**Poster sessions**

**P90 AMBULATORY OXYGEN ASSESSMENTS IN COPD AND PULMONARY FIBROSIS**

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**Background** Between 2006 and 2011, 161 patients were referred for formal ambulatory oxygen assessment at the Newcastle RVI. Their results have been reviewed.

**Method** The assessments comprised three 6-min walk tests (6MWT) supervised by a trained healthcare professional as per BTS guidelines (2006).

- Test 1: On room air (RA)
- Test 2: On room air with the oxygen supply switched off
- Test 3: On oxygen 4 l/min via nasal cannulae

Minimum SpO\(_2\) during exercise, distance walked and oxygen flow rate required to maintain SpO\(_2\) above 90% were recorded together with the respiratory diagnosis and basic demographic details.

**Results** 18 patients were excluded as they did not de saturate on walk 1 or were unable to complete the 6MWT. 145 patients’ results were analysed. 82 were male with 63 female. The two commonest clinical diagnoses were Interstitial Pulmonary Fibrosis (IPF) and COPD.

IFF patients walked on average 70 m (51%) further than COPD patients on room air. They had the greatest increase in oxygen saturation when exercising on supplemental oxygen (12%) but had the lowest improvement in walking distance (7.5%). There was no relationship between improvement in walk test distance and improvement in oxygenation in any of the subgroups.

**Conclusion** Further studies may be needed to explore the relative benefits of ambulatory oxygen in non-COPD patients.

**P91 CYCLIN-DEPENDENT KINASES 7 AND 9 SPECIFICALLY REGULATE NEUTROPHIL TRANSCRIPTION AND THEIR INHIBITION DRIVES APOTOPSIS TO PROMOTE RESOLUTION OF INFLAMMATION**

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**Introduction and Objectives** Terminally-differentiated neutrophils are short-lived but key effector cells of the innate immune response and play a prominent role in the pathogenesis and propagation of many inflammatory diseases including interstitial lung disease. BAL neutrophilia has been correlated with poor outcome in idiopathic pulmonary fibrosis (IPF) and neutrophils are the dominant cell type in acute exacerbations of IPF as well as in diffuse alveolar damage. Non-specific cyclin-dependent kinase inhibitor drugs have previously been shown to resolve neutrophil-dominant inflammation in the murine bleomycin lung injury model an established model of IPF.

Here we elucidate the mechanism by which CDK inhibitor drugs mediate neutrophil apoptosis and hence promote resolution of inflammation.

**Methods** We isolated peripheral blood neutrophils from healthy human donors and performed a variety of experiments including microarray, confocal microscopy and apoptosis assays (flow cytometry, fluorometric assay, DNA ladders and mitochondrial integrity assay and western blotting) to show that specific effects on neutrophil transcriptional capacity are responsible for CDK-inhibitor driven neutrophil apoptosis. Finally we show that specific CDK inhibitors drive resolution of neutrophil-dominant inflammation in the murine bleomycin lung injury model (Histology, BAL analysis).

**Results** CDK inhibitors drive neutrophil apoptosis. Neutrophil apoptosis is dependent on a critical balance of pro- and anti-apoptotic proteins. Functional transcriptional machinery is present in human peripheral blood neutrophils. CDKs are present in neutrophils and their activity is both demonstrated and modulated with the use of specific CDK inhibitors. Specific CDK inhibition is a successful strategy for the resolution of murine bleomycin lung injury.

**Conclusion** We highlight a novel mechanism that controls both neutrophil transcription and apoptosis that could be targeted by selective CDK inhibitor drugs to resolve established neutrophil-dominant inflammation.

**P92 ARE CASES OF GRANULOMATOUS COMMON VARIABLE IMMUNODEFICIENCY MISDIAGNOSED AS SARCOIDOSIS IN ROUTINE CLINICAL PRACTICE?**

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**Introduction** Common variable immunodeficiency (CVID) is a primary immune disorder characterised by impaired B cell differentiation and hypogammaglobulinaemia. It predisposes to encapsulated bacterial infections, commonly affecting the respiratory tract. 8%-20% of CVID patients have a granulomatous form. Granulomatous CVID may share clinical features with sarcoidosis, namely persistent cough, breathlessness, fatigue, fever, and arthralgia. Non caseating granulomata in lymph node biopsies and elevated angiotensin converting enzyme levels occur in both conditions. Differentiation between the two conditions is essential to allow management with immunoglobulin replacement and avoidance of excessive corticosteroids.

