items were recorded. This trend appeared more marked specifically looking at GP referrals (20% vs 46%).

Conclusions This analysis of referrals would suggest that the quality of referral letters is linked to clinic outcome. Referrals containing very little information resulted in more patients being discharged directly from the clinic without investigation. Referral guidelines for general practice will hopefully improve the quality of referrals.

P251 PREVALENCE AND TREATMENT OUTCOME OF OBSTRUCTIVE SLEEP APNOEA (OSA) DIAGNOSED FOLLOWING PREOPERATIVE SCREENING COMPARED WITH GP OR OTHER CLINICIAN REFERRAL

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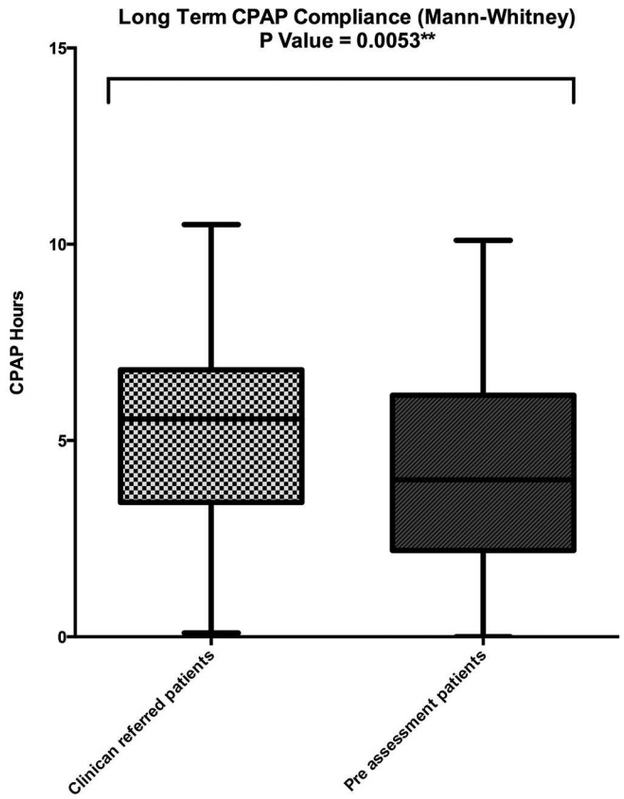
Introduction OSA is very prevalent and has potential implications perioperatively. Preoperative screening may identify high risk patients and treatment with CPAP may reduce perioperative complications, though this is unproven. We evaluated the treatment outcome and long term compliance with CPAP in patients diagnosed through preoperative screening and compared it with patients diagnosed with OSAS following GP or other clinician referral.

Method Over 2 years (October 2009–2011) 1412 patients (males-62%) had sleep studies (oximetry or respiratory variable). 44% were referred from the preassessment clinic following screening for possible OSA. The prevalence of sleep disordered breathing, the Epworth Sleepiness Score (ESS) and among those referred for a CPAP trial the outcome, long-term compliance and average use per night were compared between preassessment and clinician referred patients.



Abstract P251 Figure 1.

Results The prevalence of OSA was 62% and 58% in the clinician referred and preassessment patients respectively. There was a significant difference in age (61 +/-16 v/s 55 +/-13, P = <0.0001) and ESS (11 +/-6 v/s 8 +/-5, P = <0.0001) between the two groups. Clinician referred patients were more likely to be commenced on CPAP (P = <0.0001, OR- 2.79). Preassessment patients with mild OSA who were prescribed CPAP were more likely to fail the CPAP trial (P = 0.01, OR-3.02) and were less likely to continue CPAP treatment after one year (P = 0.02, OR-2.1). No difference was seen between the groups in patients with moderate or severe OSA. There was a significant difference in the median CPAP usage, 5.5 hours v/s 4 hours (Mann Whitney, P = 0.0053, figure-1). Both groups reported a significant improvement in ESS with CPAP (Δ ESS-5 and Δ ESS-4, P = <0.0001) between the clinician referred and preassessment patients respectively.

Conclusions The prevalence of OSA was similar in patients referred following preoperative screening or from another clinician, but preassessment patients were younger and less symptomatic. There was no difference in short or long term CPAP use in patients with moderate or severe OSA, but preassessment patients with mild OSA were less likely to use CPAP in the short or longer term. Opportunistic screening of patients awaiting surgery is worthwhile, independently of any effect of CPAP upon surgical outcomes.

P252 RESIDUAL DROWSINESS AND CPAP COMPLIANCE IN OSAS PATIENTS AND THE DVLA- ON BEHALF OF THE BRITISH THORACIC SOCIETY SLEEP APNOEA SAG

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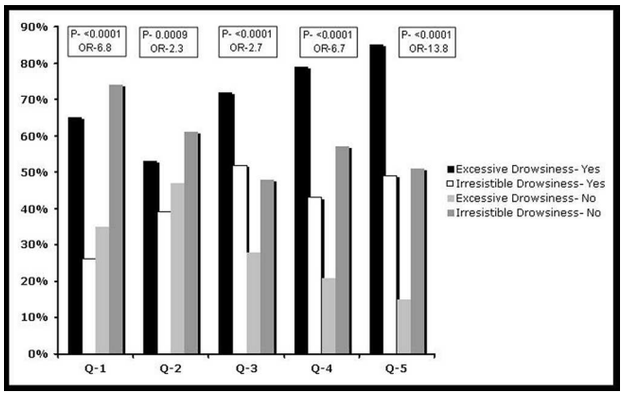
Introduction Clinicians are often asked to complete forms about patients with OSAS by the DVLA. We evaluated the current practice of assessing residual drowsiness, CPAP compliance and whether objective testing is undertaken by clinicians to assess an individual's fitness for driving.

Methods Clinicians who complete the DVLA medical forms (SL1 and SL1V) were invited to participate in a web-based survey. Respondents were presented with five vignettes of patients with OSAS offered CPAP and to answer the questions posed by the DVLA about residual drowsiness ("excessive" (SL1) or



Abstract P252 Figure 1.