to identify one case of LTBI following NICE guidelines would be £160.66 and using our protocol was £91.06.
Conclusions: Using QuantiFERON-TB Gold™ blood testing followed by CXR is more effective and more cost effective than NICE guideline for screening new entrants from high-risk countries.

S149 RESULTS OF SYSTEMATIC SINGLE-STEP TIGRA TESTING IN TUBERCULOSIS CONTACTS IN 2007

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Introduction: T-cell based interferon gamma release assays (TIGRA) are highly specific for the diagnosis of latent tuberculosis infection (LTBI) or tuberculosis disease. Given the relatively high incidence of tuberculosis in the city of Leicester, tuberculosis contacts were screened by Quantiferon (QFN) and/or chest *x* ray (CXR) in 2007.
Methods: All tuberculosis contacts below the age of 36 years and contacts of all ages of smear-positive pulmonary index cases were invited for TIGRA testing by QFN assay in 2007, 2–3 months after the notification date. Results are presented according to age and ethnicity of contacts as well as disease site, smear/culture positivity of the index case.
Results: 989 contacts of 269 index cases were identified and 464 contacts (47%) were QFN tested. 158/251 (63%) children (age <16 years), 220/383 (53%) of young adults (age 16–35 years), and 86/355 (24%) of older adults (age >35 years) were tested. QFN positivity was found in 11/158 (7%) children, 53/220 (24%) young adults and 37/86 (43%) adults above the age of 35 years. Indeterminate results were found in 11/58 (7%) children but in only 1/306 (0.3%) contacts above the age of 15 years. Positivity rates were similar for contacts of Indian subcontinent origin (80/399, 23.6%) and white caucasian contacts (13/58, 22.4%). Overall positivity rates were highly age dependent (table) but highly significant differences were seen between young contacts of respiratory and of non-respiratory index cases with the highest positivity rates in contacts of smear/culture-positive pulmonary index cases (age <10 years, 14.8%; age 10–19 years, 37%; age 20–29 years, 35.1%). Not a single positive QFN result was found in 34 contacts of non-respiratory index cases below the age of 20 years (age 0–19 years, 0%) but positivity rates increased above the age of 20 years even in contacts of non-respiratory index cases (age 20–35 years, 23.6%).
Conclusion: One-year results of a single step contact screening protocol involving TIGRA testing of all contacts below the age of 36 years are presented. Positivity is strongly correllated with smear/culture positivity and disease site of the index case. A probable cohort effect is seen in children and youngsters below the age of 20 years with no QFN positivity in those in recent contact with non-infectious index cases.

Abstract S149 Table Results summary of QFN testing in all contacts eligible for chemoprophylaxis by age groups (2007)

Age (years)	Total	Tested, n (%)	Positive, n (%)
0–4	101	49 (48.5)	1 (2.0)
5–9	77	57 (74.0)	4 (7.0)
10–14	66	42 (63.6)	5 (11.9)
15–19	91	47 (51.6)	8 (17.0)
20–24	99	37 (37.4)	7 (18.9)
25–29	77	40 (51.9)	10 (25.0)
30–34	43	27 (62.8)	5 (18.5)

Chronic obstructive pulmonary disease: exacerbations and clinical aspects

S150 GOLD VERSUS NICE DIAGNOSTIC CRITERIA FOR CHRONIC OBSTRUCTIVE PULMONARY DISEASE: IMPACT ON DISEASE PREVALENCE AND MORTALITY RISK WITHIN THE RENFREW/PAISLEY STUDY

