primaries (breast, colorectal, bladder and renal) and 2 lymphomas. Of the 248 primary lung cancers, 88 (35%) had adjuvant chemotherapy and 27 (11%) had adjuvant radiotherapy including cranial irradiation. A total of 40/298 (13%) patients had recurrence in first year of which 20 died within 1 year.

Based on previously used definition,¹ the futile thoracotomy rate was 33% (99/298) – see Table 1. If surgical resection of benign lesions is considered diagnostic, the futile thoracotomy rate would be 23% (68/298).

Abstract P108 Table 1	Distribution of futile thoracotomy, n(%)
Benign lung lesion	31 (31)
R2 Resection	3 (3)
Stage IIIA-IV	17 (17)
Recurrence within 1 year	20 (20)
Deaths within 1 year	28 (28)

Conclusion The definition of futile thoracotomy is debatable, but the risk remains high. Prior to surgery every effort should be made to minimise the risk by using combined staging modalities including minimally invasive diagnostic tools and appropriate patient selection.

REFERENCE

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Tuberculosis: Clinical Aspects

P109 THE IMPACT OF TB NICE GUIDANCE ON RESOURCE CAPACITY AND CONTACT SCREENING OUTCOMES: A RETROSPECTIVE, OBSERVATIONAL STUDY WITHIN A CENTRAL LONDON TB CENTRE

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10.1136/thoraxjnl-2016-209333.252

Introduction and objectives Recently published NICE guidance has significantly expanded the approach to adult tuberculosis (TB) contact screening by recommending tuberculin skin testing (TST) for pulmonary and laryngeal contacts only, increasing the age threshold for screening and treatment to 65 years and defining a positive TST as induration \geq 5 mm, regardless of BCG vaccination status. Interferon Gamma Release Assay (IGRA) is recommended only in situations where more evidence of infection is needed.

Our institution has previously adopted an approach comprising a chest radiograph, TST and IGRA.

The aim of our study was to evaluate the impact of NICE guidance on screening outcomes and resource capacity by applying the criteria to a well-defined historic cohort of TB contacts.

Methods This was a retrospective, observational study carried out at a central London teaching hospital. The study population comprised 593 consecutive, adult TB contacts screened between 1/1/2008 and 31/12/2010. Data was collected through a retrospective review of TST and IGRA tests.

Results Of the 593 contacts screened, 358 pulmonary contacts had TST and IGRA results. 56% had a TST \geq 5 mm, regardless of

BCG status, qualifying them for treatment as per the new NICE guidance. Of these, 61% were IGRA negative (discordant) and may therefore include false positive diagnoses, resulting in the potential for over treatment. In those with TST 5–14 mm, discordance rises to 84%. Conversely, 6% of those with TST < 5 mm are IGRA positive representing potentially missed cases.

16% of screened individuals were contacts of extra pulmonary TB. Not screening this group would reduce the demand for outpatient appointments by 151^* in our cohort. In contrast, testing contacts > 35 years would require capacity for an additional 165* appointments. Furthermore, there were 162 additional LTBI cases in comparison to previous guidance requiring an additional 648* appointments. 72% of this group were IGRA negative.

(*Approximate)

Conclusions Our results show the revised guidance will require increased resource capacity largely due to more patients being classified as having latent TB. In addition to workforce planning to meet these demands, further debate is needed to decide if this new approach truly reduces the incidence of active TB or results in unnecessary treatment.

P110 THE ROLE OF TB CHEMOPROPHYLAXIS IN RENAL TRANSPLANT RECIPIENTS

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10.1136/thoraxjnl-2016-209333.253

Background Rates of tuberculosis infection are increased after solid organ transplant. This is associated with increased mortality and allograft loss in one third of cases. The WHO recommend testing for latent tuberculosis (LTBI) in patients receiving dialysis or preparing for solid organ transplant. BTS and ERS guidelines suggest screening for LTBI where tuberculosis incidence rates are high or in patients with risk factors for developing tuberculosis in low incidence areas. They go on to propose chemoprophylaxis with isoniazid or three months of rifampicin and isoniazid, with above 60% effectiveness at preventing subsequent tuberculosis. Guidelines at a large renal transplant centre advocate isoniazid prophylaxis for 6 months post transplant in all patients of Indo-Asian or African heritage as well as anyone who is from a country with TB incidence rates above 40/100,000 who have been in the UK for less than 5 years.

Methods All patients who underwent renal transplantation between January 2011 and December 2014 were assessed to see if tuberculosis prophylaxis was prescribed as per guidelines. Cases of subsequent TB were then identified.

Results 912 patients underwent renal transplant during this time. 243 (26.6%) received isoniazid prophylaxis, with 88% adherence to trust guidelines. 42 (4.6%) patients who should have received prophylaxis did not. During this time one patient developed tuberculosis post transplant. This individual should have received isoniazid according to guidelines, but did not. Another patient from sub-Saharan Africa was discovered to have abdominal tuberculosis when on the operating table prior to transplant.

Discussion We are not aware of any LTBI screening programme amongst renal transplant units in the UK currently. Many use prophylactic isoniazid in a similar manner to our trust. Pre-emptive screening with interferon gamma release assays costs approximately £60 per test, 6 months of isoniazid £560 and 3 months of rifampicin and isoniazid costs £185. Whilst screening may