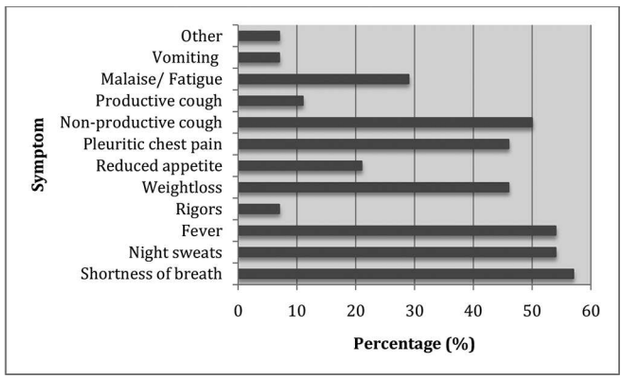
Diagnostic yields were as follows; sputum smear 3% and culture 18%; pleural fluid smear 0 and culture 36%; pleural biopsy smear 11% and culture 54%; pleural biopsy histology 93%. Culture yield for pleural fluid and biopsy was 61%, and overall culture yield for sputum, pleural fluid and biopsy was 68%.

All patients' received quadruple TB therapy, with 82% of patients being given the standard six-month therapy. 92% showed an excellent radiological response, with the x-ray being normal, or with only minor residual abnormalities. To the present date, there has been no diagnosed recurrence of TB.

Conclusions Pleural TB contributes significantly to the overall burden of pleural disease in this London hospital. TB should be considered in patients presenting with pleural disease, especially young patients from ethnic minority backgrounds. To improve the diagnosis and treatment of pleural TB, culture yields need improvement.



Abstract P222 Figure 1. Percentage of patients presenting with various symptoms.

P223 MEDICAL THORACOSCOPY - PATIENT EXPERIENCE OF ADVANCED NURSE PRACTITIONER- PROVIDED CONSCIOUS SEDATION

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Medical thoracoscopy (MT) is a safe procedure provided by respiratory physicians across the UK. The conscious sedation is administered by staff with a variable level of training.

Aim To assess a simple patient comfort score at MT when conscious sedation (CS) was provided by an advanced nurse practitioner (ANP) compared to others (senior nurse, endoscopy nurse or junior doctor).

Methods A patient comfort score is recorded routinely as part of our thoracoscopy service immediately after the procedure once the patient is awake in recovery. The ANP is an ALS provider with senior experience in critical care. Intraoperative administration of midazolam for sedation and alfentanyl for pain control pre-biopsies was undertaken by a dosing schedule determined by the level of sedation assessed by the ANP who also monitored the patient during the procedure. When CS was given by others midazolam was administered in an initial bolus followed by boluses as indicated by the thoracoscopist in keeping with information by the monitoring nurse on the level of sedation or discomfort. Patient comfort score was evaluated using a 5 point scale within 30 minutes of return to the recovery area. The CS was administered either by the ANP or others in keeping with their availability on the day; no randomisation was performed. The analysis used SPSS programme.

Results 50 consecutive patients undergoing thoracoscopy were included. 27 had CS by ANP (group 1) and 23 by others (group 2). Overall the procedure was well tolerated. Patient comfort score was better in group 1 (mean, SD 0.59 +/- 0.8) vs. group 2 (1.63 +/- 1.3), $p < 0.05$. This was achieved with a larger dose of midazolam in group 1 (2.87 +/- 1.12 mg) vs. group 2 (2.30 +/- 0.70 mg), $p < 0.05$ and smaller dose of alfentanyl (0.245 +/- 0.14 mg) in group 1 vs. group 2 (0.527 +/- 0.25 mg), $p < 0.01$.

Conclusions conscious sedation for medical thoracoscopy when provided by a critical care experienced ANP resulted in an improved patient experience of the procedure and this was achieved through and adequate use of midazolam and lesser doses of alfentanyl; this was cost-saving since the ANP also monitored the patient. Retaining of trained staff is essential for this specialised service.

Inhaled therapy in COPD

P224 EVALUATION OF INHALED CORTICOSTEROID RELATED PNEUMONIA MORTALITY IN PATIENTS WITH COPD WHO WOULD NOT FIT THE CRITERIA FOR INCLUSION IN RANDOMISED CONTROLLED TRIALS

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Background Large randomised controlled trials such as TORCH (towards a revolution in chronic obstructive pulmonary disease (COPD) health) report an increased risk of pneumonia associated with use of inhaled corticosteroids (ICS) in COPD but no corresponding increase in pneumonia-related mortality. However, these trials exclude patients who are elderly, comorbid, have co-existing lung conditions or use long-term oxygen therapy and may not be representative of 'real-world' practice. We hypothesised that ICS use in patients that are ineligible for TORCH would be associated with increased risk of pneumonia hospitalisations and mortality.

Methods We carried out an analysis of 2 independent cohorts. The EXODUS cohort included patients admitted with COPD exacerbation and considered outcomes over 1 year including pneumonia hospitalisations and pneumonia-related mortality. The Edinburgh pneumonia study included patients hospitalised with community-acquired pneumonia with the primary outcome of 30-day mortality. A secondary analysis of patients from this cohort with spirometry-confirmed COPD during clinical stability was conducted.

Results There were 977 patients included from the EXODUS cohort. 106 patients (10.8%) were hospitalised for pneumonia and 18 patients (1.8%) had pneumonia-related mortality within 12 months of initial admission. 497 patients (50.9%) would have been ineligible for the TORCH study. In a Cox proportional hazards model, adjusting for relevant confounders, patients who were ineligible for TORCH had an increased risk of pneumonia hospitalisation (HR 1.60; 95% CI 1.04–2.45) and an increased risk of pneumonia-related mortality (HR 6.1; 95% CI 1.7–22.0). Figure 1 shows a cox adjusted survival curve for