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Objective: To compare chronic obstructive pulmonary disease (COPD) prevalence and mortality risk in a single population using alternative diagnostic criteria.
Methods: The global initiative for chronic obstructive lung disease (GOLD) is based on lung function alone, whereas the UK National Institute for Health and Clinical Excellence (NICE) criteria include lung function, respiratory symptoms and other risk factors. These criteria were applied to a Scottish prospective cohort (Renfrew/Paisley (Midspan) study) of 15 402 men and women aged 45–64 years at baseline and followed for over 30 years. All-cause and COPD mortality were modelled using Cox regression analysis.
Results: Overall COPD prevalence for men (women) was 31% (20%) applying GOLD criteria compared with 12% (5%) applying NICE criteria. Prevalence was strongly related to age (see table). Kaplan–Meier curves for COPD mortality by disease severity showed greater separation under NICE criteria compared with GOLD. Following Cox regression analysis (adjusting for age, smoking pack years, diastolic blood pressure, cholesterol, body mass index and social class), participants meeting NICE diagnostic criteria were found to have increased hazard ratios (HR) by disease severity for both all-cause and COPD mortality, compared with those meeting the GOLD criteria. The HR for COPD mortality for men in the most severe COPD group, compared with those without COPD, was 92 (95% CI 58 to 148) applying GOLD and 110 (95% CI 70 to 171) applying NICE. A separate analysis showed respiratory symptoms and pack years, independent of lung function, to be significant contributors to mortality risk for all-cause and COPD mortality.
Conclusion: COPD prevalence in this population is high. GOLD diagnostic guidelines are often considered the ''gold standard'' in COPD, yet they may overestimate the COPD burden: prevalence of 31% (20%) compared with 12% (5%) has important ramifications by way of planning and funding decisions at the micro and macro level. Mortality risk increased with disease severity and was higher using NICE compared with GOLD criteria: the inclusion of

Abstract S150 Table COPD prevalence by age, sex and diagnostic criteria (%) in the Renfrew/Paisley study

Age group (years)	n	GOLD	NICE
Men			
45–49	1787	24.9	8.8
50–54	1953	28.2	10.0
55–59	1655	33.5	13.1
60–64	1534	40.9	18.7
Overall prevalence (%)		31.4	12.4
Women			
45–49	2003	16.9	4.6
50–54	2263	19.2	4.6
55–59	2005	23.1	6.3
60–64	1945	20.9	3.1
Overall prevalence (%)		20.0	4.6

COPD, chronic obstructive pulmonary disease; GOLD, global initiative for chronic obstructive lung disease; NICE, National Institute for Health and Clinical Excellence.

symptoms and risk factors within the diagnostic criteria enabled high-risk and low-risk participants to be better distinguished. Independent of reduced lung function, symptoms and pack years were found to be associated with premature all-cause and COPD mortality.

S151 PROVISION OF CARE FOR CHRONIC OBSTRUCTIVE PULMONARY DISEASE IN UK HOSPITALS: SURVEY OF DOMICILIARY OXYGEN SERVICES

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Background: Patients with chronic obstructive pulmonary disease (COPD) often require assessment for provision of domiciliary oxygen in various forms including long-term oxygen therapy (LTOT), ambulatory oxygen and short-burst oxygen. The British Thoracic Society (BTS) has published guidelines regarding assessment and follow-up of patients requiring home oxygen provision. We examined the availability of home oxygen assessment and standards of care provided by respiratory medicine departments in the UK.
Methods: As part of the National COPD audit 2008 we surveyed 239 acute secondary care units in the UK using an online questionnaire to assess home oxygen services.
Results: 96% of units had some form of hospital based LTOT assessment and 73% screened all patients in clinic to detect SaO_2 less than 92%. 97% of units optimised oxygen flow to achieve a PaO_2 greater than 8 kPa but only 46% always used a concentrator machine as the oxygen source. Only 56% of units met in full the BTS criteria for follow-up arrangements for patients prescribed LTOT. Only 58% of units met in full the provision of written information to all patients receiving oxygen. 56% of units provided ambulatory oxygen for all suitable patients and 39% screened all patients before referral for assessment. Only 41% of units met in full the BTS criteria for follow-up of patients prescribed ambulatory oxygen. 75% of units provided short-burst oxygen for all suitable patients but only 47% assessed all patients for suitability for short-burst oxygen. 71% of units carried out regular audits of oxygen prescribing. We also surveyed funding for oxygen services and the majority of units (60%) did not receive funding for providing this service.
Conclusions: The majority of respiratory medicine departments in the UK provide assessment of suitability for LTOT, but only just over half have adequate follow-up arrangements. Provision of ambulatory oxygen and short-burst oxygen is much less widely available. Despite providing these services the majority of units in the UK do not receive funding for this.

