physiological

We reviewed the clinical, biochemical, radiological and
development in predicting treatment indication and disease severity in a well-
evaluated sarcoidosis population over a 26-year follow-up period. Granulomatous CVID is
uncommon, but respiratory physicians should ensure that their routine work-up for sarcoidosis excludes this treatable condition.

Objectives The aim of this retrospective observational study is to
dermine 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.

Introduction C reactive protein (CRP) is an acute-phase protein
synthesised in response to tissue damage or inflammation. Previous
studies evaluating the role of CRP in sarcoidosis have focussed on
disease monitoring. Adequate markers to determine predictors of
progression in sarcoidosis are currently lacking.

Methods We reviewed the clinical, biochemical, radiological and
physiological findings in all confirmed sarcoidosis patients attending a
regional referral centre between 1983 and 2009. Disease progression
was defined in two ways: decline in lung function as per
Hunninghake criteria (>15% reduction in baseline FEV1 % and/or
>10% decline in baseline DLCO %); and radiological progression (defined as worsening stage of disease and/or development of
bronchiectasis or cavitation). Indication for treatment was defined as
need for corticosteroid treatment throughout duration of follow-
up. Correlation coefficients and multiple logistic regression (MLR)
analysis were performed to determine independent baseline variable relating to outcome. Results are expressed as OR, 95%-CIs and
p-values.

Results 328/409 (80.2%) of sarcoidosis patients were suitable for
inclusion, 46.6% of whom had an abnormally elevated CRP at
presentation. MLR analysis of presenting characteristics with baseline
CRP showed strong associations with Löfgren’s syndrome
(p<0.002) and FVC % (p<0.009), consistent with previously
published data. In terms of predicting outcomes, CRP was found to be
an independent predictor of both radiological progression and
physiological deterioration (p=0.026 and 0.048 respectively).
Other independent indices for radiological progression were smoking status,
Löfgren’s syndrome and Scadding CXR stage at presentation
(p=0.035, 0.002 and <0.001 respectively). DLCO % was shown to be
a further independent predictor of physiological decline (p=0.015).

Conclusion This is one of the largest clinical studies investigating the
predictive influence of CRP in sarcoidosis. The data suggests a role
for CRP as a predictive indicator of physiological deterioration and
radiological progression. Therefore, a subset of chronic sarcoidosis
patients with high baseline CRP at presentation may benefit from
closer monitoring and extra attention to parameters of physiological
and radiological decline.

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 Guideline was established in 2009, operating
565 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 50 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

<table>
<thead>
<tr>
<th>Period from July 2010 to June 2011</th>
<th>Total referrals</th>
<th>Appropriate referrals</th>
<th>Admitted at nurse 1st visit</th>
<th>Admitted within 2/52</th>
<th>Total admissions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>83</td>
<td>75 (90%)</td>
<td>10 (13%)</td>
<td>10</td>
<td>20 (27%)</td>
</tr>
</tbody>
</table>

REFERENCE
1. Intermediate care-hospital-at-home in chronic obstructive pulmonary disease: British