

RTD time was <31 days in 57/112 cases (50.8%). 31.6% of these were Stage I-IIIa, compared with 54.5% Stage I-IIIa when RTD was >31 days.

RTT time was <62 days in 59/112 cases (52.7%). 25.4% of these were Stage I-IIIa, compared with 62.3% Stage I-IIIa when RTT was >62 days.

RTT time was <62 days in 15/48 (31.3%) Stage I-IIIa patients and <62 days in 44/64 (68.8%) patients with Stage IIIB-IV.

Conclusions Despite few CWT breachers, RTT times were frequently >62 days suggesting pathway adjustments have a major impact. Patients with earlier stage disease, and the most to lose from diagnostic delay had longer diagnostic journeys. The survival disadvantage of short pathways likely reflects stage mix. Pathway redesign to accelerate the complex diagnostics needed for radically-treatable disease should be considered. CWT adjustments may have unintentionally clouded this issue.

P85 VIRTUAL LUNG CANCER CLINIC: EARLY EXPERIENCE AND FEASIBILITY

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Background With increased public awareness, cough campaigns and incidental nodules on computed tomography (CT), referrals on a Lung Cancer Pathway (LC) have risen significantly. Safe and effective methods to transfer patients to Respiratory Pathways (RP) are essential.

Aims to evaluate a chose and book, virtual Lung Cancer Clinic (VLCC) to facilitate non-face-to-face "blind" rapid patient assessment, next investigation and appropriate out-patient review.

Methods A retrospective review of all referrals during the period March–May 2016 was undertaken to assess whether blind clinical decision-making at point of referral was sufficient to plan on-going management.

Results 60 referrals were reviewed in VLCC by a Lung Cancer Consultant Physician (average time from referral 2 days, range 0–4 days) as their first 2 week wait appointment. 17 (28%) patients had a final diagnosis of Lung Cancer (histological 12, radiological 5).

Only 29/60 (48%) were of an acceptable quality for blind decision making. 16 (27%) referrals did not have sufficient information provided to allow any decision to be made and further information from the GP was requested.

26 referrals (43%) were removed from CP onto RP at VLCC review: 14 did not require a CT; 12 scans were undertaken (7 high resolution CT, 1 CT pulmonary angiogram, 4 staging CT), 8 prior to clinic attendance.

34 referrals (57%) remained on CP: 30 (88%) proceeded to staging CT with average wait 12 days (range 3–17 days) from referral, all performed prior to clinic attendance. 1/34 died prior to clinic attendance. 3/34 were scanned before VLCC. A further 8 referrals were removed from CP after imaging.

Thus, only 36/60 (60%) referrals were seen in the Lung Cancer Clinic. There was appropriate pathway change in 30% of referrals to General Respiratory (25%) and Pleural Clinic (5%).

Conclusion The VLCC can effectively assess and plan next investigation with appropriate clinic follow-up for suspected Lung Cancer patients. However, blind decision-making relies upon good clinical information from the referrer and administrative time can be wasted chasing this. Our data confirms that the VLCC facilitates efficient use of Out-patient and Radiology Services.

P86 OPTIMISING PATIENT FLOW AND USE OF RESOURCES IN THE TWO WEEK WAIT PATHWAY

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Introduction Lung cancer is the most common cause of cancer death in the UK. Survival is improving but is worse than in some European countries and North America.¹ NICE guidelines recommend that patients with suspected malignancy are seen within two weeks of referral.

An earlier local audit found that 22% of patients referred on the pathway had lung cancer and identified a need to streamline the service. Referrals are triaged as high, intermediate and low risk by a respiratory Consultant based on chest X-ray and clinical details. High-risk patients are prioritised for CT imaging and lung clinical nurse specialist (CNS) time. All patients remain on the two week pathway regardless of triage status.

This study reviewed whether this triage system is accurate in identifying patients with malignancy, thereby improving resource utilisation.

Method Data was collected retrospectively on two week wait referrals during June and July 2015, using referral forms and electronic medical records. Data included key dates in the pathway, triage status and diagnosis.

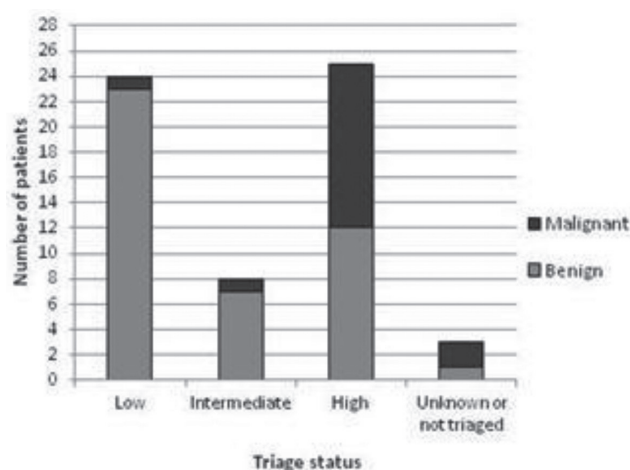
Results 25 of 60 patients were triaged as high risk. Thirteen of these patients had cancer. Two patients with lung cancer were not triaged as high risk.

Triaging a patient as high risk had a sensitivity for lung malignancy of 86.7% and specificity of 71.4%. Positive predictive value was 0.52.

