Poster sessions

Table 1: Patient characteristics of 95 screened patients

<table>
<thead>
<tr>
<th></th>
<th>Eligible patients (n=55)</th>
<th>Non-obstructive ratio (n=27)</th>
<th>Obstructive ratio &amp; FEV&lt;sub&gt;1&lt;/sub&gt;≠80% (n=10)</th>
<th>History of asthma (n=3)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age, years (mean[SD])</td>
<td>69 (10)</td>
<td>68 (10)</td>
<td>72 (14)</td>
<td>68 (1)</td>
</tr>
<tr>
<td>Gender, Male (patients [%])</td>
<td>42 (76)</td>
<td>16 (59)</td>
<td>5 (50)</td>
<td>2 (67)</td>
</tr>
<tr>
<td>History of smoking (patients [%])</td>
<td>55 (100)</td>
<td>27 (100)</td>
<td>10 (100)</td>
<td>2 (67)</td>
</tr>
<tr>
<td>Pack-year history (mean[SD])</td>
<td>45 (37)</td>
<td>31 (25)</td>
<td>36 (16)</td>
<td>2 (3)</td>
</tr>
<tr>
<td>Exacerbation frequency (mean[SD])</td>
<td>1.8 (2.3)</td>
<td>1.8 (2.4)</td>
<td>1.1 (1.1)</td>
<td>1.7 (1.5)</td>
</tr>
</tbody>
</table>

**Spirometry (mean[SD])**

<table>
<thead>
<tr>
<th>FEV&lt;sub&gt;1&lt;/sub&gt;</th>
<th>1.41 (0.46)</th>
<th>2.30 (0.52)</th>
<th>2.28 (0.55)</th>
<th>1.73 (0.72)</th>
</tr>
</thead>
<tbody>
<tr>
<td>FVC</td>
<td>2.70 (0.84)</td>
<td>3.06 (0.70)</td>
<td>3.68 (0.78)</td>
<td>2.86 (0.82)</td>
</tr>
<tr>
<td>FEV&lt;sub&gt;1&lt;/sub&gt;/FVC</td>
<td>54 (13)</td>
<td>86 (19)</td>
<td>89 (4)</td>
<td>60 (13)</td>
</tr>
<tr>
<td>FEV&lt;sub&gt;1&lt;/sub&gt;/FVC</td>
<td>0.52 (0.09)</td>
<td>0.75 (0.05)</td>
<td>0.62 (0.06)</td>
<td>0.60 (0.10)</td>
</tr>
</tbody>
</table>

[5%] were enrolled in other research, and 37 [21%] were unsuitable for other reasons, 8 appointments were pending with screening data available for 95 patients (Table 1). 40 patients (42%) did not satisfy the spirometric inclusion criteria; 27 did not show airflow obstruction, 10 had mild COPD, and 3 had asthma. Approximately 25 contact letters and up to £260 were therefore required per eligible patient identified.

**Conclusion** A high proportion of patients on primary care databases fail to meet spirometric criteria for COPD trials and the screening failure rate via this recruitment pathway is much higher than previously reported. A large number of initial contacts are required for each patient identified. COPD patients are increasingly managed in primary care and these findings therefore have implications for planning future studies.


**APPLYING THE GOLD 2011 CLASSIFICATION TO A REAL-WORLD COPD POPULATION IN GERMANY**

**Objectives** The GOLD 2011 Strategy now recommends assessment based on exacerbation history and symptoms in addition to airflow limitation. Our goal was to better understand this classification system by analysing the distribution of patients across the 4 groups, their treatment and comorbidities in a real-world population.

**Methods** GOLD 2011 criteria were applied to a German COPD population sampled from the Adelphi Respiratory Disease Specific Programme undertaken in 2011. Patients were recruited from consulting primary and specialist physicians. Chi-squared tests were performed.

