

Abstract P186 Table 1 Comparison between symptomatic and asymptomatic groups from EBUS culture positive subcohort

	Symptomatic (n = 19)	Asymptomatic (n = 8)	P-value
Gender (M:F)	68.4% : 31.6%	50% : 50%	0.42
Age (mean ± SD) (years)	35.58 ± 12.81	46.0 ± 17.97	0.12
Ethnicity			0.81
White	15.79%	25%	
Black-African	26.32%	37.5%	
Indian	31.58%	25%	
Born in UK			0.53
Y	5.26%	12.5%	
N	89.47%	87.5%	
U	5.26%	0%	
Duration in UK (median; IQR)	12 (4–19.5)	2 (1–6)	0.01*
Exposures			
Diabetes	0%	14.29%	0.33
HIV	5.26%	0%	0.75
Travel endemic	68.42%	42.86%	0.23
Smoking	13.33%	14.29%	1.00
TB contact	37.5%	33.33%	1.00
Disease sites			0.01*
Pulmonary	47.37%	0%	
Pleural	5.26%	0%	
ETLN	26.32%	0%	
Skin	0%	12.5%	
Eye	5.26%	12.5%	
% Isolated	31.58%	62.5%	0.03*
% Pulm + ITLN	47.37%	0%	
% EPTB (excl skin & eye)	42.11%	12.5%	
% Hypersens TB	5.26%	25%	
Cytology			0.01*
Granulomatous w/ caseation	52.63%	0%	
Granulomatous w/o caseation	26.32%	75%	

based on clinical severity, disease phenotype and diagnostic and radiological findings. Host response in the lymph nodes is reflected by both symptom manifestation and disease dissemination, implicating the lymph nodes in a critical role in the natural history of TB infection. Finally, a subclinical phenotype was identified, suggesting an early stage of disease progression in TB.

P187 THE USE OF MOXIFLOXACIN FOR THE TREATMENT OF OPHTHALMIC TUBERCULOSIS

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10.1136/thoraxjnl-2014-206260.316

Background The number of patients we are treating for ophthalmic tuberculosis (TB) have increased year on year, from two in 2009 to twenty in 2013. A recent global review of the strategies used in the diagnosis and treatment of ophthalmic TB showed a wide disparity of diagnostic and treatment strategies. We present a review of our current practice and justification for our treatment regimens.

Methods We identified all the cases in our hospital treated for ophthalmic TB between 2009 and 2013. Age, gender, ophthalmic examination findings, blood tests, treatment regimens, including durations and outcomes, and adverse drug reactions were collected and analysed.

Results A total of 60 cases were identified. Mean age was 45.0 +/- 14.4 years. 61.7% were male. The most commonly used regimen was 2 months rifampicin, isoniazid, pyrazinamide and moxifloxacin followed by 10 months of rifampicin, isoniazid and moxifloxacin. A response to treatment, with no evidence of disease recurrence on cessation of therapy, was seen in 78.3% of cases. 5% experienced hepatotoxicity requiring a change in treatment. There was no significant difference in either the success of treatment (p = 0.102) or the risk of hepatotoxicity (p = 0.264) between regimens with moxifloxacin (n = 43) or without it (n = 17). 32 patients on moxifloxacin had ECGs of which 6

(18.8%) newly developed a raised QTc. This resulted in moxifloxacin being stopped during the step-down phase of treatment in two patients. Maximum QTc was never found to be above 500 milliseconds and there were no episodes of documented arrhythmias or syncope.

Conclusions We recommend a treatment regimen including moxifloxacin in place of ethambutol so that any reported visual change is unlikely to be related to treatment, and we propose continuing moxifloxacin beyond the intensive phase, if tolerated, when culture is unavailable. We treat ophthalmic TB for the same duration as central nervous system TB. Our data shows that this is a safe and effective regimen but more evidence is required before recommending definitive guidelines.

P188 INCREASED PULMONARY M. AVIUM-INTRACELLULARE ISOLATES ACCOUNT FOR MUCH OF THE NATIONAL RISE IN NON-TUBERCULOUS MYCOBACTERIA INCIDENCE, 2007–2012

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10.1136/thoraxjnl-2014-206260.317

Introduction The incidence of nontuberculous mycobacteria (NTM) isolation from humans is increasing worldwide. In England, Wales and Northern Ireland (EW and NI) the reported rate of NTM more than doubled between 1996 and 2006. It is unclear if this trend has continued. We present an updated analysis with national NTM data from 2007 to 2012.

Methods All individuals with culture positive NTM isolates between 2007–2012 reported to Public Health England by the five mycobacterial reference laboratories serving EW and NI, were included. The annual incidence of NTM was calculated based on the year of the first positive NTM isolate from each individual.

Results 21,024 individuals had NTM culture positive samples. Over the study period the incidence rose from 5.57 (n = 3126) to 7.63 (n = 4454) per 100,000 population. The majority were male (57%) and older (71% >50 years of age). 77% of individuals had a pulmonary isolate – and here the incidence increased from 3.97 to 6.05 per 100,000 population between 2007 and 2012. In those with extra-pulmonary samples it remained stable at 1.61 per 100,000 population. In patients

Table 1 indicates the seven most frequently reported organisms; *M. avium-intracellulare* (MAI) accounted for 35% of isolates (75% in people >50 years). 78% of these were from pulmonary samples. 42% of *M. abscessus* isolates were in patients 60 years.

Abstract P188 Table 1 Most common NTM reported from total samples 2007–2012

Organism	Total number of samples 2007–12	2007 incidence (per 100,000 population)	2012 incidence (per 100,000 incidence)
<i>M. avium-intracellulare</i>	7400	1.90	2.80
<i>M. gordonae</i>	3373	0.74	1.38
<i>M. chelonae</i>	2318	0.60	0.9
<i>M. fortuitum</i>	1681	0.47	0.58
<i>M. kansasii</i>	1299	0.42	0.29
<i>M. xenopi</i>	1065	0.34	0.34
<i>M. abscessus</i>	986	0.26	0.38