Nineteen patients triaged as high risk had a CT prior to clinician review and the remaining three had a CT within 3 days. This was three times higher than in the low/intermediate group.

The CNS attended the majority of initial clinic appointments in prioritised patients, unless CT showed benign disease.

Conclusion The triage method correctly identified patients with malignancy in the majority of cases. This led to efficient use of resources. Patients with lung cancer had earlier imaging and access to the CNS. Lung cancer symptoms can overlap with other respiratory conditions and following the initial clinical review, the respiratory clinician may decide to investigate some patients less urgently. In future, this method could help stratify urgency of referral.



Abstract P86 Figure 1 Number of patients triages high/intermediate/low with benign or malignant disease

REFERENCE

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P87 THE USE OF A VIRTUAL CLINIC TO SPEED UP AND IMPROVE THE CANCER DIAGNOSTIC PATHWAY – 2 YEAR EXPERIENCE

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In order to speed up the diagnostic pathway, in January 2014 we set up a “straight to CT” service for patients with suspected lung cancer from primary care, where positive scans undergo immediate chest physician review to decide the next diagnostic test and a lung cancer nurse specialist (CNS) offers the patient a telephone assessment to plan this. We have looked at the utility of this “virtual clinic” in the management of our patients with lung cancer over the first 2 years, in particular paying attention to patient uptake and satisfaction, and outcomes.

Of about 300 patients annually who have been triaged in this way, 82% have chosen the virtual clinic, 13% preferred or the CNS advised a outpatient appointment, 4% required immediate inpatient referral, and the remaining and 1% were referred back to the GP as outpatient intervention not felt appropriate (too unwell). Overall, 75% subsequently were diagnosed with lung cancer.

For those patients who chose the virtual clinic consultation, feedback has been overwhelmingly positive. This has been captured qualitatively at the time and at subsequent events e.g. patients report feeling well informed and supported, and quantitatively by an ongoing survey: 98% prefer the telephone clinic versus clinic appointment, 97% felt prepared for next test.

This study has shown that performing a number of diagnostic investigations using a telephone support is not only feasible but preferred by patients with suspected lung cancer. By avoiding unnecessary clinic attendances it improves patient convenience, speeds up the diagnostic pathway and reduces unnecessary costs. This early CNS assessment and interventions reduces the level/scope of patient concerns prior to the time of diagnosis, this has further significance to the team formalising the Holistic Needs Assessment process.

CNSs are best placed to do the consultations as they have the specialist skills and knowledge of the local clinical pathways, tests, disease symptomology and ultimately provide the continuity throughout the diagnostic pathway through to treatment and we recommend this to other cancer units.

P88 FOLLOW-UP AFTER SURGICAL TREATMENT OF LUNG CANCER: THE POTENTIAL IMPACT OF INTERNATIONAL GUIDELINES ON CURRENT UK PRACTICE

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Introduction and objectives International guidelines suggest regular CT scan follow-up for non-small-cell lung cancer (NSCLC) that is surgically treated with curative intent.^{1,2} NICE guidance does not specify the type or frequency of imaging. Our aims were to assess current follow-up practice in such patients in our region, and estimate the potential impact of implementing international guidelines.

Methods We surveyed a majority of hospitals (six NHS trusts) in our region about their current follow-up practice. A retrospective study was performed of patients in our trust who underwent curative surgery for NSCLC between March 2013 and December 2014.

Results None of the surveyed trusts were following ESMO or ACCP guidelines. Only two had a local policy in place. The majority used chest X-ray (CXR) rather than CT follow-up, which reflected our practice.

We identified 79 patients who had undergone surgery with curative intent in our trust. 5 patients were excluded, as notes were unavailable for 2, and 3 died before any follow-up. Amongst the remaining 74 patients, follow-up was for a mean of 19 months. During this time the mean number of CTs and CXRs per patient was 1.3 and 2.7 respectively. Following ESMO guidelines would reduce the number of CT scans compared to our overall current practice, to 1.1 per patient,¹ whilst ACCP guidelines would result in an increase to 2.7 CTs per patient.²

Conclusions Most patients in our region are followed-up by CXR rather than CT. Most hospitals are not using follow-up guidelines, resulting in practice variation. Compared to current practice in our trust, following ESMO guidelines would not result in an increase in CT scans for this purpose, and no CXRs would be required for routine follow-up. Therefore it may be feasible to adopt this more uniform, evidence-based approach.

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Cystic Fibrosis

P89 MODELING NUTRITIONAL OUTCOMES FOR INFANTS DIAGNOSED WITH CYSTIC FIBROSIS BY NEWBORN SCREENING

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Introduction Cystic Fibrosis (CF) newborn screening (NBS) was implemented across the UK in 2007. It has been associated with improved clinical outcomes particularly related to nutrition. We reviewed the nutritional progress of infants diagnosed with CF by NBS in the West Midlands. Our aim was to develop a model for predicting height and weight in the first 2 years of life based on information available at the first clinic visit.

Methods Anthropometric data is recorded at each outpatient visit for children with CF. This data was reviewed in conjunction with the CF NBS data for all children diagnosed with CF in the West Midlands between November 2007 and October 2014. Cluster analysis, classification and polynomial regression modelling were used to analyse these data. Models were validated using the 5-fold cross validation method.

Results 144 children were identified with CF at a mean age of 22 days. There was no difference in birth weight z scores between