S152 CHARACTERISTICS OF PATIENTS BEFORE HOSPITALISATION WITH EXACERBATION OF CHRONIC OBSTRUCTIVE PULMONARY DISEASE

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Background: Little is known about the course of chronic obstructive pulmonary disease (COPD) patient care before admission or the opportunities to improve primary care interventions. As part of the 2008 National COPD Audit, hospital teams were asked to send questionnaires to the general practitioners (GPs) of the first 30 patients admitted with a COPD exacerbation during the audit period. This detailed patient care in the 12 months before the index admission.
Results: 2521/6660 (38%) GP responses were received. Missing data for specific questions were omitted from the relevant analysis and are reflected by denominators of 2521 or less. 90% of patients were recorded by GPs to have COPD before their index admission. Patient contacts with primary care in the 12 months before admission are given in the table. A median (interquartile range; IQR) of two (0–4) courses of prednisolone and three (1–6) courses of antibiotics was prescribed to each patient in the previous 12 months. 34% (686/2041) of patients were prescribed a rescue pack of antibiotics. Spirometry information was available for 84% (1893/2244) of those known to have COPD with a median FEV_1 of 0.89 (0.65–1.21) recorded a median (IQR) of 8 (4–15) months before their admission. 74% (1786/2400) of patients were using a combination inhaler (Symbicort/Seretide) and 11% were not on any long-acting BD or inhaled corticosteroid medications at all. 15% (313/2054) had undergone pulmonary rehabilitation in the past 12 months. GPs rated the communication of discharge information about COPD exacerbations as average, poor or very poor in 45% (1068/2384).
Conclusion: This is the first UK survey of COPD patient characteristics before admission. Most are known to have COPD and are characterised by frequent exacerbations. They have multiple contacts with primary care. Despite this, many are not seen in practice airway clinics and are not treated with LABA and inhaled steroids. Only one-third are given rescue antibiotics. Few patients undergo pulmonary rehabilitation and GP's report dissatisfaction with hospital discharge summaries. There appears to be an opportunity for primary care interventions to reduce admission and exacerbation frequency. Communication between hospital and primary care must be improved if interventions are to be effective.

Abstract S152 Table

	Median	IQR	Zero	1–2	3–4	5+	Cases
No of COPD exacerbations recorded in 12 months before index admission	3	1–5	14%	31%	25%	30%	2204
No of contacts with GP out-of-hours service in 12 months before index admission	0	0–2	51%	32%	9%	8%	2164
Times patient was seen in practice airways clinic in 12 months before index admission	0	0–2	31%	52%	12%	5%	2122
No of visits to practice in 4 weeks before admission	1	0–3	26%	43%	21%	10%	2201
	Median	**IQR**	**<5**	**5–9**	**10–19**	**20+**	**Cases**
No of contacts with or visits to practice in 12 months before index admission	12	7–20	19%	20%	36%	25%	2215

COPD, chronic obstructive pulmonary disease; IQR, interquartile range.

