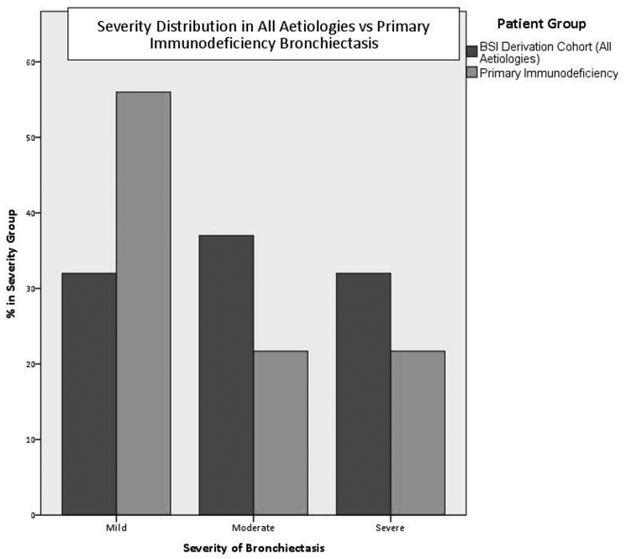

Abstract P79 Figure 1 Severity Distribution in all aetiologies vs primary immunodeficiency bronchiectasis

REFERENCE

1 Hurst JR *et al*. Activity, severity and impact of respiratory disease in primary antibody deficiency syndromes. J C Immunol 2014;34:68–75
2 Chalmers JD *et al*. The bronchiectasis severity index. An international derivation and validation study. Am J RCCM 2014;189:576–585

P80 CHARACTERISATION OF THE EQ-5D-5L AND EXERCISE PERFORMANCE IN BRONCHIECTASIS

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Introduction and objectives NHS England have been looking at using the EQ-5D-5L as a measure of health outcome across the NHS. It is a simple measure which patients complete at the start and end of treatment to evaluate quality and effectiveness of interventions. To date there is no evidence on its use in Bronchiectasis (Bx). Moreover, evaluation of exercise performance is also vital as this can be associated with increased dyspnoea, reduced lung function or increased malaise. Sit to stand (5STS) and six minute walk test (6MWT) can be used to evaluate exercise performance but there is limited guidance on responsiveness and feasibility in Bx. This abstract provides novel data for these outcome measures (OM) in Bx patients during a routine inpatient stay.

Methods 20 Bx inpatients (Male: Female 20:20, Median age: 63 (29–74) Median FEV_1: 1.26 (0.51–2.9) were assessed. 6MWT, 5STS and EQ-5D-5L were completed on all patients during their initial and final assessment.

Results Median length of stay was 10 days. Data is presented as median difference and comparisons were made using Wilcoxon Signed Rank tests.

Conclusion The EQ-5D-5L improved but did not show a significant difference, moreover there is currently no reported MCID for this OM. Significant differences were seen in both the 6MWT and 5STS. The 5STS is quick and feasible to complete and therefore maybe more preferable to use than the 6MWT. More understanding is needed on the utility of the EQ-5D-5L in this population.

Abstract P80 Table 1 Outcome measures completed on Bx inpatients on admission and discharge

	Pre	Post	Median difference (MD)	Significance level	MCID
6MWT (m)	310	360	50	0.028	35
STS (seconds)	12.53	10.40	-2.13	0.019	-1.7
EQ-5D-5L	65.9%	75.8%	9.8%	0.508	Not known

Minimal clinically important difference (MCID)

REFERENCES

1 Pasteur *et al*. 2010 'BTS Guidelines for non-CF Bronchiectasis'
2 EQ-5D-5L (www.euroquol.org)

P81 THE INCREASING SECONDARY CARE BURDEN OF BRONCHIECTASIS IN ENGLAND

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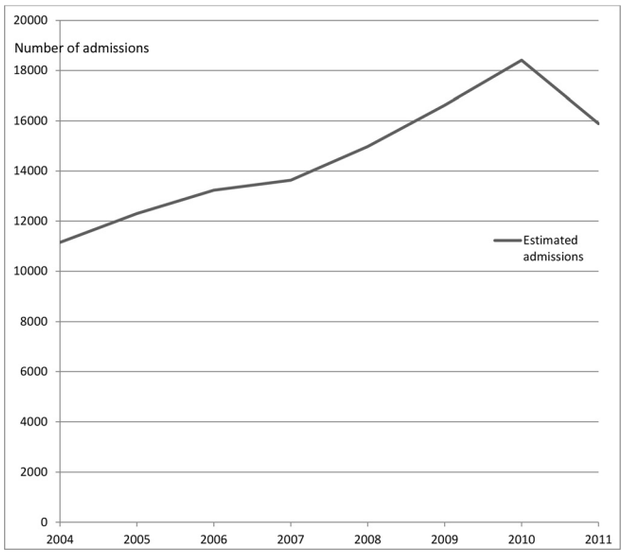
Background A recent study suggested that the bronchiectasis is now a relatively common condition in the UK.[1] The healthcare burden of bronchiectasis on secondary care, in terms of hospital admissions is also unknown, yet is essential for allocation of healthcare resources and planning of service pathways. We used data from Hospital Episode Statistics (HES) to determine age standardised annual hospital admission rates in England.

Methods We obtained annual number of hospital admissions (finished consultant episodes), total number of bed days and mean age at time of admission where bronchiectasis was the primary reason for admission for all hospital trusts in England. The ONS mid-year England population for 2011 was used as the standard population. Age specific admission rates for bronchiectasis were calculated for each year and these rates were applied to the 2011 population in order to generate annual standardised estimated number of admissions. An estimate of the average



Abstract P81 Figure 1 Hospital admissions from bronchiectasis in England from 2004–2011