Hypothesis Greater physician involvement with a prospective coding cross-checking system would improve coding outcome for EBUS-TBNA and financial disparity.

Methods From November 2010 to June 2011, 52 consecutive patients underwent EBUS-TBNA in a UK teaching hospital. After every procedure, anonymised patient details were emailed securely to the Trust Coding Lead. Every month, the Trust Informatics Lead would email the final coding outcomes and tariffs for all the EBUS-TBNA patients. These were cross-checked against a prospective anonymised procedure database. Primary outcome was coding accuracy. Data were compared to a previous EBUS-TBNA coding study[2] as a control (no coding intervention) using contingency table analysis with Fishers Exact Test and a p value of <0.05 was deemed significant (GraphPad Prism 5 software). Differences in financial loss were calculated using a tariff of £504 for conventional bronchoscopy and £3404 for EBUS-TBNA (E63.2+T87.4).

Results All 52 patients were coded correctly with no financial loss. From the previous study of 52 patients, 8 (14.4%) were coded incorrectly which was significant (OR 20.1, 1.1–357.5, p=0.006, Fishers Exact). Financial loss to the NHS Trust was calculated as £23 200, projected to £40 000 per year.

Conclusion Greater physician engagement with coders improves coding outcomes. This is of particular importance in interventional specialties where the potential for financial loss is of a higher magnitude. A simple prospective cross-checking system can achieve better outcomes with no extra cost and minimal effort.

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P188 IMPACT OF WARD BASED CHEST ULTRASOUND ON THE RADIOLOGY DEPARTMENT

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Introduction The ability for chest physicians to perform chest ultrasound is on the increase since the NPSA report concerning chest drain insertion and the BTS Pleural guidelines 2010. Our respiratory department received a portable ultrasound device (Sonosite 180 Plus) in April 2010 and by August 2010 we had 3 physicians who have achieved level 1 thoracic ultrasound skill (1 Chest Consultant, 2 Specialist Registrars—1 Respiratory, 1 Acute Medicine). We were keen to see what kind impact this has made on the chest ultrasound requests on the radiology department.

Methods Data collected comparing 2 periods. Dataset 1: Nov 2009–Jan 2010 and Dataset 2: Nov 2010–Jan 2011. Information was gathered via the Webpacs system (GE Medical System: Centricity® Enterprise Web) and the CRIS—Clinical Radiology Information System (Healthcare software system). Only adult (=16 years) inpatient request were included.

Results

Dataset 1: Nov 2009–Jan 2010	Dataset 2: Nov 2010–Jan 2011
n=81	n=45
55 (68%) scan done on same day of receiving request	32 (71%) scan done on same day of receiving requests
All scans done within 6 days	All scans done within 3 days
Imaged saved 62 (77%)	Images saved 35 (78%)

Summary Having physicians with skills to perform chest ultrasound by the bedside has reduced the burden on the radiology department and the response times to the scan all the patients has halved from 6 to 3 days. We hope this service can be further improved with more physicians attaining this skill.

P189 EVALUATION OF THE ROLE OF CARDIO-PULMONARY EXERCISE TESTING IN THE DIAGNOSIS OF UNEXPLAINED BREATHLESSNESS

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Introduction and Objectives Cardio-Pulmonary Exercise Testing (CPET) provides a non-invasive measurement of cardiac and pulmonary function. CPET offers a unique assessment tool for the investigation of patients with unexplained dyspnoea (UD). These individuals often undergo exhaustive, expensive and invasive assessment without definitive diagnosis. CPET can provide valuable diagnostic information and helps to focus further assessment of the dyspnoeic patient. The aim of this retrospective cohort study was to evaluate the outcome of CPET in patients with UD and to determine how clinically useful the test is at influencing further management.

Methods CPET data were collected between February 2008 and February 2011 for patients with UD and analysed retrospectively. Data included demographics, pre-CPET investigation results, the CPET report and post-CPET clinic letters. This information was accessed via hospital reporting systems as well as a local CPET database and patient notes.

Results Patient demographics and pre-CPET investigation data are shown in Abstract P189 table 1. Patients were assigned diagnoses based on test reports. A total of 96 (64%) patient letters were obtained to

Abstract P189 Table 1 Table demonstrating —A: Patient demographics, B: Investigation performed in 6 months prior to CPET (unless stated), C: Post CPET diagnosis

Pre-test		Post-test	
A		C	
Demographics	**Mean (range)**	**Diagnosis**	**No. with specific diagnoses (%)**
BMI	27.7 kg/m^2 (17.6–43.8)	Normal	41 (27)
Age	53.5 yrs (17–80)	Deconditioning	26 (17)
Sex distribution	Female 70% Male 30%	Pulmonary vascular disease	24 (16)
B		Dysfunctional breathing	23 (15)
		Cardiac pump failure	18 (12)
Investigation	**% Performed**	Chronotropic Insufficiency	11 (7)
Lung function	91	Heart Failure	10 (7)
Any blood test (6 months)	67	None	10 (7)
Chest radiograph	67	Ischaemic heart disease	9 (6)
Echocardioram	45	Myopathy	9 (6)
CT scan	27	Drugs	7 (5)
V/Q scan	23	Raised BMI	7 (5)
Coronary angiogram	15	Obstructive lung disease	5 (3)
Cardiac treadmill test	7	Restrictive lung disease	5 (3)
6-min walk test	4	Cardiomyopathy	1 (1)
Cardiac MRI	3	Metabolic causes	1 (1)
Pleural biopsy	1	Rhythm abnormality	1 (1)