or both. Using multivariate logistic regression analysis, aspirin was found to be protective for ICU mortality. Additional factors that predicted ICU mortality for patients with ALI were vasopressor use and APACHE II score (Table).

Conclusion Aspirin usage is associated with reduced mortality in patients with ALI. Whilst trials are ongoing to assess if aspirin can prevent ALI, these new data support the need for a clinical trial to investigate if aspirin improves outcomes in patients with established ALI.

Abstract P148 Table 1.

Predictor	Multivariate analysis	
	OR [95% CI]	p-value
Age	1.02 [1.00–1.05]	0.079
APACHE II score	1.07 [1.02–1.13]	0.010
Aspirin use	0.42 [0.18–0.96]	0.040
PaO ₂ / FiO ₂ ratio	0.97 [0.93–1.00]	0.085
Vasopressor use	2.09 [1.05–4.16]	0.036

Pulmonary hypertension: mechanisms and treatment

P149 EFFECT OF MACITENTAN ON PULMONARY ARTERIAL HYPERTENSION-RELATED HOSPITALISATIONS: RESULTS FROM THE RANDOMISED CONTROLLED SERAPHIN TRIAL

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Introduction and objectives Macitentan, a novel dual endothelin receptor antagonist with sustained receptor binding, significantly reduced the risk of morbidity and mortality in pulmonary arterial hypertension (PAH) patients in the SERAPHIN trial (NCT00660179), the first event-driven outcomes trial in PAH. The effect of macitentan on the risk of PAH-related hospitalisation was evaluated in this study.

Methods In SERAPHIN, a multicentre, double-blind, placebo-controlled trial in PAH, patients (aged ≥12 years) in WHO functional class II–IV were randomised (1:1:1) to oral macitentan 3mg, 10mg, or placebo once-daily. Time to death due to PAH or hospitalisation for PAH up to end of treatment (EOT), and time to hospitalisation for PAH up to EOT were evaluated (Kaplan–Meier analysis). Treatments were compared using log-rank tests. Annual rates of PAH-related hospitalisations and inpatient hospital days up to EOT were also assessed.

Results For the 742 patients randomised, the median treatment duration was >2 years. The risk of death due to PAH or hospitalisation for PAH was reduced vs placebo by 33% (97.5% CL: 3–54%; $P = 0.0146$) in the macitentan 3mg group and 50% (97.5% CL: 25–67%; $P < 0.0001$) in the macitentan 10mg group. Risk of hospitalisation for PAH was reduced by 39% (97.5% CL: 10–58%; $P = 0.0040$) with macitentan 3mg and 50% (97.5% CL: 24–66%; $P = 0.0001$) with macitentan 10mg. Overall, 33% ($n = 82$), 23% ($n = 58$), and 20% ($n = 49$) of patients randomised to placebo, macitentan 3mg, and macitentan

10mg, respectively, were hospitalised at least once for PAH. Compared with placebo, the rate of PAH-related hospitalisations and number of inpatient hospital days per year were reduced by 43% ($P = 0.0068$) and 33% ($P = 0.2707$), respectively, with macitentan 3mg, and by 55% ($P = 0.0002$) and 52% ($P = 0.0416$), respectively, with macitentan 10mg (Table). Macitentan was well tolerated, with similar incidences of elevated liver aminotransferases and peripheral oedema across groups. Adverse events more frequently associated with macitentan vs placebo were headache, nasopharyngitis, and anaemia.

Conclusions Macitentan significantly reduced the risk of hospitalisation for PAH and the number of PAH-related hospitalisations and inpatient days (10mg only). These data offer further evidence that macitentan has beneficial effects on long-term outcomes in PAH.

Abstract P149 Table 1. Rates of PAH-related hospitalisations and hospital inpatient days up to EOT in SERAPHIN

	Placebo N=249	Macitentan 3mg N=250	Macitentan 10mg N=242
PAH-related hospitalisations per year			
Adjusted* annual rate per 100 patient-years (95% CL)	27 (20–36)	15 (11–21)	12 (9–17)
Treatment effect vs placebo (95% CL)		0.57 (0.38–0.86)	0.45 (0.30–0.69)
P-value		0.0068	0.0002
PAH-related inpatient hospitalisation days per year			
Adjusted* annual rate (95% CL)	5.5 (3.3–9.0)	3.7 (2.2–6.1)	2.7 (1.6–4.4)
Treatment effect vs placebo (95% CL)		0.67 (0.33–1.37)	0.48 (0.24–0.97)
P-value		0.2707	0.0416

*Adjusted in a negative binomial regression model for WHO functional class (III vs IV) and 6-minute walk distance at baseline (>380 m vs ≤380 m)
CL: confidence limit; PAH: pulmonary arterial hypertension

P150 TREATMENT OF PULMONARY EMBOLISM IN ACTIVE MALIGNANCY - PRESCRIBING PRACTICES AMONGST PHYSICIANS

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Introduction Pulmonary embolism (PE) is a common complication of malignancy. NICE guidance for the treatment of venous thromboembolism (VTE) issued in June 2012 recommended that those with active cancer and confirmed PE be treated with low molecular weight heparin (LMWH) rather than alternative anticoagulants.¹ We assessed whether this guidance is being adhered to in our Trust.

Methods A retrospective review of electronic discharge summaries was undertaken on those who were discharged from the two acute hospitals in our Trust (population 600,000) with a diagnosis of PE between July 2012 and June 2013, the 12 months following the publication of the NICE guidance. In addition, an anonymised, internet-based survey was undertaken of the 62 consultant physicians within the Trust, to determine which anticoagulant they would routinely prescribe for PE in active malignancy.

Results Within the 12 month period of this study, 298 patients (173 women, 125 men) survived to discharge, having had PE confirmed on imaging. Forty six of these were known to have malignancy and a further 13 were found to have cancer at the