S153 CYTOKINE DIFFERENCES BETWEEN RHINOVIRAL AND BACTERIAL EXACERBATIONS OF CHRONIC OBSTRUCTIVE PULMONARY DISEASE

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Background: Exacerbations of chronic obstructive pulmonary disease (COPD) are associated with a rise in sputum and systemic inflammatory markers. We investigated whether this rise varied depending upon the pathogen detected at exacerbation and whether viral load affects cytokine response.
Methods: We studied 24 patients (15 men) from April 2006 to April 2008; mean age 74.1 years (SD 9.3), FEV_1 1.13 litres (0.44), FEV_1% predicted 49.3% (17.9), body mass index 27.5 kg/m^2 (5.3) and smoking history 41.5 pack years (25.8). All patients were sampled at baseline (>42 days post and >14 days pre an exacerbation) and within 7 days of the onset of an exacerbation, before initiation of treatment. Exacerbations were defined using diary cards according to our usual definition of two symptoms (major and/or minor), or if in the opinion of the clinician the patient had an exacerbation. All patients had sputum samples sent for routine bacterial culture, real time PCR for quantification of viral load for human rhinovirus (HRV) and cytokine analysis (IL-6 and IL-8). 38 patients had blood for IL-6, 22 for IL-8. All baseline sputum samples were negative for bacteria or HRV.
Results: 42 exacerbations were studied; 19 no pathogen detected, five HRV only, 14 bacteria only and four HRV and bacteria. In all there was a statistically significant increase in sputum IL-8 and blood IL-6 from baseline to exacerbation (both Wilcoxon $p<0.001$). The increase in blood IL-6 was greater with bacterial detection at exacerbation compared with HRV (mean 80.2 (116.0) vs −0.73 (8.4), Mann–Whitney $p = 0.001$). Absolute sputum IL-8 and blood IL-6 levels were higher at exacerbation if bacteria was detected (*Haemophilus influenzae*, *Moraxella catarrhalis* or *Streptococcus pneumoniae*) compared with HRV; log sputum IL-8 mean 3.9 (0.31) versus 3.5 (0.36); analysis of variance (ANOVA) $p = 0.04$ and log blood IL-6 mean 1.5 (0.67) versus 0.46 (0.32); ANOVA $p = 0.008$. The cytokine response at exacerbation was independent of viral load; sputum IL-8 ANOVA $p = 0.42$ and blood IL-6 ANOVA $p = 0.40$.
Conclusions: Bacterial exacerbations of COPD result in greater cytokine increases of sputum IL-8 and blood IL-6 than HRV exacerbations. HRV may trigger a different type of cytokine response.
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S154 RESPIRATORY ASSESSMENT CENTRE: DOES IT INCREASE THE NUMBER OF PATIENTS TAKEN HOME WITH THE EARLY SUPPORTED DISCHARGE TEAM?

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Introduction: We have previously reported a pilot of a respiratory assessment centre (RAC) that consists of a 14-bed unit alongside the medical admissions unit. Patients with respiratory conditions are admitted direct from A&E and the GP assessment area and are then looked after by a dedicated consultant respiratory physician and training medical staff from 09:00 to 17:00 hours, 7 days per week. We postulated this improved quality and possibly the efficiency of respiratory care.
Methods: A prospective audit of numbers of chronic obstructive pulmonary disease (COPD) patients taken home with the early supported discharge (ESD) team during the pilot phase and since the formal establishment of the RAC was performed and compared with the 2 years prior to this. In addition, as a control we compared the data with the same period at the Royal Liverpool University Hospital (RLUH), which utilises the same ESD team and protocols and has very similar admission patterns.

Abstract S154 Table

	Winter months (January–May)				Summer months (June–November)		
	2005	2006	2007	2008	2005	2006	2007
UHA	126	125	195	244	142	164	168
RLUH	88	89	62	NA	65	83	88

RLUH, Royal Liverpool University Hospital; UHA, University Hospital Aintree.

Results: In 2007 between January and May 195 patients went home with ESD, in 2008 244 when the RAC was operating, before this 126 and 125 went home in 2005 and 2006, respectively. This is therefore almost double the number of patients able to go home with the ESD in 2008 compared with the years before the RAC existed. The numbers of patients from RLUH going home with ESD over this time period were stable: 2005, 88; 2006, 89; 2007, 62; 2008, not available. During the summer months (June–November) when the RAC was not operating numbers were stable: 2005, 142; 2006, 164; 2007, 168. In the RLUH there was no change seasonally (see table).
Conclusion: These results demonstrate that the RAC increases the discharges achieved by the ESD team. In the summer months with no RAC the numbers approximate to historic levels and when compared with the control site numbers are higher. On reviewing case notes this difference could not be explained by protocol variances and we postulate that this is due to more effective utilisation of the ESD team. These data support the development of speciality-based acute care such as RAC.

