by GOLD, on the basis of their CAT/mMRC scores and GOLD stage/Exacerbation frequency. Using CAT as the symptom grade, we compared patient distribution in the 4 categories using scores between 10 and 20 to determine the CAT threshold at which the distribution of patients in each group is proportional.

**Results**
The proportion of patients in each of the 4 categories was consistent for each symptom score whether risk was assessed by FEV1 or exacerbation number. However, the proportions using CAT 10 and mMRC 0–1, ≥2 were significantly different in each category. When the CAT threshold was changed to 13, the proportions of patients in the four groups were no longer significantly different to those using mMRC.

**Conclusion**
We have demonstrated that in patients with AATD, using CAT score of 13 as the threshold for assessing symptoms results in a similar proportion of patients being categorised into the risk categories. This affects risk assessment and therapeutic choice. Longitudinal follow up and monitoring will enable confirmation of this threshold for patient management.

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**P189**  
**REDUCED COPD EXACERBATIONS ASSOCIATED WITH ACLIDINIUM BROMIDE VERSUS PLACEBO: A POOLED ANALYSIS OF PHASE III DATA**

doi:10.1136/thoraxjnl-2012-202678.250

1Paul W Jones, 2Dave Singh, 3Edward Kerwin, 4Rosa Lamarca, 5Cynthia Caracta, 6Esther Garcia Gil. 

**Introduction and objective**
Aclidinium bromide is a novel, long-acting, inhaled muscarinic antagonist indicated for the treatment of chronic obstructive pulmonary disease (COPD, 10 pack-years, were included. Exacerbations (≥60% of patients were classed as GOLD stage II (moderate), and >60% of patients were classed as GOLD stage II (moderate), and 51% reported ≥1 exacerbations in the previous 12 months. In both studies, there was an increase towards relative reduction (approximately 30%) in the rate of moderate or severe exacerbations (requiring antibiotic or corticosteroid treatment, or hospitalisation) with both aclidinium doses versus placebo (Figure). A significant reduction in moderate or severe exacerbation rate was observed with aclidinium 400 µg versus placebo when data from both studies were pooled (0.31 vs 0.44; rate ratio 0.71, p = 0.01).

**Conclusions**
This pooled analysis provides evidence to support a reduction in moderate or severe COPD exacerbations with aclidinium 200 µg and 400 µg BID compared with placebo.

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**P190**  
**QVA149 ONCE DAILY PROVIDES SIGNIFICANT IMPROVEMENTS IN LUNG FUNCTION OVER 1 YEAR IN PATIENTS WITH COPD: THE ENLIGHTEN STUDY**

doi:10.1136/thoraxjnl-2012-202678.251

1R Dahl, 2K Chapman, 3M Rudolf, 4R Mehta, 5P Kho, 6V Alagappan, 7I Berhane, 6H Chen, 8D Banerji. 

**Introduction**
QVA149 is a novel inhaled once-daily dual bronchodilator, containing a fixed-dose combination of the long-acting β₂-agonist indacaterol and the long-acting muscarinic antagonist NVA257 (glycopyrronium) in development for the treatment of COPD. This study evaluated the long-term effect of QVA149 on lung function in patients with COPD.

**Methods**
This was a multicentre, double-blind, parallel group, placebo-controlled study in which patients with moderate-to-severe COPD were randomised (2:1) to receive QVA149 (110/50µg) or placebo once daily via the Breezhaler® device for 52 weeks. Treatment was taken in the morning at the same time of day. Lung function was measured as forced expiratory volume in 1 second (FEV₁) and forced vital capacity (FVC) at 30 and 60 minutes post-dose at clinic visits over 52 weeks.

**Results**
359 patients (77% male, mean age 63 years; mean post-salbutamol FEV₁, 57% predicted, FEV₁/FVC 54%) were randomised to receive QVA149 (n=226) or placebo (n=133); 86% and 79% of patients respectively completed treatment, respectively. QVA149 significantly increased FEV₁ and FVC versus placebo at all assessment points (table).

**Conclusion**
QVA149 once daily provided rapid and clinically meaningful bronchodilation compared with placebo. No tachyphylaxis was observed and the bronchodilator effect was sustained over the 52 week treatment period.

Ronal Dahl: he participated in advisory boards for Novartis, AstraZeneca, Boehringer-Ingelheim, Pfizer, ALK-Abello, UCB, Nycomed, Dainippon and ONO.

Kenneth R Chapman: he holds the GSK-CIHR Research Chair in Respiratory Healthcare Delivery at the University Health Network, has served as a consultant to CSL Behring, GlaxoSmithKline, Novartis, Nycomed (Takeda), and Toleris (Grifols), and has received payment for lectures or service on speakers bureaus from Boehringer-Ingelheim, GlaxoSmithKline, Grifols, Nycomed (Takeda), Family Physicians Airways Group of Canada, Canadian Network for Respiratory Care, and Toleris.

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**Abstract P189 Figure 1**

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**Abstract P190 Figure 1**

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**Table:**

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<th>Symptom Category</th>
<th>Treatment</th>
<th>p-value</th>
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<tr>
<td>Severe</td>
<td>Placebo</td>
<td>0.05</td>
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<tr>
<td>Change in FEV₁</td>
<td>QVA149</td>
<td>0.02</td>
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<tr>
<td>Placebo</td>
<td>0.05</td>
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Thorax 2012;67(Suppl 2):A1–A204

**Poster sessions**

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**Table:**

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<th>Treatment</th>
<th>p-value</th>
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Boehringer-Ingelheim, GlaxoSmithKline, Grifols, Nycomed, UCB, Novartis, ALK-Abello, UCB, Nycomed, Dainippon and ONO.

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