



Abstract P75 Figure 1 Word-cloud to represent patient experience of NIV (n = 15 patients, 5 relatives). (Size of word is proportional to the frequency of use of word in response to being asked to describe NIV, Black association with negative experience grey with positive).

P76 INITIATION OF LONG-TERM NON-INVASIVE VENTILATION (NIV) IN A SPECIALIST RESPIRATORY FAILURE UNIT IN THE UK

SJ Tetlow, PS Marino, PD Murphy, H Pattani, J Steier, N Hart. *Lane Fox Respiratory Unit, St Thomas' Hospital, London, UK*

10.1136/thoraxjnl-2016-209333.219

Introduction and objectives There are currently no guidelines for the provision of long-term NIV and little data into the settings and interfaces employed by different centres. Our aim was to assess long-term NIV provision in a Specialist Respiratory Failure Unit (SRFU).

Methods A retrospective observational study was performed of all patients commenced on long-term NIV by the SRFU. Data was collected from electronic patient records and technician databases on all initiations from August 2014 to January 2015.

Results Data was obtained from 113 patients. Oronasal masks were used in 87% of patients, nasal pillows in 10%, total face masks in 2% and nasal masks in 1%. Oronasal masks were used to deliver higher inspiratory positive airway pressures (IPAP) (mean \pm SD 23.3 \pm 5.3 cm H₂O). Nasal interface use was associated with lower IPAPs (mean \pm SD 12.5 \pm 4.5). A relatively higher IPAP was applied at initiation to the study group (mean \pm SD 22.3 \pm 6.2 cm H₂O) but this varied according to diagnosis; patients with obstructive sleep apnoea (OSA), chronic obstructive pulmonary disease (COPD) and motor neurone disease (MND) received a mean \pm SD IPAP of 24.3 \pm 5.4 cm H₂O, 23.4 \pm 4.2 cm H₂O and 12.4 \pm 3.6 cm H₂O respectively.

Conclusions Oronasal masks were predominantly used reflecting the frequent application of IPAPs above 20 cm H₂O as high pressures are poorly tolerated with nasal interfaces. High mean IPAPs were used in OSA and COPD patients, whilst lower IPAPs were administered to MND patients. No guidelines exist for long-term NIV use, with practice on the SRFU differing from the British Thoracic Society's guidelines on acute NIV that recommend a "pressure target" of 20 cm H₂O (Royal College Of Physicians et al. Concise Guidance to Good Practice Series, 11). However, the relevance of these guidelines to long-term NIV provision is unclear, and the lack of data has impeded the development of specific guidance. A database of patients receiving long-term NIV

in the UK would facilitate research and the formulation of evidence-based best practice guidelines.

P77 EXPERIENCE OF A JOINT PALLIATIVE AND RESPIRATORY CLINIC ON NIV TREATMENT INITIATION IN MOTOR NEURONE DISEASE

T Burden, C Davis, E Johnstone, J Spence, D Shrikrishna. *Musgrave Park Hospital, Taunton, UK*

10.1136/thoraxjnl-2016-209333.220

Introduction Signs and symptoms of ventilatory failure are a proxy for disease progression in Motor Neurone Disease (MND). Recent National Institute for Health and Clinical Excellence (NICE) guidance for MND recommends early referral to specialist palliative care (NICE, 2016) and this may help inform patient decisions around the initiation of non-invasive ventilation (NIV).

A service evaluation was conducted on a new joint palliative and respiratory clinic to determine access to specialist palliative care and the initiation of NIV in MND patients.

Methodology The joint palliative care and respiratory clinic began in September 2015, at Musgrave Park hospital, Taunton and all patients with MND were included. Electronic records were retrospectively accessed, both from the acute hospital electronic document system (EPRO) and also the palliative care database (Crosscare). The joint clinic group were compared with patients discussed in the local MND multi-disciplinary team meeting prior to initiation of the joint clinic, who had respiratory symptoms (standard care group).

Results Data was collected in 35 patients with MND. Of these, 9 did not have any respiratory symptoms and were excluded. The joint clinic group (N = 11), included 5 women (45%), mean age 67.9 (SD 8.9); in the standard care group (N = 15) there were 7 (47%) women, mean age 69.2 (7.6) years. Eighty percent of patients receiving standard care were referred to palliative care compared to 100% in the joint clinic. In the standard care group, 12 (80%) of patients were initiated on NIV compared to 5 (45%) in the joint clinic group. There were only 3 unplanned admissions in both groups and the location of patient deaths were not different.

Conclusion Attending the joint clinic appeared to improve access to palliative care services. Furthermore, patients with MND may benefit from combined palliative and respiratory care input in a joint clinic when making decisions around the initiation of NIV. Further work is needed to evaluate the role of these clinics in informing patient choice for the management of ventilatory failure in this condition.

REFERENCE

- 1 National Institute for Health and Care Excellence. Motor Neurone Disease: assessment and management. <https://www.nice.org.uk/guidance/ng42?unlid=3630474112016629201321> (accessed July 2016).

How can we improve lung cancer pathways?

P78 TACKLING EMERGENCY LUNG CANCER ADMISSIONS

RV Reddy, Y Vali, M Naeem. *Kettering General Hospital, Kettering, UK*

10.1136/thoraxjnl-2016-209333.221