**Method** Patients with a diagnosis of “sarcoidosis” recorded in chest clinic letters between April 2009 and September 2010 were identified. Clinic letters, blood tests, histology and imaging were reviewed.

**Results** 175 patients with a diagnosis of sarcoidosis were identified. 80% had lymphadenopathy and 62% pulmonary involvement. Dermatological, ocular, rheumatological and other involvement was found in 19%, 17%, 16% and 9% respectively. 24% had potential features of CVID, such as recurrent chest infections, sinusitis, bronchiectasis or inflammatory bowel disease. Total globulin had been measured in 172/175 (98%) patients. 45/172 (26%) had elevated total globulin; 3/172 (2%) had low total globulin levels. Immunoglobulins had been measured in 172/175 (98%) patients. Immunoglobulins had been measured in 106/175 (61%). Immunoglobulins had been measured in: 20/28 (71%) of those with recurrent sinusitis or lower respiratory tract infections; 20/25 (80%) of those with bronchiectasis; and 8/8 (100%) of those with both recurrent chest infections and bronchiectasis. Four patients had persistently low IgM, two had persistently low IgA and one had persistently low IgG. No single...
patient had polyclonal hypogammaglobulinaemia, but levels were not measured in 11/42 (26%) with potential features of CVID.

**Conclusion** Our study identified a cohort of patients with a diagnosis of sarcoidosis and features associated with CVID. We found that immunoglobulins were not being routinely measured during the work-up of patients with sarcoidosis as recommended by the Map of Medicine. Recent review of 28 local CVID patients identified two who were initially misdiagnosed with sarcoidosis. In one case this misdiagnosis persisted for 8 years. Granulomatous CVID is uncommon, but respiratory physicians should ensure that their routine work-up for sarcoidosis excludes this treatable condition.

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**Integrated respiratory care**

**P93 HOSPITAL ADMISSION AVOIDANCE FOR PEOPLE WITH EXACERBATIONS OF CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD) THROUGH COLLABORATIVE WORKING BETWEEN SUFFOLK COPD SERVICES AND EAST OF ENGLAND AMBULANCE SERVICE**

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**Introduction** BTS Guidelines recommend that admission avoidance schemes should be available for patients with exacerbations of COPD. The Suffolk COPD Service was established in 2009, operating 365 days/year. One strand of the service aims to avoid inappropriate hospital admission by encouraging GPs to refer to the service rather than sending patients into hospital. However, despite wide publicity hospital admission rates remained high. Review of 24 COPD hospital admissions suggested that 50% would have been suitable for admission avoidance through Suffolk COPD Services. 95% of these patients had been brought in to A&E by ambulance. Feasibility of direct ambulance referral into Suffolk COPD Services was discussed with ambulance personnel.

**Method** A business case, working protocol and pathway were developed jointly, along with a robust clinical governance system. It was planned that a member of the Suffolk COPD nursing team would visit the patient within 4 h of referral. Approval was gained from the Local Medical Council and Expert Clinical Steering Group. The system was launched following wide publicity and training of both ambulance and nursing staff.

**Results** The first successful referral was received 40 min after the launch. In the first year 83 referrals were received, of which only eight were inappropriate and requiring redirection to other services or hospital admission.

**Advantages of ambulance referral system:**
- Reduction in ambulance call cycle time by up to 30 min
- Increased ambulance personnel COPD knowledge
- Development of patient group directives
- Improved team working/collaboration across services
- Ability to discharge duty of care to a specialist community service
- Increased admission avoidance
- People cared for in own home
- “Self supported” care encouraged
- Cost efficient

**Conclusion** 73% were admissions avoided compared to the 50% which had been predicted. The collaboration was a successful model of service delivery, reducing hospital admissions by the seamless transition of the duty of care from the ambulance service to the Suffolk COPD Services, who supported the patient at home.

**Abstract P93 Table 1**

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**REFERENCE**