valuable for stratification in clinical trials and for identifying individuals in a higher risk group for intensified treatment.

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P203 WITHDRAWN: A DESCRIPTION OF IMMUNOLOGICAL AND SPECIFIC ANTIBODY PROFILE IN A COHORT OF NON-CF BRONCHIECTASIS PATIENTS

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P204 RISK FACTORS FOR REQUIRING INTRAVENOUS ANTIBIOTIC THERAPY DELIVERED IN HOSPITAL FOR EXACERBATIONS OF BRONCHIECTASIS

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10.1136/thoraxjnl-2015-207770.340

Introduction Recurrent exacerbations requiring IV antibiotic therapy are a feature of advanced bronchiectasis. Our group has previously established the safety and efficacy of domiciliary antibiotic therapy compared to inpatient hospital treatment for exacerbations of bronchiectasis. In this study we aimed to identify factors at presentation that could predict the requirement for inpatient antibiotic therapy compared to domiciliary antibiotic therapy.

Methods We assessed the management of bronchiectasis exacerbations referred to a specialist respiratory unit over a 1-year period (April 2013 to 2014). All patients received 10 to 14 days of IV antibiotic therapy and were assessed at the beginning and end of their treatment course. We assessed demographic data, treatment outcomes, morbidity, mortality and 30-day readmission rates. Logistic regression analysis was performed to identify factors predictive of the treatment modality used.

Results A total of 72 patients were treated with 131 courses of IV antibiotic therapy. Thirty-six cases (27.5%) were managed as inpatients, 20 cases (15.2%) required initial admission and subsequently received early supported discharges (ESD) to complete IV antibiotic therapy at home and 75 cases (57.2%) received domiciliary IV antibiotics.

Logistic regression showed that Charlson Co-morbidity Index was independently predictive of the requirement for inpatient antibiotic therapy ($p = 0.03$). White Cell Count at presentation was also positively associated with the requirement for inpatient antibiotic therapy approaching statistical significance ($p = 0.05$).

There were no mortalities in the ESD or domiciliary antibiotic groups but 2 mortalities (5.6%) were noted in the inpatient group (Table 1). Morbidity in the inpatient, ESD and domiciliary antibiotic groups were 8.3%, 5.0% and 2.9% respectively ($p = 0.40$). The median length of stay before early supported discharge was 7 (interquartile range 7 – 9) days. Thirty-day readmission rates were 11.1%, 25.0% and 2.7% respectively (2×3 Chi-square; $p < 0.05$). Total bed days saved from ESD and domiciliary antibiotic therapy was 1153 days (interquartile range 9–14).

Conclusions Our study has demonstrated that the Charlson Co-morbidity Index is the independent risk factor that predicts the need for inpatient intravenous antibiotic therapy in exacerbations of bronchiectasis. Those patients that received domiciliary treatment received it safely.

Abstract P204 Table 1 Biochemical indices, Morbidity, Mortality and 30-day readmission between treatment groups

	Inpatient (n = 36)	Early supported discharge (n = 20)	Domiciliary (n = 75)
WCC (Median)			
Pre	9.6	12.5	8.1
Post	8.3	7.8	7.1
CRP (Median)			
Pre	21	34.5	13.5
Post	10	9	5
ESR (Median)			
Pre	29	50	26
Post	28	32	18.5
Morbidity	8.3% (3)	5% (1)	2.9% (2)
Mortality	5.6% (2)	0	0
Access related complications	2.8% (1)	5% (1)	1.3% (1)
Anaphylaxis	0	0	0
Readmission within 30 days	11.1% (4)	25% (5)	2.7% (2)

P205 ADMISSION TRENDS AND OUTCOMES OF INDIVIDUALS WITH BRONCHIECTASIS ADMITTED TO ADULT GENERAL CRITICAL CARE UNITS IN ENGLAND, WALES AND NORTHERN IRELAND

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10.1136/thoraxjnl-2015-207770.341

Introduction Whilst studies suggest increasing incidence and mortality from bronchiectasis in UK, there are sparse data on outcomes of individuals with bronchiectasis admitted to intensive care (ICU). We investigated trends in bronchiectasis admissions to ICU and estimated outcomes in patients with bronchiectasis admitted to ICU compared to a better studied group, i.e. Chronic Obstructive Pulmonary Disease (COPD).

Methods We used data from the Intensive Care National Audit and Research Centre (ICNARC), a database of patient outcomes from adult critical care units across England, Wales and Northern Ireland. 95% of adult critical care units contribute data to ICNARC which includes information from 1.5 million individuals. Admissions from bronchiectasis and COPD from 1/1/2009 to 31/12/2013 were extracted. Bronchiectasis admissions included patients whose primary or secondary reason for admission was exacerbation of bronchiectasis, excluding people with cystic fibrosis. COPD admissions were those whose primary or secondary reason for admission was either COPD with acute lower respiratory infection; or COPD with acute exacerbation. Patients with COPD-bronchiectasis overlap were excluded. ICU mortality was defined as status on leaving ICU.

Results There were 614,352 admissions across 219 critical care units during the study period, 536 (0.1%) of which were from