

Methods We set up a pathway to allow us to screen selected discharged patients to identify those who required further investigations. Discharged patients were identified following admission between March and June 2020 using electronic hospital records. Patients who were not suitable to be called were excluded, and a letter was written to their GP explaining this. All other patients were called approximately 6 weeks after discharge. Information was collected including ongoing symptoms, admission radiological changes, and selected questionnaires. Patients with ongoing symptoms were invited back for investigations and face-to-face appointment, and anyone without symptoms but x-ray changes was invited for repeat X-ray at 10 weeks.

Results Of the 828 admissions, 281 died, and a further 182 were unsuitable to call. Of those called, 88% (321) answered, and 65 remained symptomatic and were seen in clinic. 154 people required a repeat chest x-ray, 8 subsequently had a CT thorax and clinic review. 56 people did not attend for follow-up x-ray and were discharged. Of the 73 people seen, 59 had interstitial changes based on radiological criteria; 29 of these were resolving inflammation which did not require further follow up as the patients were also clinically improving. 30 patients, 11 with fibrotic changes, required observation or treatment. Four patients received oral prednisolone and 7 had received intravenous methylprednisolone earlier. In the symptomatic group, PEs, pulmonary hypertension, adenocarcinoma in situ and breathing pattern disorders were also diagnosed.

Conclusion Less than 10% of patients required treatment with steroids after admission with COVID-19 infection. This is lower than previous estimates following MERS/SARS infection. Interestingly, severe radiology changes did not predict the likelihood of developing fibrosis. The screening telephone clinic was a useful way of identifying those with ongoing symptoms who required further investigation.

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'UNCOVERED COVID': THE ADDITION OF A CLINICO-RADIOLOGICAL PRE-FOLLOW UP MULTIDISCIPLINARY TEAM REVIEW IMPROVES THE PROVISION OF FOLLOW-UP PATHWAYS IN COVID-19

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Introductions and Objectives BTS guidelines advise that patients with a clinico-radiological diagnosis of COVID-19 undergo follow-up based on severity of disease: either Group 1 (required ICU/HDU admission or significant respiratory support), or Group 2 (any other admitted patients).

The BTS guidelines themselves address concerns that delivering this follow-up might prove difficult due to disrupted working patterns and large caseloads. To address these concerns, we established a post-COVID-19 Pre-Follow Up Multi-Disciplinary Team (pre-FU-MDT). We have reviewed its impact on COVID-19 follow-up streams.

Methods To capture all relevant patients we cross-referenced a list of all RT-PCR swabs sent for symptomatic purposes against those who had a recent CXR. The CXR reports, coded in real time, were used to establish a list of patients who had CXRs consistent with or indeterminate for COVID-19 pneumonia.

The database was screened by a specialist respiratory nurse who assigned follow-up streams based on level of respiratory support required and CXR report.

All Group 1, Group 2 and Indeterminate cases were discussed at MDT, which consisted of a consultant respiratory physician and a thoracic radiologist. Cases were discussed with discharge summaries, results and imaging. Follow-up streams were reallocated as necessary. Time for MDT was re-allocated from services reduced during the pandemic.

Abstract P174 Table 1 Change in follow-up status caused by the intervention of the pre-follow up multidisciplinary team clinico-radiological review

	Allocated to Group 1 Follow-Up Without Pre-FU MDT	Allocated to Group 2 Follow-Up Without Pre-FU MDT	Patients Requiring No Follow-Up Without Pre-FU MDT	Non-COVID CXRs Without Pre-FU MDT	Indeterminate CXRs Without Pre-FU MDT	Total
Allocated to Group 1 Follow-up With Pre-FU MDT	25	1	0	0	1	27
Allocated to Group 2 Follow-up With Pre-FU MDT	2	44	3	0	38	87
Patients Requiring No Follow-Up With Pre-FU MDT	5	12	16	6	150	189
Non COVID 6/52 CXR (with Pre-FU MDT)	3	8	1	1	65	78
Non COVID bespoke follow-up† (with Pre-FU MDT)	0	3	0	1	7	11
Total	35	68	20	8	261	392*

*Consecutive subgroup analysis of 392 patients of the 495 that were reviewed in the COVID-19 pre-Follow Up MDT

†Non-COVID bespoke follow-up refers to non-COVID respiratory follow-up e.g. review in Pleural Clinic

Results Of 1532 'symptomatic' swabs, there were 495 patients with a potential clinico-radiological diagnosis of COVID-19 pneumonia discussed at the Pre-FU-MDT.

We performed a subgroup analysis on 392 consecutive cases (Table 1). The pre-FU-MDT changed the follow-up pathway in 21% of non-indeterminate cases (23/108). Follow up was ceased in 5% (17/108). Patients with indeterminate CXRs represented the largest cohort. The pre-FU-MDT ceased follow-up in 57% (150/261) and the remaining 43% (111/261) were stratified to Group 1, Group 2 or other appropriate non-COVID follow up.

