compared with treated patients (12% versus 26%, respectively; $p \leq 0.01$).

Conclusions Despite recent regulatory approval of antifibrotic therapies, many European patients with confirmed IPF do not receive approved antifibrotic treatment. Possible explanations may include: lack of MDT diagnosis; lack of referral to specialist centres; patients not meeting treatment thresholds; subjective perceptions of disease severity; reluctance to treat patients with 'stable' disease; variations in patient/physician awareness or knowledge of IPF; or lack of confidence in prescribing new treatments.

P162 CURRENT INTERSTITIAL LUNG DISEASE SPECIALIST MDT PROVISION ACROSS THE UK

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The advent of novel anti-fibrotic therapies and the introduction of specialist, commissioned Interstitial Lung Disease (ILD) centres, has led to an increased workload for Multidisciplinary Team (MDT) meetings. We set out to survey specialist UK centres to gain a better understanding of their organisational processes and associated challenges.

Methods Between August and December 2015 we conducted an online survey of all 23 NHS England commissioned ILD centres, plus 5 specialist ILD centres in Scotland, Wales and Northern Island. The survey was sent to the clinical lead of each centre. A total of 20 questions assessed the workforce composition and frequency of meetings. Their workload was also evaluated and we asked them to identify areas that required improvement.

Results 26 out of 28 centres responded.

MDTs are coordinated by the ILD lead consultant (57%) or a medical secretary (26%), with only 17% directed by a MDT coordinator.

Peripheral hospitals participate in MDTs in 78% of centres; in person, via video-link or paper referrals; however, the majority of discussed patients are reviewed at the specialist centre.

MDTs are typically held weekly, lasting 1 to 2 hours, with 10 to 20 patients discussed. 26% of MDTs discuss all new referrals, 87% discuss all patients considered for anti-fibrotic therapy, whilst only 22% discuss all patients considered for immunosuppressive therapy (aside from oral steroids).

All respondents agreed that the available MDT time was insufficient. The most common reasons were cited as; lack of dedicated MDT funding (83%), lack of sufficient respiratory radiologist consultant time (78%) and lack of dedicated administrative support (61%).

In 96% of cases there is no local tariff in place to fund MDT discussion and all respondents agreed that a dedicated tariff would improve MDT provision.

92% of centres enrol MDT patients into clinical trials.

Conclusion Specialist ILD MDTs are able to concentrate a high level of expertise and allow patients access to vital clinical trials. They are, however, under considerable strain due to lack of funding and administrative support. A dedicated funding stream for this specialist service would be beneficial.

P163 SURGICAL LUNG BIOPSY IN THE DIAGNOSIS OF INTERSTITIAL LUNG DISEASE- A SYSTEMATIC LITERATURE REVIEW

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Methods We performed a systematic literature review based on the PRISMA guidelines following a pre-specified protocol. Pubmed and Embase databases were searched for studies reporting the use of Surgical Lung Biopsies (SLB) in the diagnosis of adults with Interstitial Lung Disease (ILD). Randomised controlled trials, case control studies and case series with more than 20 subjects were included, restricted to papers published from 2000 till September 2015 taking into consideration changes in surgical techniques and diagnostic criteria. All relevant abstracts were assessed by two independent reviewers utilising EPPI reviewer 4, an online software tool for research synthesis. Full papers were obtained for those deemed potentially eligible, and two reviewers agreed the final set of review papers. Primary outcomes were 90 day mortality and complications while secondary were diagnostic yield, mean length of stay and change of treatment following biopsy.

Results (see Figure 1). 24 studies were included reporting on the use of SLB in 2600 patients. The overall quality of the reports was moderate to poor with mainly retrospective case series available. Mean mortality was 4.9% (CI 90% −0.04 −0.14) with a wide range of 0 – 22.4%. Complication rates were reported in 19 of the studies. Mean overall complication rate was 19.4% (CI −0.05 – 0.48) with a range from 7.1% to 65.7%. Mean length of stay adjusted for patient numbers was 5.4 days and diagnostic yield for definite pathological diagnosis was 89%. Eight studies recorded treatment change following SLB in a total of 588 patients out of 869. Mean percentage of patients in whom treatments was changed on the basis of the SLB result was 60% (CI 90% 0.35–0.87).

Conclusions High-quality data on the outcomes of SLB in ILD diagnosis are sparse. Comparison between different studies is difficult due to heterogeneous patient populations (e.g. acute vs elective cases) and differences in outcome reporting. Nonetheless, the overall mortality and morbidity rates are similar to a recent analysis of a US national database. SLB in ILD remains a useful diagnostic tool but carries significant mortality and morbidity. More prospective data and evaluation of surgical risk stratification is required.