Conclusion Although SBx is here to stay, it has significant morbidity and mortality. Transbronchial cryobiopsy may in the future sit alongside SBx in the diagnostic pathway for ILD, but in addition to offering low morbidity and mortality it must also offer a high diagnostic yield.

Abstract P165 Table 1

Major complications	% of cases
HDU/ITU admission	6
Required re-intubation	3
Required tracheostomy	1
Acute renal failure	3
Empyema	1
Ileus	1
Minor complications	**% of cases**
Pneumothorax	6
Persistent air leak	4
Atrial fibrillation	1
Lower respiratory tract infection	11
Urinary retention	1
Wound infection	2

REFERENCE

1 Travis WD, Costabel U, Hansell DM, *et al*. An official American Thoracic Society/European Respiratory Society Statement: Update of the international multidisciplinary classification of the idiopathic interstitial pneumonias. *Am J Respir Crit Care Med* 2013;**188**:733–748.

P166 THE EMERGING ROLE OF AIRWAY CLEARANCE TECHNIQUES IN THE TREATMENT OF INTERSTITIAL LUNG DISEASE

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Introduction Patients with interstitial lung disease (ILD) may develop airway abnormalities as part of their underlying condition, in response to fibrotic/tractional dilatation or as a result of repeated bronchiolar infection. While current practice guidelines recommend the provision of pulmonary rehabilitation for ILD patients, no other interventions have been endorsed. We assessed the symptomatic need of patients with ILD for airway clearance techniques (ACT's) using a visual analogue scale, and whether, in those with fibrotic ILD, the presence of traction bronchiectasis was correlated with the need for ACT's.

Methods Over a 15-week period, data were prospectively collected on ILD patients who consented for detailed physiotherapy assessment and intervention. Those who reported a sensation of persistent secretion retention, frequent chest infections (>2 in 6 months) or those with pre-existing airway disease had a full clearance assessment. The radiological presence or absence of traction bronchiectasis was noted, as was evidence of other airway pathology such as bronchiolitis.

Results 30 ILD inpatients (16 females) were included in the study (Table 1). The commonest causes for admission were ILD staging (n = 10) and disease deterioration requiring intravenous treatment (n = 14). 27 patients (90%) required physiotherapy input and 11 patients (41%) required ACT's. 9 patients had positive sputum microbiology; of these, 3 were first isolates. 7 of these 9 patients had traction bronchiectasis on CT acquired within 3 months of assessment. One patient did not undergo CT. The presence of traction bronchiectasis correlated with a higher sputum microbial yield ($p < 0.05$) but not with a need for ACT ($p > 0.05$).

Conclusion Airway abnormalities are often not a principal therapeutic focus in ILD but symptoms related to mucostasis, recurrent infection and airflow limitation may be disabling. In this study, the majority of patients with positive microbiology had traction bronchiectasis. Although no firm conclusions can be drawn regarding the role of ACT's in their management, this intervention improved the yield of specimens for microbial analysis and facilitated pathogen-directed antimicrobial therapy. These findings suggest that a systematic physiotherapy approach including optimisation of airway clearance can benefit patients with parenchymal lung disease.

Abstract P166 Table 1 Patient demographics

Total patients, *n*	30
Age (year), mean (SD)	59.1 (15.7)
Gender, *n* females (%)	16 (53)
Length of stay (days), mean (SD)	11.3 (8.3)
Patients with traction bronchiectasis, (%)	17 (56.6)
Sarcoidosis	7
Idiopathic Pulmonary Fibrosis	5
Chronic Hypersensitivity Pneumonitis	5
CTD-ILD	3
Other*	10

CTD-ILD, Connective Tissue Disease – Interstitial Lung Disease.

*Other ILD diagnosis or suspected ILD.

P167 DOES ANTIFIBROTIC TREATMENT OUTCOMES DIFFER IN USUAL INTERSTITIAL PNEUMONIA BASED ON HRCT CRITERIA ESTABLISHED BY ATS/ERS/JRS/ALAT IN 2011?

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Background Idiopathic pulmonary fibrosis (IPF) is an age-related, progressive and irreversible lung disease.[1] The diagnosis of IPF is made using clinical history, pulmonary function testing (PFT), and radiological appearances of Usual Interstitial Pneumonia (UIP) on High Resolution CT (HRCT) Scanning provided other appearances have been excluded. The diagnosis is frequently made at MDT where the images are categorised into Definite UIP, Possible UIP, or Inconsistent with UIP using HRCT criteria.[2] In the west of Scotland, patients demonstrating definite or possible UIP patterns on HRCT with a FVC < 80% are considered for antifibrotic therapy. The aim of this study was to assess whether response to antifibrotic therapy in IPF is correlated with the aforementioned categories. The presence of pleural plaques was also considered.

Methods We retrospectively divided 170 patients into three categories: definite UIP pattern, possible UIP pattern, and UIP with pleural plaques. Serial pulmonary function test results were obtained and the change in FVC calculated. Treatment failure was defined as a change in FVC% predicted of >10% per year. The rate of treatment failure, overall mortality, 6-month and 12-month survival was compared between the three groups.