the degree of distress they'd caused in the preceding month. Ratings were 0 "not at all", 1 "a little bit", 2 "quite a bit" and 3 "very much".

Responses were analysed using descriptive statistics. To highlight the most troubling issues, the percentage of patients reporting either "very much" or "quite a bit" of distress was identified for each question.

Results 97 patients with Idiopathic ILD (77 male) with median age 69 (range 47- 86) were included. 79 (81%) had IPF, 18 (19%) NSIP. 38 (39%) had severe lung function defects (TLCO <40%).

Table 1 shows the 20 most common issues reported to cause "quite a lot" or "very much" distress.

Conclusions and implications Symptoms causing highest levels of distress in the Idiopathic ILD group reflect the commonly observed 'fibrotic triad' of dyspnoea, fatigue and cough.