

Abstract P182 Table 1

	Inpatient	Elective outpatient	Missing data
Indication for IPC:			
Lung cancer	5	16	
Mesothelioma	7	14	
Other cancer	26	22	
Benign or unknown	1	6	1
Number of IPCs	43	59	
IPC: number removed	10 (23%)	17 (29%)	3 drain still <i>in situ</i> , 1 displaced
Removed due to spontaneous pleurodesis	3 (7%)	5 (8%)	
Median days <i>in situ</i> until removal (range)	97.5 (3–168)	92.5 (22–340)	1 unknown
IPC <i>in situ</i> at time of death	31 (72%)	35 (59%)	5 lost to follow up
Median days <i>in situ</i> until death (range)	22 (7–317)	79 (2–346)	

Conclusion The TIME2 cost analysis was based on a median stay of 0 nights which has been replicated in our hospital this year. The optimisation of community support and increasing confidence with the procedure led to reductions in inpatient stays.

The rate of IPC removal was substantially less common in our cohort and the indication for removal was often not due to spontaneous pleurodesis alone unlike the TIME2 trial. Indications for removal included infection, pain and blockage as well as pleurodesis. The data from our centre did not exclude any patients, including those who died, and the follow up period often continued beyond 6 months.

Some large differences exist between the TIME2 trial data and our cohort. While this could reflect a different patient population and setting, it could also highlight differences in outcomes between controlled clinical trials and day-to-day practice.

REFERENCE

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TB: non pulmonary and hepatotoxicity

P183 ENDOBRONCHIAL ULTRASOUND AND TUBERCULOSIS: BEWARE THE NON-CASEATING GRANULOMA

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Introduction Endobronchial ultrasound-guided transbronchial needle aspiration (EBUS-TBNA) is now the standard of care for investigating intra-thoracic lymphadenopathy. Although well validated in malignancy and sarcoidosis, the literature for intra-thoracic tuberculous lymphadenitis is limited. Previous work from neighbouring London boroughs reported a sensitivity (histology or microbiology consistent with tuberculosis (TB)) for TB of 94% with positive TB culture in 47% of 156 patients

Methods We examined retrospectively all EBUS-TBNA procedures performed at a London district general hospital between April 2010 and January 2014. Patients were referred to our EBUS service from our own hospital and two local centres. All patients were assessed clinically prior to the procedure and

underwent a CT scan. Bronchoscopy reporting software was used to identify all EBUS procedures. Patient notes, clinic letters, electronic patient records and the London TB Register (LTBR) were used to obtain clinical information then matched with pathological and microbiological results. All patients were followed up for a minimum of 6 months.

Results 363 patients were included. The overall sample yield (either lymph node or tumour identified) was 94%. 63 cases of tuberculosis were identified and EBUS-TBNA had been diagnostic in 57 (90%). Pathological findings were consistent with TB in 84% of cases and culture was positive in 62%. Culture identified 5 cases of drug resistance. Where caseating granulomas were identified, 18/25 cases were culture positive and 15/23 where non-caseating granulomas were identified ($p = 0.76$). In addition, where necrotic material was obtained 3/5 samples were culture positive and where reactive lymph nodes were identified 4/9 samples were culture positive.

Conclusion EBUS-TBNA is a useful tool in the investigation of intra-thoracic tuberculous lymphadenitis. We show the possibility of achieving higher culture positivity from that reported in the literature. It highlights the importance of the TB culture for definitive diagnosis and detecting drug resistance. It is important to examine these findings in the context of appropriate clinical information and investigations.

P184 FEMALE GENITAL TUBERCULOSIS: THE LONG ROAD TO DIAGNOSIS

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Introduction Female genital tuberculosis (TB) is rarely encountered in the UK but early diagnosis and treatment can prevent significant morbidity.

Methods We conducted a retrospective study of all patients treated at our institution for female genital TB between 2004 and 2014. Data including demographics, symptoms, microbiological and histological diagnoses and treatment outcomes were recorded.

Results 10 cases of female genital TB were identified. These account for approximately 0.71% of our TB cases, giving a local incidence of female genital TB of approximately 0.5/100,000 population. Mean age was 37.9 +/-14.3. Five patients were from Bangladesh, two from India and one from Pakistan, Cyprus and Somalia. Mean duration of symptoms prior to diagnosis was 24.3 months, range: 0–84. Presenting symptoms included infertility (50%), menorrhagia (10%), amenorrhoea (20%), irregular menstrual bleeding (40%), dyspareunia (20%), vaginal discharge (10%), post coital bleeding (10%) and lower abdominal pain (50%). Patients also experienced fevers (30%), night sweats (10%) and weight loss (10%). All patients had either a laparoscopy or hysteroscopy with biopsy of the endometrium in nine cases and the ovary in one case. Seven cases were found to have necrotising granuloma on biopsy of which two were positive for Ziehl-Neelson (ZN) staining, two were negative and three were not performed. Non-necrotising granuloma was seen in one case and histology was unrecorded for two cases but PCR was positive in both these biopsies. Samples were sent for culture in three cases and all had fully sensitive TB. All cases were treated with standard TB treatment. In two cases treatment is ongoing. One patient died from a co-existing condition. Seven patients completed treatment, of which four had full symptom