S155 ARE EMERGENCY "EXACERBATION PACKS" A USEFUL COMPONENT OF SUPPORTED SELF-MANAGEMENT FOR PATIENTS WHO HAVE BEEN ADMITTED WITH AN ACUTE EXACERBATION OF CHRONIC OBSTRUCTIVE PULMONARY DISEASE?

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Introduction and Objectives: Early use of oral corticosteroids for acute exacerbations of chronic obstructive pulmonary disease (COPD) is recommended but not routine locally (*Thorax* 2007;**62**:IIIA117). This study evaluated the practicalities of providing emergency "exacerbation packs" (EEP) to inpatients with COPD to treat subsequent acute exacerbations of COPD and the effect on re-admission over 3 months.
Methods: Patients admitted with COPD (November 2007 to May 2008) were seen by a respiratory nurse specialist. Patients meeting the criteria for safe provision of EEP (7 days prednisolone 30 mg and amoxicillin/doxycycline) received one with discharge medication. EEP usage was assessed by monthly telephone follow-up. 3-month data on admissions and bed-days were analysed.
Results: Of 145 patients assessed, only 11/145 (8%) met the inclusion criteria (six women, five men; mean (range) age 70 years (61–80); mean (SD) FEV_1 0.73 litres (0.33); FVC 1.63 litres (0.72); MRC dyspnoea score 3.7 (0.7); new COPD diagnosis in 3/11 (27%); first admission in 8/11 (73%)). The EEP was used appropriately by 6/11 (55%) patients; one had a further admission. It was not used appropriately by two patients; one with two further admissions. The EEP was not needed by three patients. Hence 2/11 (18%) patients were re-admitted within 3 months. In the year before EEP, the 11 patients used a total of 187 bed-days per year. After EEP the patients used 41 total bed-days at 3 months equivalent to 164 bed-days per year.

Abstract S155 Table

Reasons for exclusion	n = 134; 68 men; 66 women; age 72 years (32–102)
Medical contra-indications	n = 77
Co-morbidities	50
Abnormal CXR	12
Diabetes mellitus	9
Co-existing asthma	5
Peptic ulcer disease	1
Unable to understand how to use EEP	n = 26
Cognitive impairment	9
Language difficulties	8
Unable to follow instructions	9
Other reasons	n = 31
Chronic respiratory support at home	26
Lives abroad	2
Did not want EEP	2
Self-discharged	1

CXR, chest *x* ray; EEP, emergency exacerbation pack.

Conclusions: EEP were of limited value for our patients admitted with severe COPD. Fewer than 10% patients were suitable for EEP, mainly because of other medical problems or inability to master using one. In the small group given an EEP, half used it appropriately within 3 months. Patients admitted with COPD have complex medical and educational needs, which are not specifically addressed by a self-administered EEP.

Diagnosis and staging of lung cancer

S156 ENDOBRONCHIAL ULTRASOUND: TRANSOESOPHAGEAL ULTRASOUND-GUIDED LYMPH NODE SAMPLING USING A LINEAR ULTRASONIC BRONCHOSCOPE IN THE STAGING OF LUNG CANCER

