Abstract M266 Table 1 Top '5' rankings from rounds 1 and 2 in the Nominal Group

Descriptor	R1	R2	Descriptor	R1	R2
Abandonment*			Planning analysing		
Chest Pain*			Relationships with others		
Control*			Sexual Relationships		
Cough			Shortness of breath	1	2
Energy Level	5		Sleep		
Fatigue*			Spirituality		
GORD			Therapies for IPF		
Level of independence		5	Uncertainty*		5
Mental & emotional wellbeing	2	3	Wheeze		
Mortality	2	1	Impact on Physical State		
Nausea*			Impact on Psychological health	4	3
Oxygen Therapy*			Impact on Social participation		
Perception by others*			Impact on Finances		
Phlegm - expectorating *			Impact of Chest Trouble on work		

*Key descriptors defined by focus group participants (n=9) added in Round 2

Discussion This methodological approach to item generation will enhance the content validity of the IPF-PROM instrument. Items generated to date will be modified further by 80 patients from 4 UK centres and 20 ILD physicians participating in 3 rounds of a Qualtrics Delphi survey. This study is ongoing.

1 http://www.fda.gov/downloads/Drugs/Guidances/UCM193282.pdf

M267 HEALTH STATUS AND QUALITY OF LIFE IN IDIOPATHIC PULMONARY FIBROSIS AND SARCOIDOSIS: EFFECT OF FATIGUE

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Introduction and Objective Sarcoidosis and Idiopathic Pulmonary Fibrosis (IPF) are two common forms of interstitial lung disease. Sarcoidosis frequently causes extra-pulmonary disease whereas IPF specifically affects the lungs. Fatigue is a common feature of sarcoidosis, but an association between fatigue and IPF has not been investigated. We investigated the frequency and severity of fatigue in sarcoidosis and IPF, how it correlates with quality of life (QOL) scores, and whether fatigue is affected by disease severity.

Methods This was a cross-sectional questionnaire study of patients with sarcoidosis and IPF. Questionnaire data was analysed to investigate health status, QOL, and symptom prevalence (fatigue, depression and sleepiness). Comparison of scores between groups, and an analysis of the effect of markers of disease severity on fatigue, was undertaken.

Results Questionnaires were administered to 235 participants; 82 healthy volunteers, 76 sarcoidosis patients and 77 IPF patients. IPF patients had statistically higher St George's Respiratory Questionnaire ($p = 0.034$) and Epworth Sleepiness Scale scores ($p = 0.003$) than sarcoidosis patients, but there was no difference in mean fatigue scores. When stratified by questionnaire scores (Table 1), including pathological fatigue levels, no statistical difference was seen between IPF and sarcoidosis, although there was a trend towards a higher frequency of 'severe fatigue' in sarcoidosis. Fatigue scores correlated strongly with quality of life scores (King's Brief Interstitial Lung Disease score and St George's Respiratory Questionnaire) in both IPF (r=-0.615 and 0.659 respectively) and sarcoidosis (r=-0.529 and 0.502). In sarcoidosis, no measures of dyspnoea or disease severity (spirometry abnormality, immunosuppression use or extrapulmonary disease) were associated with fatigue scores. In IPF increasing dyspnoea scores were associated with increased fatigue scores ($p < 0.001$).

Conclusions Both sarcoidosis and IPF patients suffer with high levels of fatigue, although the sarcoidosis cohort showed a trend towards greater frequency of severe fatigue compared with IPF. In IPF patients increasing fatigue was associated with worsening dyspnoea, suggesting an association with disease progression, but no similar relationship was seen in sarcoidosis. This suggests that fatigue in sarcoidosis occurs independently of common markers of disease activity, whereas it occurs as a sequelae of progressive disease in IPF.

Abstract M267 Table 1 Prevalence of Anxiety, depression, sleepiness and fatigue symptoms

		Healthy Volunteers	Sarcoidosis	IPF
HADS-A – Anxiety	Normal (%)	73 (89.0)	42 (60.9)	54 (71.4)
	Mild (%)	5 (6.1)	18 (26.1)	14 (18.2)
	Moderate (%)	3 (36.6)	8 (11.6)	6 (7.8)
	Severe (%)	1 (1.2)	1 (1.4)	2 (2.6)
HADS-D - Depression	Normal (%)	78 (95.1)	51 (73.9)	63 (82.9)
	Mild (%)	3 (36.6)	10 (14.5)	3 (3.9)
	Moderate (%)	1 (1.2)	5 (7.2)	8 (10.6)
	Severe (%)	0 (0)	3 (4.3)	2 (2.6)
Epworth Sleepiness Scale	No sleepiness (%)	66 (85.7)	47 (67.1)	52 (85.2)
	Borderline (%)	7 (9.1)	19(27.1)	7 (11.5)
	Severe Sleepiness (%)	4 (5.2)	4 (5.7)	2 (3.3)
Fatigue Assessment Scale	Normal (%)	74 (91.4)	34 (49.3)	40 (54.8)
	Fatigued (%)	5 (6.2)	27 (39.1)	30 (41.1)
	Severe Fatigue (%)	2 (2.4)	8 (11.6)	3 (4.1)

†Due to incomplete responses for some questionnaires there are fewer patients stratified by depression, anxiety, sleepiness and fatigue than were enrolled.

M268 THE IPF DIAGNOSIS – COMMUNICATING A LIFE SENTENCE

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Background The aim was to explore the patients' emotional experience of receiving a diagnosis of IPF.

Methods Market research was conducted with an independent agency. Patients with IPF were asked to record a personal account of their experience on a hand-held camera. Face to face interviews with patients were conducted in their home. Carers were also interviewed to add an alternative perspective.

Results The sample included 13 male and 3 female patients with IPF. Patients with lung function impairment of all severities were included, five patients were treated with oxygen therapy and another had received a lung transplant. There was a national spread geographically throughout England.

There is a fine balance to providing information and patients can benefit from an individually tailored approach. Too much information at the start can be overwhelming. Too little information can leave the individual uncertain about how to deal with their future.

Gaps that were identified focused on the practicalities of living with IPF, including social care. There was a high expectation for their physician to explain the trigger for developing IPF. Patients felt a blame culture exists, whereby others felt that IPF is self-inflicted, like COPD, particularly when a patient was