Methods A retrospective analysis of case report forms of 140 (65 asthma and 75 COPD) patients who underwent research bronchoscopy at our centre since November 2010.
Results See Table 1 for details.

Baseline characteristics were the same among COPD and asthma patients who did and did not receive bronchodilators. There was no significant change in procedure tolerance, sedation used, complications or adverse events and samples obtained in patients who received pre-procedure bronchodilators. Mean volume of saline inserted for BAL during bronchoscopy was 414.3 ± 140.5 ml for asthmatics and 392.1 ± 123.5 ml for COPD patients.

Overall, serious complications were rare: 2 patients bled during the procedure requiring cold saline and adrenaline, 1 was observed for a few hours due to low saturations, 1 was admitted overnight for hypotension and 1 was admitted with pleuritic chest pain.

41 patients were symptom free at 24 hours and 85 were symptom free at 7 days. The most common mild symptom reported at 24 hours was sore throat, being reported by 50 patients; at 7 days 21 patients reported cough.
Conclusion Nebulised bronchodilators pre-bronchoscopy in patients with asthma or COPD appears to have little impact. Overall, research bronchoscopy with significant BAL in these patients appears relatively safe.

* The first 2 authors contributed equally to this work.

M16 STAFF-PATIENT PERCEPTION OF DISCOMFORT WITH FIBRE-OPTIC BRONCHOSCOPY-IS THERE A CORRELATION?

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Introduction Patient comfort and safety are crucial aspects of fiberoptic bronchoscopy. This is usually performed under sedation and at times it is tricky to judge the degree of sedation and patient comfort during the procedure.
Methods We conducted a prospective survey to assess patients' satisfaction with sedation and the overall experience during flexible bronchoscopy. This was a questionnaire based survey, wherein the patients' completed a questionnaire within 48 hours after the procedure. We advised them not to complete the questionnaire on the same day of the procedure to avoid bias due to the effects of sedatives used during procedure. The questions were scored on a 5-point Likert scale. The questionnaire included satisfaction regarding the procedure, staff professionalism, the endoscopy suite, perception of adequacy of sedation, technical ability of the interventionalist, and post procedure care. Nursing staff were requested to record their perception of the degree of sedation and patient discomfort. Correlation between patients perception of discomfort/pain were compared with the staff perception.
Results 52 patients completed the questionnaire over a 3 month period. 33/52 (63.7%) experienced pain/discomfort during the procedure. 73.1% felt sufficient steps were taken to reduce the pain/discomfort. 46 (88.4%) of patients' disclosed that they did not mind to have a repeat procedure if needed. While there was poor correlation between the protocol of sedation used and patient comfort, there was a significant correlation between the staff perception of adequacy of sedation with the patients perception ($p = 0.0007$).
Conclusion Regular patient surveys would give us an idea about the sedation practices we employ for bronchoscopy. As staffs perception significantly correlates with patients' pain/discomfort this can be a valuable tool in judging the sedation requirements especially in a partly sedated patient.

M17 SURVEY ASSESSING METHODS OF VOCAL CORD ANAESTHESIA DURING BRONCHOSCOPY

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Introduction To anaesthetise the vocal cords during bronchoscopy there are 2 methods in general use, transcricoid lidocaine or lidocaine administered directly through the bronchoscope (direct vision). The choice between the two methods is down to individual operator choice and there has been little work comparing each method. We performed a survey assessing several aspects of bronchoscopy to see if there was a difference between the 2 approaches.
Methods The bronchoscopist (one of three consultants and two registrars) and two nurses assessed patients degree of coughing, choking, sedation and overall tolerance of the procedure using a 10-point visual analogue scale. All patients were given 2–4 mg of midazolam as a sedative as is normal practice in our trust. Method of local anaesthesias and outcome of the bronchoscopy were noted. Results were analysed with a paired t test.
Results 33 patients were assessed, 14 patients had direct vision lidocaine and 19 had transcricoid lidocaine. 2 of the procedures were abandoned due to patient's intolerance (both in the direct vision group). There was a significant reduction in coughing (3.5 vs. 5.7 p value 0.009) choking (1.9 vs. 3.9 p 0.004) and overall tolerance was better in the transcricoid group (8.0 vs. 5.6 p 0.003). There was no difference in the degree of sedation (5.4 vs. 4.9 p 0.4). There was no significant difference in the amount of successful biopsies performed in each group. There was no difference in the amount of midazolam given to each group (2.65mg vs. 2.68mg) and the differences were preserved despite the individual bronchoscopist.
Conclusions In this small pilot study The transcricoid group coughed and choked less and tolerated the procedure better in this survey. There was no difference between the groups in terms of sedation, total midazolam dosage or operator suggesting that this difference may due to the differing methods of local anaesthesia. A previous patient survey in our trust has shown patients themselves tolerated the transcricoid approach well. Further studies are needed to fully assess the differences between these two approaches and inform further practice.

COPD: a clinical spectrum

M18 THE RELATIONSHIP BETWEEN ANXIETY AND DEPRESSION TO EXACERBATIONS OF COPD RESULTING IN HOSPITAL ADMISSIONS; A NARRATIVE SYSTEMATIC REVIEW

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