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P261 DOES THE PROVISION OF A RESCUE PACK KEEP PATIENTS WITH CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD) AT HOME?

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Introduction COPD accounts for one in eight hospital admissions, 1 million bed days and costs £870–930 m a year.¹ Early treatment of exacerbations with steroids reduces severity and may reduce the need for hospital admission.² We evaluated the acceptance and use of a rescue pack provided on discharge from hospital.

Methods 38 patients, discharged between 1 February and 30 June 2011, were supplied a 7 day rescue pack comprising Prednisolone 25 mg and Doxycycline 100 mg (total cost of £7) with education and a self-management plan.

A telephone questionnaire was conducted in July:

1. Do you remember being given a rescue pack on discharge from hospital?
2. Have you had a flare-up of your COPD since discharge?
3. Did you use your rescue pack?
4. Did you take both antibiotic and steroid?
5. Did you complete the course?
6. Do you think it helped keep you at home?
7. Have you got a replacement rescue pack?

Results 25 out of 38 (66%) patients were contactable. 11 (44%) were male and 14 (56%) female. The median age was 77 (range 53–89) years. The median time from discharge to telephone contact was 110 (range 21–168) days. 24 (96%) patients acknowledged receipt of the rescue pack. 14 out of 15 (93%) patients who had experienced an exacerbation of COPD had used the rescue pack. Of these 14 patients, 13 (93%) were confident of the benefit and 10 (71%) had obtained a replacement pack. Six of the 38 (16%) patients supplied with a rescue pack were re-admitted with an exacerbation.

Conclusions The results of this service evaluation suggest a cost-effective initiative that may reduce hospital re-admission by promoting earlier treatment. Rescue packs should be supported by education and a self-management plan.

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P262 ORAMORPH FOR BREATHLESSNESS: IN PURSUIT OF GUIDELINES AND PATIENT INFORMATION FOR USE IN COPD

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Introduction Breathlessness is the most common and frightening symptom in Chronic Obstructive Pulmonary Disease (COPD). Short-acting morphine (Oramorph) has traditionally been used to treat breathlessness in palliative care. Although used in COPD

(Simon *et al*, 2010), there is no consensus/guidelines for prescribing and patients stigmatise morphine, associating it with dying or addiction. In this study, we assessed current prescribing practice, patient use and safety of Oramorph, to inform local prescribing guidelines and patient information.

Method Case notes of patients who were prescribed Oramorph for breathlessness while having multidisciplinary COPD care between 2004 and 2011 were reviewed. The following were documented: patient demographics, disease severity (FEV₁, MRC dyspnoea score, nebulisers, long term oxygen therapy (LTOT), domiciliary Non-Invasive Ventilation (NIV), social/healthcare support and palliative care referrals; Oramorph starting dosage, dosage range, increase in dosage, patient choice to continue, duration of and use of morphine sulphate slow release tablet (MST).

Results 28 COPD patients prescribed Oramorph for breathlessness were identified (14 M), median (range) age 70 (52–83) years FEV₁ (mean±SD) 0.58±0.22, MRC dyspnoea score 4.6±0.49. 19/28 (68%) were on LTOT, 28/28 (100%) on nebulisers, 5/28 (17%) on domiciliary NIV, two current smokers, 10/28 (36%) lived alone, 27/28 (96%) had professional healthcare domiciliary visits, 8/28 (29%) had palliative care input. Starting, incremental and current dosing of Oramorph are shown in the Abstract P262 table 1. 25/28 (89%) patients chose to stay on Oramorph once started. Median (range) duration on Oramorph was 8 months (45 days–7.5 years). MST was added for breathlessness in three patients. 13/28 (46%) patients died; all were MRC 5 and starting Oramorph was not felt to be a contributing factor by the clinical team. Time to death after starting Oramorph was median (range) 7 months (68 days–2.6 years). Oramorph prescribing in COPD increased year-on-year (one patient in 2004 to 12 in 2010).

Conclusion Oramorph prescribed by a respiratory team for breathlessness is safe in this group of patients. This study indicates that its effect is sustained despite low dosages with little requirement for incremental dosing over time. Guidelines for prescribing and patient information will be critical to ensure that patients are not denied this useful treatment of breathlessness.

Abstract P262 Table 1

Oramorph	Median dose mg	Range dose mg
Starting dose (n=28)	2.5 mg bd	1.25 mg bd–5 mg qds
Increase (n=12)	2.5 mg bd	2.5 mg bd–10 mg qds
Current dose	2.5 mg bd–2.5 mg qds	1.25 mg bd–10 mg qds

P263 CANNABIS USE, RESPIRATORY SYMPTOMS AND LUNG FUNCTION, IN A NORTH EDINBURGH PRIMARY CARE POPULATION

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Background We are conducting a cross-sectional study of cannabis and tobacco smokers in a primary care population and reporting respiratory symptoms and lung function in two groups: Group 1=persons who smoke tobacco cigarettes (branded cigarettes +/- "roll-your-own"); Group 2=persons who smoke cannabis +/- tobacco cigarettes.

Methods Information on tobacco and cannabis smoking is obtained from the Avon Longitudinal Study of Parents and Children. Cumulative smoking is quantified by use of tobacco pack-years (py) and joint years (jy). Additional tobacco use in cannabis smokers is recorded. Other instruments used include the NHANES III and MRC breathlessness questionnaires, measurement of ventilatory capacity (Vitalograph α) and the Scottish Indices of Multiple Deprivation