exacerbations and exclusion criteria. The analysis was limited to patients aged = 45 years to reduce contamination by COPD. Patients with non-asthma respiratory diagnoses were excluded. Results In the 3 year period about 395,000 patients received repeated medications for asthma with a monthly point prevalence of 255,000 asthma patients; equating to a prevalence of 7.0% of the 3.6 million people aged 0–45 registered with a GP in Scotland. These patients collected 5.6 million prescriptions for inhaled/oral asthma therapies and 253,000 short courses of oral corticosteroids were dispensed to these patients in primary care. Patients were categorised on a daily basis into BTS Steps 1-5 according their medication use. As of June 2011: 83,663 (32.4%) of patients were in Step 1; 99,374 (38.5%) were in Step 2; 42,555, (16.5%) were Step 3; 27852 (10.8%) were Step 4, and 4,500 patients (1.7%) were Step 5 receiving daily oral corticosteroids. Table 1 presents the exacerbation rates for these patients, 1.9% of the patients received an emergency short course of prednisolone,. Conclusion This current and whole population database indicates that in Scotland asthma prevalence is about 7% in this age group. The proportion of asthma patients treated at Steps 3–5 (25%) is greater than the often quoted 15%. Although proportionately small, a sizeable number of patients (~7000) with Step 1 and 2 asthma had at least one exacerbation requiring short course prednisolone and/or hospital contact over a three year period.

Abstract P16 Table 1. Dispensed inhaled therapy and A&E attendance data from the Scottish NHS databases

BTS Steps	1	2	3	4	5
N	83,663	99,374	42,555	27,852	4,500
% ≥1 short-course prednisolone	1.0%	2.0%	2.2%	4.3%	0.5%
% ≥1 A&E attendance with asthma over 3 years	1.4%	2.7%	3.3%	4.5%	10.9%

P17 THE BURDEN OF ICS/LABA-TREATED ASTHMA PATIENTS IN THE UK ADULT POPULATION

[1]D Price, [2]N Mathieson, [2]A Mulgirigama, [2]A Scowcroft, [3]R Pedersini, [3]G Isherwood, [4]ID Pavord; *[1]Academic Centre of Primary Care, University of Aberdeen, Aberdeen, UK; [2]Boehringer Ingelheim Ltd UK, Berkshire, UK; [3]Kantar Health, Epsom, UK; [4]University Hospitals of Leicester NHS Trust, Institute for Lung Health, Glenfield Hospital, Leicester, UK*

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Objectives According to NHS QOF (Quality and Outcomes Framework) figures, 3.3 million UK citizens have asthma. Previous studies have shown an association of asthma with increased direct and indirect healthcare costs, but similar studies have not been conducted specifically for UK asthma patients. The aim of the current study is to assess the impact of poor asthma control on UK patients treated with ICS + LABA maintenance treatment.

Methods Data were from the 2010 and 2011 UK National Health and Wellness Survey (NHWS), an Internet-based questionnaire from a representative sample of UK adults stratified by age and gender. 701 respondents self-reported a diagnosis of asthma without concomitant COPD, chronic bronchitis, or emphysema and were currently being treated with ICS + LABA.

Patients Not Well Controlled (NWC) according to ACT (score < 20) were compared to well-controlled (WC) patients (score ≥ 20) on demographics, medications, health status, BMI, comorbidities, adherence (MMAS-4), healthcare use (number of physician visits, emergency visits and hospitalizations), work productivity and activity impairment (WPAI) and health-related quality of life (HR-QoL) (SF-12).

Results A greater proportion of the 452 NWC patients (64% of the overall sample) go to emergency (21% vs. 14%, p = 0.016) or are hospitalised (13% vs. 8%, p = 0.022), in comparison with the WC; Their mental and physical HR-QoL is lower (SF-12 MCS: 43 vs. 47/100; PCS: 40 vs. 48/100; Health utility: 0.65 vs. 0.74/1.00; all p's < 0.001);while their work and activity impairment are greater: presenteeism (23% vs. 11%, p < 0.001), overall work impairment (29% vs. 17%, p < 0.001) and activity impairment (46% vs. 24%, p < 0.001). In the current sample, NWC did not show significantly different levels of adherence from WC (50% vs. 55%, p = 0.361).

Conclusions Over 60% UK ICS + LABA-treated adult patients are poorly controlled. Poor control is associated with lower HR-QoL, greater healthcare use and productivity impairment, but not with significantly different levels of adherence to WC patients. The recognition of patients remaining symptomatic and utilising healthcare resource whilst treated with ICS + LABA maintenance therapy is an important step to improving their management.

P18 IDIOPATHIC PULMONARY FIBROSIS SURVIVAL HAS NOT IMPROVED IN THE 21ST CENTURY; ANALYSIS OF CPRD GOLD PRIMARY CARE DATA

[1]Tm Maher, [2]H Strongman, [2]R Boggon, [3]I Kausar; *[1]Royal Brompton Hospital, London, United Kingdom; [2]Clinical Practice Research Datalink, London, United Kingdom; [3]InterMune UK and Ireland, London, United Kingdom*

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Introduction and Objectives Idiopathic pulmonary fibrosis (IPF) is a progressive and invariably fatal disease. Historical cohort studies have reported a median survival of 2.8–3.2 years[1]. The UK has seen a number of important developments for IPF patients in the last year which it is hoped will translate to improved outcomes for individuals with this devastating disease. These include: the licensing and approval by NICE of the first anti fibrotic therapy, pirfenidone; specialist commissioning of ILD services; and publication of NICE IPF guidelines. If the impact of these important developments is to be measured it is vital that current IPF disease burden is understood.

Methods The incidence and mortality of IPF-Clinical Syndrome, using broad and narrow disease definitions, was assessed via the Clinical Practice Research Datalink (CPRD) GOLD dataset.

Results The incidence of broadly defined IPF-CS between 2000–2012 was 8.65 (95% CI 8.40–8.90) per 100,000 person years and significantly increased over time (incidence rate ratio adjusted by gender, region and age category = 1.02, p for linear trend <0.0001). Kaplan-Meier survival estimates show no significant survival difference by year of diagnosis (log rank test for equality of survivor functions, p = 0.17) with a median survival of 3.0 years (95% CI 2.8–3.1). There was no significant survival difference for broad and narrow definitions (log rank test for equality of survivor functions, p = 0.06) validating the definition of IPF-CS.

Conclusions In keeping with previous data the incidence of IPF-CS continues to rise and the survival time from diagnosis remains unchanged. The mortality burden of IPF-CS is therefore increasing. The results of this study provide an important benchmark against which the effects of changes in the management and delivery of care for individuals with IPF can be measured.