sponding an altered inflammatory phenotype, at least in these models, to these stimuli.

REFERENCES

Abstract P159 Figure 1.

P160 RETROSPECTIVE STUDY ANALYSING WHETHER OPTIMIZATION OF PULMONARY VASCULAR ENHANCEMENT INFLUENCES DIAGNOSTIC OUTCOME IN THE INTERPRETATION OF CT PULMONARY ANGIOGRAMS (CTPA)

Introduction and Objectives Pulmonary embolism (PE) is a common cardiovascular emergency and is one of the most preventable cause of hospital deaths. Various factors can impact on the diagnostic accuracy of CTPA, which is now considered the first line imaging due to presumed persistent or recurring patient symptoms, the majority (87.5%) of these negative scans were still negative and only 12.5% were positive for PE. No major pitfall has been identified in local CTPA acquisition technique that may have led to subsequent misses of potentially life-threatening PEs.

Clinical trials in asthma

P161 A RANDOMISED CONTROLLED TRIAL OF SINGLE COMBINATION BUDESONIDE/FORMOTEROL INHALER AS MAINTENANCE AND RELIEVER THERAPY IN ASTHMA PATIENTS AT RISK OF SEVERE EXACERBATIONS

Introduction The single budesonide/formoterol inhaler Maintenance And Reliever Therapy (SMART) regimen reduces severe asthma exacerbations, but it is uncertain whether it increases the risk of adverse effects due to high beta-agonist and corticosteroid doses with both short-term and cumulative exposure. Objectives Our hypothesis was that treatment with the SMART regimen would reduce the risk of beta-agonist overuse but that when such episodes occurred, patients were less likely to seek medical review and, that any reduction in severe exacerbations would be at the cost of a higher systemic corticosteroid burden. Methods This was a 24-week, open-label, parallel group trial in 303 asthma patients with a recent exacerbation, conducted at four primary healthcare practices and one secondary care hospital. Participants were randomised to 200/6µg budesonide/formoterol metered dose inhaler according to the SMART regimen (two actuations twice daily maintenance with one extra actuation as-needed) or a fixed-dose regimen (two actuations twice daily maintenance) with one to two actuations of 100µg salbutamol as-needed (‘Standard’), with electronic monitoring of actual inhaler use. The primary outcome was the proportion of participants with at least one high beta-agonist use episode (>12 budesonide/formoterol actuations/day in SMART or >16 salbutamol actuations/day in Standard). Results There was no significant difference between groups in the proportion of participants with at least one high use episode: SMART 84/151 (56%) vs Standard 68/152 (45%); relative risk (95% CI) 1.24 (0.99–1.56), p = 0.058. There were fewer days of high use [mean (SD) 5.1 days (14.3) vs 8.9 days (20.9), relative rate (RR) (95% CI) 0.58 (0.39–0.88), p = 0.01] and days of high use without medical review [8.5 days (17.8) vs 18.3 days (24.8) per high use patient, RR 0.49 (0.31–0.75), p = 0.001] in the SMART group. The SMART regimen resulted in higher average daily inhaled corticosteroid exposure, but reduced oral corticosteroid exposure, with no difference in composite systemic corticosteroid exposure [ratio of means (95% CI) 1.03 (0.86–1.22), p = 0.76]. SMART participants had fewer severe asthma exacerbations [35 vs 66, RR 0.54 (0.36–0.82), p = 0.004].

Conclusions The SMART regimen has a favourable risk/benefit profile in patients at risk of severe asthma exacerbations.

P162 EFFECT OF ADDING PROPRANOLOL OR INCREASED INHALED CORTICOSTEROID DOSE IN PERSISTENT ASTHMA

Poster sessions