Abstract P11 Table 1

Parameter assessed	Baseline (pre-omalizumab)*	16-weeks*	1-year*	2-year*
Maintenance Steroid Dosage	7.3 (0, 11)	4 (0, 6.25)	5.1 (0, 10)	5.1 (0, 10)
FEV1	1.60 (1.1, 2.1)	1.51 (1.35, 2.6)	2.74 (1.71, 2.87)	1.35 (0.81, 2.29)
FEV1%	64.5 (39.0, 78.0)	58.0 (52.0, 81.0)	84.0 (56.0, 97.0)	52.0 (35.0, 75.0)
FVC	2.30 (2.12, 2.94)	2.74 (2.34, 3.8)	3.83 (2.95, 4.42)	2.74 (2.36, 3.43)
FVC%	75.0 (70.0, 88.0)	84.0 (63.0, 118)	113.0 (92.0, 123)	80.0 (74.0, 97.0)
FEV1/FVC %	53.0 (51.0, 75.0)	66.0 (58.0, 72.0)	60.0 (47.0, 66.0)	51.0 (43.0, 69.0)
Morning PEF	250 (176, 300)	300 (230, 350)	260 (250, 350)	220 (185, 320)
ACT	7 (7, 7)	13 (11, 18)	11 (9, 13)	13 (11, 13)
Overall AQLQ	2.26 (2.26, 3.2)	4.06 (3.8, 5.7)	4.43 (4.35, 4.52)	4.00 (3.4, 4.6)
AQLQ Symptoms domain	2.4 (2.3, 2.6)	4.4 (4.03, 5.5)	3.6 (3.6, 3.6)	4.9 (4.45, 5.1)
AQLQ Activities domain	3.38 (2.69, 4.75)	5.0 (4.38, 6)	4.63 (4.31, 4.94)	4.38 (3.5, 4.94)
AQLQ Emotions domain	2.50 (2.07, 3.75)	4.0 (3.33, 5.0)	6.33 (5.6, 6.67)	4.1 (3.45, 5.2)
AQLQ Environment domain	2.47 (1.99, 2.95)	3.0 (2.5, 4.5)	3.63 (3.15, 4.12)	2.8 (2.45, 3.5)

FORM 500/20 µg and 100/10 µg in the severe asthma group were significant at the 5% level for sleep disturbance scores [treatment difference -0.138 (95% CI: -0.265, -0.012) $P=0.032$], percentage awakening-free nights [treatment difference 11.754 (95% CI: 2.234, 21.274) $P=0.016$] and mean AQLQ score [treatment difference 0.302 (95% CI: 0.013, 0.591) $P=0.041$].

Conclusion High dose FLUT/FORM (500/20 µg) was consistently associated with greater symptomatic treatment benefit than low dose (100/10 µg) treatment in patients with severe asthma. These data provide a rationale for dose escalation with FLUT/FORM, which appears most likely to confer additional treatment benefit in patients with severe asthma.

Clinical observations in acute and chronic lung infection

P13 MISMATCH BETWEEN CLINICAL AND RADIOLOGICAL DIAGNOSIS OF PNEUMONIA

doi:10.1136/thoraxjnl-2012-202678.154

SV Ruickbie, E Kursumovic, B Narayan, K Opong, P Luce, T Toma, LV Baker, KK Lee.
University Hospital Lewisham, London, United Kingdom

Introduction National guidelines on management of pneumonia stipulate the need for radiological evidence of consolidation to confirm the diagnosis. An incorrect diagnosis may lead to sub-optimal management, inappropriate antibiotic use and prolonged hospital stay. We sought to determine the relationship between clinical diagnosis of pneumonia and radiological evidence on chest x-ray.

Methods We performed a retrospective case-note study of admissions with a diagnosis of pneumonia in a large district general hospital during a three month period. Cases with pneumonia were identified using the ICD-10 coding system; those with co-existing diagnoses of malignancy or bronchiectasis were excluded. Clinician diagnoses of pneumonia were established by examination of clinical discharge summaries. All chest radiographs performed throughout the admission episode had been evaluated by a radiologist. Serum white cell count (WCC) and C-reactive protein (CRP) at admission were also examined.

Results 132 coded records of pneumonia were identified, of which a clinician diagnosis of pneumonia was recorded on 91. Median (interquartile range) age was 75 (61–89) years, 57% female, and median length of stay was 9 (3–23) days. CAP accounted for 65%, hospital acquired pneumonia 15%, aspiration pneumonia 1% and in 19% the origin was unclear. In 37% of all cases, there was no

evidence of consolidation on any of the chest radiographs performed during inpatient stay. Subjects without radiological consolidation had similar length of stay to those with consolidation. There was no significant difference in age ($p=0.34$) or gender ($p=0.28$) between groups. WCC and CRP were significantly lower in those without consolidation. Analysis of cases where pneumonia was highlighted as the primary reason for admission ($n=47$) was similar to the overall cohort: 26% had no radiological evidence of consolidation.

Conclusion A significant proportion of clinical diagnoses of pneumonia are made despite no radiological evidence of consolidation. Studies are required to investigate if this could be due to a lack of awareness of diagnostic criteria, mismatch in chest x-ray interpretation or other factors in the clinical presentation.

Abstract P13 Table 1 Length of stay and inflammatory indices in patients with and without radiological evidence of pneumonia

	Consolidation on x-ray (n=57)	No consolidation on x-ray (n=34)	P Value
Length of stay	9 (4–19)	11 (2–31)	0.87
Median WCC	11.8 (9.0–15.7)	8.5 (6.3–12.6)	0.002
CRP	123 (55–209)	34 (8–66)	<0.001

Data presented as median (IQR). WCC: white cell count; CRP: C-reactive protein

P14 PNEUMONIA: 30 MONTHS OF ADVANCING QUALITY IN NORTH WEST ENGLAND

doi:10.1136/thoraxjnl-2012-202678.155

¹MA Woodhead, ²L Kitchen, ¹G Morrow. ¹Central Manchester University Hospitals NHS Foundation Trust, Manchester, UK; ²Advancing Quality, Salford, UK

As part of an initiative to improve the quality of care within the North West Strategic Health Authority, five 'quality markers' (QMs) were measured in all adult admissions with pneumonia in all 23 Acute Trusts in the North West Region. Results for discharges for 30 months from October 2008 are presented. Data reporting was changed to match the financial year in 2009 so cohorts from October 2008–September 2009, October 2009–March 2010 and April 2010–March 2011 are presented. Only adults who fulfilled a prescribed definition of 'pneumonia' were included.

QMs were taken from a USA initiative and adapted for UK use. Patient identification was based on clinical coding. Data was recorded in each individual Trust and centrally collated.

Data on 31,972 pneumonia episodes were included (11,127, 6,683, 14,162 in each time period respectively). Mean results of %