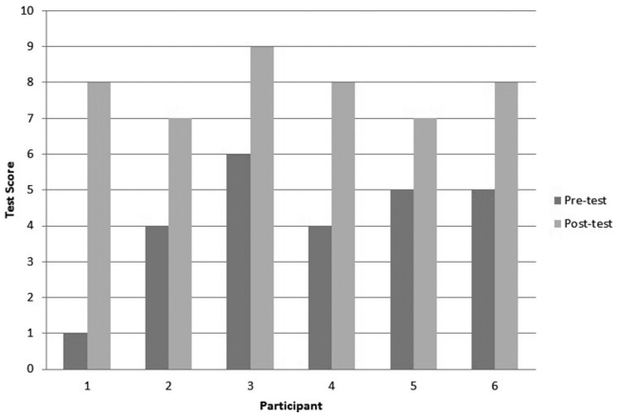

Abstract M25 Figure 1

(PaO_2 = 84.9 mmHg), caused mild hypercapnia ($PaCO_2$ = 49.6 mmHg) and the blood pH was normal (pH = 7.37). 100% oxygen enabled better arterial oxygenation (PaO_2 = 129.3 mmHg) but caused severe hypercapnia ($PaCO_2$ = 100.9 mmHg) and acidosis (pH = 6.98). Preclinical medical students were randomly allocated to simulation or lecture-based learning (the study has a crossover design) and were taught the correct use of oxygen administration. A greater proportion of students rated they had an excellent understanding of the key learning points after simulation (100%) compared to the lecture- based learning (33%) and it was sufficient to significantly improve test scores (p = 0.0135). Simulation could be used to educate future health professionals in using 28% oxygen to reduce the risk of hypercapnic respiratory acidosis in AECOPD.

M26 TWEETING IS TEACHING - #RESPED: FREE, OPEN-ACCESS TWITTER EDUCATIONAL RESOURCE FOR TRAINEES AND SPECIALISTS IN RESPIRATORY MEDICINE

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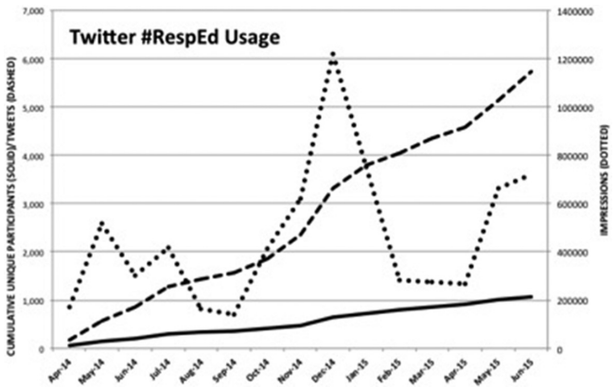
Introduction Social media use in medical education is expanding rapidly, bringing with it a novel means of learner engagement, feedback, collaboration and professional development.[1] A growing body of respiratory specialists and trainees are now engaging in such activities via Twitter.[2] We describe one of the commonest dedicated Respiratory 'Hashtags' ("#RespEd") where content related to evidence-based medicine (EBM), e-learning and collaboration is curated.

Methods "#RespEd" tweets were reviewed for usage statistics since 01/01/2013 using www. Symplur.com with more detailed review of monthly analytics since 01/04/2014. All "#RespEd" tweets were downloaded from Twitter and Symplur. Transcripts were reviewed for content using Microsoft Excel. A review of related hastags identified through Symplur was conducted to assess reach across Respiratory hashtags in a similar timeframe.

Results The "#RespEd hashtag" was first used in January 2013. Since this time, Symplur identified 1,099 participants and 5,973 tweets. Audience 'reach' was recorded as 7,384,722 impressions. A steady increase in users has evolved in the last 18 months with clear peaks in activity around the BTS Summer and Winter meetings. Participants included a wide range of professionals including doctors, nursing staff, pharmacists, physiotherapists, patients and representatives of societies and mainstream respiratory journals. Users were from numerous countries. Common content included evidence-based medicine (e.g. recently published articles), e-learning resources and 'live-tweets' from training days, which were usually picture tweets of lecturers slides. Other established respiratory hashtags included (participants): #ATS2015 (2,812), #ERS2014 (2,179), #Pulmcc (1,927), #BTSWinter (487).

Conclusions Twitter represents an untapped respiratory educational resource, which is truly multi-disciplinary and breaks boundaries between professional groups. The BTS conferences have provided a clear platform to broaden this resource. There is an opportunity to reach out to trainees and others seeking continuing professional development and provide both reliable resources and a 'place' to foster debate and discourse on topical respiratory themes.



Abstract M26 Figure 1

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M27 WHEEZES, COUGHS AND SPLUTTERS: HOW DO PAEDIATRIC TRAINEES MANAGE THEM?

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Introduction and objectives Wheezy pre-school children frequently present to paediatric departments. There is a wide variation in how paediatric trainees investigate and manage these children, which can be associated with unnecessary costs to the NHS. Our aim was to assess this diversity in management options initiated by paediatric trainees.

Methods Web-based survey on how paediatric trainees approach scenarios of wheezy pre-school children. Trainees across the UK were asked to fill in a questionnaire consisting of four case scenarios involving wheezy children under the age of 5.