Conclusions A Pre-FU-MDT has significant clinical impact. By redistributing clinicians' time, an efficient mechanism has been created to reduce unnecessary CXRs and clinic appointments, and focus on those most likely to require follow-up. Review of our follow-up outcomes is ongoing and the results will be available at the time of the BTS meeting.

REFERENCE

1. BTS Guidance on Respiratory Follow-Up of Patients with a Clinico-Radiological Diagnosis of COVID-19 Pneumonia (2020)

P175 CLINICO-RADIOLOGICAL RECOVERY FOLLOWING SEVERE COVID-19 PNEUMONIA

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Background The recovery course following COVID-19 pneumonia remains poorly understood. Analysis of routine clinical and imaging follow up of patients admitted with COVID-19 pneumonia undertaken in accordance with British Thoracic Society (BTS) guidance offers an opportunity to improve our understanding of the recovery course following acute infection.

Methods All patients requiring Intensive or Respiratory High Dependency Unit care with COVID-19 pneumonia who survived to discharge were offered telephone review and interval chest radiograph (CXR) at 6 and 12 weeks respectively in accordance with BTS guidance. Patients were contacted in chronological order by discharge date. The data presented here covers discharges between 25/03–03/05/20 inclusive. All chest radiographs were reported by a consultant radiologist.

Results A total of N=73 patients were identified (74% male, mean age 57.6 years, range 22–84). N=41 (56.1%) had been admitted to ITU, with the remainder admitted to HDU.

Following discharge, N=6 (8.2%) were re-admitted within 30 days (median time to first re-admission 19.1 days). N=2 (3.5%) patients were diagnosed with pulmonary emboli following the index admission. 1 patient died within 30 days of discharge (unrelated to COVID infection).

Follow up calls occurred with N=57 patients, at median 9.6 weeks post discharge (range 6–12 weeks). Patient reported persistence of symptoms at time of review is summarised in table 1. Interval CXR was available in N=49 patients. Of these, N=34 (71.7%) were clear, N=10 (19.5%) showed linear atelectasis, and N=5 (8.7%) showed persistent consolidation (all improved compared to admission CXR).

Discussion These data describe the clinico-radiological course following admission with severe COVID-19 pneumonia. Limitations of this analysis include limitation to patients receiving HDU/ITU level care and the retrospective categorisation of

Abstract P175 Table 1 Self-reported persistence of selected symptoms at initial telephone review (N=57)

	Persisting	Improving	Resolved	Never experienced
Dyspnoea	6 (10%)	25 (44%)	26 (46%)	0
Cough	4 (7%)	1 (2%)	42 (74%)	10 (18%)
Fatigue	14 (25%)	13 (23%)	29 (51%)	1 (2%)

symptom persistence. Prospective studies serially assessing full symptomatology are required. Nevertheless, these data highlight persistent symptoms at 6–12 weeks; particularly exertional dyspnoea and fatigue. 91% of patients were free from cough at this time; investigating for possible alternative causes should therefore be considered in patients experiencing chronic cough.

These data are valuable in planning long-term support for patients following COVID-19 pneumonia, and support the BTS recommendations for early proactive follow up of this cohort.

P176 EARLY RESULTS OF RADIOLOGICAL FOLLOW-UP OF NON-ITU INPATIENTS WITH COVID-19 PNEUMONIA IN A LARGE UK DISTRICT GENERAL HOSPITAL

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Introduction and Objectives Emerging data suggests COVID-19 pneumonia could lead to fibrotic changes post-infection.¹ In this study we seek to establish the radiological changes of non-ITU patients 3 months after hospital discharge based on the follow-up models recommended by the British Thoracic Society.²

Methods Patients admitted with swab-positive COVID-19 pneumonia were identified. Those who required intensive care and those deceased were excluded from analysis. Those who survived to hospital discharge were invited for a 3-month follow-up chest radiograph (CXR). Patients with normal CXRs were informed and discharged. Patients with persistent CXR changes were contacted and a decision made for further interval CXR or CT imaging.

Results 200 patients were admitted with swab-positive COVID-19 pneumonia without escalation to intensive care and discharged between mid-March and mid-May 2020. 25 were excluded from follow-up due to patient factors (e.g. extreme frailty). The patients' characteristics and outcomes are summarised in table 1. 87% of patients had their CXR return to normal after 3 months. The patients whose CXR returned to normal after 3 months are younger than those with persistent changes ($p < 0.05$).

Conclusions Our results demonstrated reassuring findings that the majority of patients receiving ward-based care for COVID-19 pneumonia who survived to discharge have normal CXR findings by 3 months post-discharge. Younger patients are more likely to have CXR changes resolved completely by 3 months. Most patients with persistent CXR changes at 3 months are improving symptomatically and radiologically so up-front CT was not requested. More follow-up is required to characterise the longer term respiratory sequelae of COVID-19. Our follow-up is ongoing and more results will be