of asthma, little is known about the specific relationship between asthma, occupational exposures and health-related quality of life.

**Methods** Adults aged over 55 years in the Sheffield area of the UK were randomly mailed a self-completed questionnaire (including questions on respiratory symptoms and physician-diagnosed disease, smoking and occupational history); responders were invited to perform lung function (FEV₁ and FVC), and to complete the EQ-5D-3L instrument. A measure of socioeconomic deprivation (SED) derived from postal code data was also included.

**Results** 623 individuals provided data as detailed above. 57% were male, 62% were “ever smokers”, 13% had an exclusive diagnosis of asthma (without any other respiratory disease) and 62% reported occupational exposure to vapours, gases, dusts or fumes (VGDF). A linear regression analysis was performed using the EQ-5D summary index score as the dependent variable and reported doctor diagnosed asthma, age, gender, percentage predicted FEV₁ (PFVEF), smoking history and prior history of VGDF exposure as independent variables. SED (p<0.001), Age (p<0.001), gender (p<0.001) and VGDF exposure (p<0.001) were all independently associated with a lower quality of life. Asthma (p=0.594) and smoking (p=0.541) were not.

**Discussion** These data do not support a link between self reported doctor diagnosed asthma and a reduction in quality of life in this population, after correcting for the effects of other relevant factors, although do support a link between occupational exposure to VGDF and a reduced health-related quality of life.

**Introduction** The interpretation of Specific Inhalation Challenge (SIC) can be equivocal, particularly for late asthmatic reactions. It has been suggested that increases in FE(NO) 24-hours post-challenge might help separate positive from negative challenges.

**Methods** We reviewed all positive and equivocal SIC tests with occupational agents between March 2008 and June 2012 from our tertiary referral centre. FE(NO) was measured pre- and 24-hours post control and active challenges using a Niox Mino handheld machine at 50 ml/sec, compliant with ERS/ATS recommendations. Post-challenge changes >20% for FE(NO) >50 ppb, or >10 ppb for <50 ppb, were counted as per ATS guidelines for a clinically significant change (1).

**Results** 24 patients had complete data related to control and active challenges, which were positive in 15 and equivocal in 9 cases. 13/24 patients had raised pre-control challenge FE(NO) (mean=51.3) after adjusting for smoking and inhaled corticosteroid use. Increases in FE(NO) more than the minimum clinically relevant difference, were seen after 13/24 control challenges: including 6/7 exposures to vapours, gases, dusts or fumes (VGDF).

**Conclusions** The previously defined minimum clinically relevant difference for FE(NO) was seen as commonly following control as active challenges. Measuring changes in FE(NO) pre- and 24-hours post challenge to the diverse range of low molecular weight agents tested did not provide useful additional information for interpreting SIC responses.

**Reference**