**Results** 507 patients had a FEV<sub>1</sub>, value and/or exacerbation history and COPD Assessment Test (CAT) score. 10.5% of patients scored 0–9 using CAT, resulting in an uneven distribution of patients in groups A-D, 7.7, 2.8 and 39.6% respectively. Using mMRC, the distribution of patients in groups A-D was 35.1, 20.9, 19.1, and 24.9%. Inhaled corticosteroid (ICS) therapy was prescribed to 51.3, 57.9 and 42.7% of group A, B and D patients, respectively. Cardiovascular disease (51.3, 68.0, 75.2% [p=0.02]), diabetes (6.5, 17.8, 18.9% [p=0.20]) and obesity (0, 12.6, 16.8% [p=0.04]) increased across groups A, B and D respectively. Due to low numbers, group C was excluded from the comparison analysis.

**Conclusion** 2.8% of patients qualified as high risk/low symptoms suggesting this patient type is rare based on a CAT evaluation, using mMRC this proportion was 19.1%. An education gap exists regarding the appropriate use of ICS given the high proportion of treated low risk patients. CV and metabolic comorbidities are more prevalent with increasing risk/symptoms so a holistic approach may be necessary, especially for group D patients.


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proportion of patients in categories A, B, C and D, respectively, when evaluated by CAT was 10, 49, 1 and 40%, and when evaluated by mMRC was 39, 20, 13 and 28%. By CAT evaluation in categories A, B, C, and D, patients were using a long-acting β₂-agonist (LABA) alone (8, 6, 0 and 1%), long-acting muscarinic antagonist (LAMA) alone (37, 25, 8 and 5%), inhaled corticosteroid plus LABA (ICS/LABA) alone (22, 18, 8 and 8%), and ICS/LABA plus LAMA only (11, 20, 46, 43%).

**Conclusion** CAT assessment increased the number of patients in the more symptomatic categories (B and D), compared with mMRC. Contrary to the GOLD 2011 recommendations, by CAT assessment, a high proportion of low-risk patients (A and B) were using ICS/LABA.

**P186** PERSPECTIVES OF PATIENT AND PROFESSIONAL PARTICIPANTS ON TELEHEALTHCARE AND THE IMPACT ON SELF-MANAGEMENT: QUALITATIVE STUDY NESTED IN THE TELESCOT COPD TRIAL

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**Background** The TELESCOT randomised control trial, is investigating the impact of a telemonitoring service for COPD with the primary aim of reducing hospitalisation.

**Aim** The nested qualitative study explored the views of patients and professionals on models of telemetric service delivery and the impact on self-management.

**Method** Semi-structured interviews with patient and professional participants at different time points in the TELESCOT trial were transcribed, coded and analysed thematically. Interpretation was supported by multidisciplinary discussion.

**Results** 38 patients (47% male, mean age 67.5 years) and 32 healthcare professionals provided 70 interviews. Both patients and professionals considered that home telemonitoring had the potential to reduce the risk of hospital admission.

**Patients** generally appreciated being ‘watched over’ by the tele-monitoring, which gave them confidence to manage their own condition. They used tele-data to improving their understanding of COPD, determine their current state of health and influence decisions about their daily activities. Numerical data (e.g. oxygen saturations) were particularly valued. Changes in readings validated their decisions to adjust treatment or seek timely professional advice, and eased access to clinical care.

Professionals emphasised the potential role of telemetry in encouraging prompt compliance with medically defined behaviours and attitudes, though there was concern that ‘fixation’ on monitoring physiological parameters (especially oxygen saturation levels), promoted a medical model of the disease and might increase dependence on services in some patients.

The GPs and community nursing or physiotherapy teams who provided home telemonitoring support services emphasised the importance of ‘knowing the patient’ and ‘knowing what’s normal for the individual’ in using their clinical skills to interpret incoming telemonitoring data.

**Conclusion** Enthusiasm for telemonitoring as a means of facilitating self-management and thereby reducing admissions is tempered by concerns about increased medicalisation and dependence on support services. Tele-monitoring provides data which can be used to support self-management decisions and act as a channel for seeking clinical care.

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