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Lung cancer treatment planning requires accurate staging of mediastinal lymph nodes. Current methods include mediastinoscopy, positron-emission tomography (PET-CT) and endobronchial (EBUS) or transoesophageal (EUS) ultrasound-guided lymph node aspiration. PET-CT is non-invasive but has only a moderate positive-predictive value in the assessment of lymph node metastases. The ''gold standard'' is mediastinoscopy, which allows surgical evaluation of lymph node stations 2, 3, 4 and 7. EBUS and EUS are less invasive than mediastinoscopy and are performed as outpatient procedures under conscious sedation. EBUS allows sampling from stations 2, 3, 4, 7, 10 and 11. EUS allows staging of stations L4, 7 and 8. We have performed over 500 EBUS procedures (2005–8) using an Olympus linear ultrasonic bronchoscope (BF-UM40). Lymph node samples were obtained using a 22G needle and tissue processed as a cell block before immunohistochemical analysis. Although EBUS is well tolerated, we have found that in a proportion of cases it was easier to aspirate lymph node stations L4, 7 and 8 via the transoesophageal route using the EBUS bronchoscope (EUS (EBUS)) and identical sample collection technique. We have analysed data from the first 40 EUS (EBUS) cases. This approach was employed to evaluate station L4 (different angle to transbronchial approach) in 15 cases, to provide additional sample from L7 in 11 cases, to access L8 in one case and to access a lung mass in four cases. Technical difficulties with the EBUS approach (extrinsic compression of the airway and inability to penetrate tracheal wall) prompted EUS (EBUS) in five cases. In addition, the EUS (EBUS) approach was used to minimise patient distress (cough, SpO_2 <90%, FEV_1 <1.0 l) in five cases. Tissue samples from lymph nodes or lung mass were obtained at 28/40 EUS (EBUS) procedures. 16 confirmed a diagnosis of malignancy (lung cancer in 12) and 12 were negative for cancer with no ''false-negative'' aspirates. In 12 cases no aspirates were taken either due to the absence or small (<5 mm) size of lymph nodes. There were no complications and the procedure was well tolerated. In conclusion, transoesophageal aspiration using the linear ultrasonic bronchoscope should be considered a safe and effective method of mediastinal staging as an alternative to mediastinoscopy.

S157 TEST PERFORMANCE OF ENDOBRONCHIAL ULTRASOUND AND TRANSBRONCHIAL NEEDLE ASPIRATION BIOPSY FOR MEDIASTINAL STAGING IN PATIENTS WITH LUNG CANCER: SYSTEMATIC REVIEW AND META-ANALYSIS

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Introduction: Endobronchial ultrasound (EBUS) and transbronchial needle aspiration (TBNA) is becoming widely used for mediastinal lymph node staging in patients with known or suspected lung cancer. Whereas there are a number of case series evaluating the sensitivity and specificity of this investigation, many have small numbers that limit the ability to assess the precision of EBUS TBNA as a staging modality. The aims of our study were to perform a systematic review of published studies evaluating EBUS TBNA for mediastinal lymph node staging and to ascertain the pooled sensitivity and specificity of this investigation in comparison with published results of computed tomography (CT) and positron emission tomography (PET).
Methods: A literature search was constructed and performed by a professional medical librarian from 1960 to February 2008. Pooled specificity and sensitivity was estimated from the extracted data with an exact binomial rendition of the bivariate mixed-effects regression model.
Results: Of 365 EBUS publications, we identified 24 that specifically focused on mediastinal lymph node staging, with only 10 reporting data possible for extraction. The overall test performance was excellent, with an area under the summary receiver operating characteristics curve of 0.99 (95% CI 0.96 to 1.00), similarly the EBUS TBNA has excellent pooled specificity of 1.00 (95% CI 0.92 to 1.00) and good pooled sensitivity of 0.88 (95% CI 0.79 to 0.94).
Conclusions: The results of our study indicate excellent overall test performance and specificity of EBUS TBNA when used for mediastinal lymph node staging in patients with lung cancer. In addition, the pooled test specificity and sensitivity compares favourably with published results of CT and PET. More work is required to compare directly the role of EBUS TBNA in relation to mediastinoscopy and define its clinical utility in the era of integrated PET-CT.

S158 ENDOSCOPIC ULTRASOUND-GUIDED TRUCUT BIOPSY FOR EVALUATION OF MEDIASTINAL LYMPHADENOPATHY AND LUNG CANCER STAGING

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Introduction and Objectives: Transoesophageal endoscopic ultrasound (EUS) guided biopsy has been used to diagnose and stage mediastinal lymphadenopathy and can reduce the need for mediastinoscopy.[1] EUS fine needle aspiration (FNA) has been performed at Queen's Medical Centre, Nottingham since May 2002 and Trucut biopsy since December 2002. We evaluated the