Results 194 trainees responded to the survey. There was a good representation amongst different training grades across UK deaneries. In the bronchiolitis scenario, 13% requested blood tests or

a chest x-ray, whilst 27% of trainees stated they would not investigate further. Treatment options included oxygen, salbutamol, ipratropium, 0.9% saline drops or nebulisers, 3% saline nebulisers or not doing anything at all.

It appears that trainees are less confident at differentiating episodic viral wheeze from multi-trigger wheeze. 49% of trainees stated they would be give prednisolone to children with a first episode of viral wheeze. Trainees used different cut-off levels of oxygen saturations to initiate oxygen therapy. 69% of trainees felt that recurrent episodes of multi-trigger wheeze warranted regular inhaled beclomethasone, whilst 15% felt that montelukast was more appropriate. The need for an asthma action plan and asthma clinic follow up was raised by 85% and 76% of trainees respectively.

We sought to assess the knowledge of trainees on predisposing factors for early-onset multi-trigger wheeze. The two most predictive risk factors are a personal history of eczema, and a family history of asthma in mum or dad, which were identified by 78% and 59% of trainees respectively.

Conclusions There is a marked variation in how paediatric trainees deal with childhood wheeze. Rationalising investigations and therapeutic measures in bronchiolitis is associated with cost savings. Commonly used steroids are well known to have side-effects and should only be used where indicated. Local and national guidelines on childhood wheeze should aim to standardise practice across the UK for paediatric trainees, and reduce the financial burden on the NHS.

M28 RESPIRATORY CLINICIANS' EXPERIENCES OF END-OF-LIFE CARE IN IDIOPATHIC PULMONARY FIBROSIS

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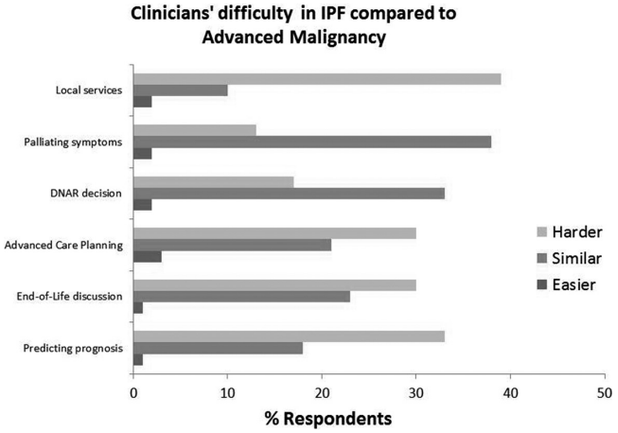
Introduction Referral rates to Specialist Palliative Care are low in Idiopathic Pulmonary Fibrosis (IPF) despite mean survival of 3 years,[1] and a high symptom burden in the final year, in particular dyspnoea, chest pain, anxiety and depression, and fatigue.[2] This study aimed to explore chest clinicians' experiences in delivering care in advanced IPF.

Methods Questionnaires were distributed at a regional Respiratory meeting, focussing on initiating End-of-Life discussions, predicting prognosis, training, and reasons for low palliative care referrals.

Results 57 completed questionnaires - 17 chest consultants, 28 chest registrars, 11 physiotherapists, and 1 nurse clinician. 23 (40%) initiated End-of-Life discussions in severe IPF frequently or very frequently, and 47 (84%) felt it was a very important or important part of their role, but 42% felt predicting prognosis in advanced IPF was difficult or very difficult. More consultants felt End-of-Life discussions were an important part of their role than registrars.

Several aspects of End-of-Life care were felt to be harder in severe IPF than advanced malignancy (Figure 1), although similar to advanced COPD. 22 (42%) referred patients with severe IPF to hospital palliative care services very frequently or frequently, and 19 (37%) to community palliative care very frequently or frequently. Less than 10% of all respondents felt they had significant training in initiating End-of-Life discussions, palliating symptoms, or services available.



Abstract M28 Figure 1

The three symptoms perceived to be experienced most in patients dying with IPF were breathlessness, anxiety and fatigue (cohort data supports this[2]). The three commonest reasons for low palliative care referrals were healthcare team perceptions that palliative care services focussed on cancer, patient's lack of awareness of prognosis, and difficulty clinicians have in predicting prognosis.

Conclusion Chest clinicians find predicting prognosis in ILD difficult, and this contributes to low palliative care referrals. They have minimal training in End-of-Life issues in IPF and there is a lack of local services for such patients. Respiratory training, and commissioning groups, are challenged to develop better End-of-Life services for a condition carrying a high symptom burden and often distressing death.

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M29 TRYING TO CAUSE LESS PAIN FOR OUR PATIENTS! USING LOCAL ANAESTHESIA FOR ARTERIAL BLOOD GAS SAMPLING

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Background Direct radial artery puncture (DRAP) is considered the gold standard procedure for arterial blood gas (ABG) sampling, but it is associated with significant pain. The current 'BTS guidelines for oxygen use in adult patients' recommend using local anaesthesia (LA) for all ABG sampling except in emergency situations. LA can be administered subcutaneously or topically.

Aims

1. To assess the attitudes towards LA for ABG sampling in a population of medical junior doctors (JD).
2. To assess the effectiveness of topical lidocaine cream for ABG sampling by DRAP for respiratory inpatients.