disease experience. Pirfenidone was well tolerated and offered hope to the majority of patients (83%). However 44% of patients reported anxieties re continuing access.

Conclusions Post diagnosis, many patients demonstrate resourcefulness in accessing information and have realistic expectations of how to improve care. There is a need to improve the information given in the consultation to improve subsequent understanding and to increase provision of psychological support particularly when prescribing O2 therapy. The availability of pirfenidone was perceived by patients to offer hope and reassurance. Strategies to reduce the delay in diagnosis and standardise access to information and therapies are needed.

P201 RITUXIMAB AS RESCUE THERAPY IN INTERSTITIAL LUNG DISEASE REFRACTORY TO CONVENTIONAL IMMUNOSUPPRESSION

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10.1136/thoraxjnl-2013-204457.353

Background Rituximab, a B cell-depleting monoclonal antibody, may offer an effective rescue therapy in a subgroup of patients with severe interstitial lung disease (ILD), progressing despite conventional immunosuppression.

Methods Retrospective assessment of 50 patients with severe, progressive ILD treated with rituximab between 2010 and 2012. This included 33 with connective tissue disease-associated ILD (CTD-ILD), 6 with fibrotic hypersensitivity pneumonitis, 3 with likely drug-induced ILD, 2 with desquamative interstitial pneumonia (DIP) and the rest with miscellaneous ILD patterns, excluding idiopathic pulmonary fibrosis. At the time of rituximab treatment, mean FVC was 49.1% (+ 17.6) and DLco 25.5% (+ 9.9). Four patients were mechanically ventilated. Prior to rituximab, all patients except one had received immunosuppressive treatment, including IV cyclophosphamide in 44 patients. Change in pulmonary function tests, as compared to pre-rituximab levels, was assessed at six to twelve months post-treatment and analysed by Wilcoxon signed rank test. Categorical trends (improvement, stability, deterioration) before and after treatment were defined using either ≥10% change in forced vital capacity (FVC) or ≥15% change in diffusing capacity for carbon monoxide (DLco) as threshold values.

Results In the six to twelve months following rituximab treatment, a median improvement in FVC of 5.7% ($p < 0.01$) and stability of DLco ($p < 0.01$) was observed. This was in contrast to a median decline in FVC and DLco of 14.6% and 18.8% respectively, in the six to twelve months prior to rituximab therapy ($p < 0.01$). Patients with CTD-ILD were most represented in this cohort and were more likely to improve or stabilise following Rituximab (28/33), than those with non CTD-related ILD (8/17) ($p = 0.008$, Fisher exact test). However, of the four patients requiring invasive ventilation, improvement to extubation was observed in three patients with non CTD-ILD (one DIP, one acute interstitial pneumonia, one unclassifiable ILD). Two patients developed serious infections (pneumonia) requiring hospitalisation following rituximab, and ten patients died, all from progression of underlying ILD, a median of 5.1 months after treatment.

Conclusions Rituximab may offer a safe and effective therapeutic intervention in a subgroup of patients with severe, progressive ILD unresponsive to conventional immunosuppression. Future prospective, controlled trials are warranted to validate these findings.

P202 A SURVEY OF ILD EXPERTISE AVAILABILITY AND HIGH RESOLUTION COMPUTER TOMOGRAPHY (HRCT) PROTOCOLS USED IN PATIENTS WITH INTERSTITIAL LUNG DISEASE (ILD) ACROSS HOSPITALS IN ENGLAND

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10.1136/thoraxjnl-2013-204457.354

Introduction and aims ILD is increasingly being recognised as complex condition necessitating a multi-disciplinary approach to diagnosis and management requiring availability of a clinician and a radiologist with declared interest in ILD. HRCT is the imaging of choice used for assessment of ILD. The BTS ILD guidelines do recommend a "standard" HRCT protocol to be used in diagnosis of patients with ILD. It is however not known if there is a uniform availability of expertise within different centres in England and if "standard "HRCT protocol as recommended is being followed.

Method A questionnaire was handed to radiologists with special interest in thoracic imaging working in different hospitals sites in England, at an ILD radiology conference. Questionnaires enquired about availability of ILD services and HRCT scanning technique used at their establishment.

Results Of the 150 questionnaires, 100 were returned for analysis. There were responses from 39 teaching hospitals and 61 district general hospitals (DGH).

Abstract P202 Table 1. Results of questionnaire given to thoracic radiologists across Hospitals in England.

Question	Overall "yes"	Teaching Hospitals (n = 39)	DGH (n = 61)	p value
1) Is there a ***specialist thoracic radiologist***?	72%	92%	59%	0.0002
2) Is there a ***lead clinician*** for ILD?	41%	59%	34%	0.0062
3) Do you have a ***local departmental protocol*** for HRCT scanning technique?	95%	95%	97%	NS
4) Do you routinely perform additional ***expiratory phase*** scans during HRCT?	30%	33%	28%	NS
5) Do you routinely perform HRCT in ***prone position***?	32%	26%	36%	NS
6) Do you use image ***reconstruction routinely***? (only 44 responded)	77%	55% (n = 18)	92% (n = 26)	NS
7) Do you use ***discontinuous*** imaging protocol?	42%	41%	43%	NS
8) Do you use ***volume*** imaging protocol?	27%	21%	31%	NS
9) If you use volume CT do you use ***"Low Dose"*** Technique?	48%	54%	44%	NS

Conclusions Despite increasing focus on ILD as a sub-speciality, there is still a significant difference in the provision of expert care within district general hospitals in UK for patients with ILD. This may affect the quality of care provided with potential to variability of care standards.

The "standard protocol" for HRCT techniques as specified by BTS is not being followed in England. Despite recommendations from BTS, aspects of HRCT scanning technique applied were variable and influenced by local preferences and expertise. This may lead to differences in scan interpretation, diagnosis and outcomes. This gap in provision of care and variability of techniques should be bridged to ensure uniformity of care and outcomes.

REFERENCES

1. NICE guidelines, June 2013; CG163 2: *Thorax*; 63 (Suppl V); v1-v58