

P245 A DEDICATED PNEUMONIA FOLLOW UP CLINIC-IS IT WORTHWHILE?

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Background It is routine clinical practice, based on British Thoracic Society recommendations, to arrange a clinical review and chest x-ray approximately 6 weeks following an episode of pneumonia in most patients. However there is a paucity of published evidence to support or refute this practice.

Objective To determine the clinical and radiological outcomes of patients admitted with an episode of pneumonia.

Methods This was a retrospective analysis of the post-pneumonia clinic database at a large district general hospital over a one year period from May 2011 to April 2012. Data on demographic characteristics, radiological and clinical follow up, and final diagnosis were collected. Follow up data including a new diagnosis of cancer as well as new benign lung disease was available for most (97%) patients for 12 months after the index episode of pneumonia. Resolution was defined as complete resolution on chest X-ray at 6–8 weeks or >90% resolution on chest X-ray, absence of ongoing physical symptoms and signs, and decision to discharge from clinic after discussion at a multi-disciplinary radiology meeting.

Results 179 patients were included in the analysis (32 who did not attend for follow up were excluded). One hundred and thirty nine (78%) showed resolution and were discharged. Of the 40 (22%) patients that did not show resolution, 16 (9%) had a new diagnosis made; including 3 (1.7%) lung cancer. One of the identified lung cancers was stage I disease, while the other two were stage IV. New benign diagnoses made on follow up were recurrent aspiration (3), interstitial lung disease (2), pleural effusion (2), allergic bronchopulmonary aspergillosis (1), cryptogenic organising pneumonia (1), functional antibody deficiency (1), lung nodule (1), pleural plaques (1), and pulmonary embolism (1). Males, ever smokers, older patients, and those with a history of pre-existing lung disease (including COPD) had higher rates of non-resolution but the differences were not statistically significant.

Conclusion Following up patients in a dedicated post pneumonia clinic with a repeat chest radiograph and clinical review had a low but significant pick up rate of new respiratory diagnoses. A larger study will be performed to improve risk stratification and enable more selective follow up.

Abstract P245 Table 1. Comparison of clinical characteristics of patients with resolved versus non-resolved pneumonia

Clinical characteristics	Resolved (n = 139)	Did not resolve (n = 40)	P value
Male (n, %)	67 (48.2%)	13 (32.5%)	0.078
Age (mean +/- SD)	65.57 (15.8)	70.56 (12.1)	0.064
Age >= 50 years (n, %)	115 (83%)	38 (95%)	0.052
Current or former smokers (n, %)	92 (66.2%)	29 (72.5%)	0.452
Any previous lung disease (n, %)	76 (54.7%)	28 (70%)	0.081
History of COPD (n, %)	56 (40.3%)	23 (57.5%)	0.053
History of any cancer within 5 years (n, %)	8 (5.8%)	2 (5%)	-
History of lung cancer within 5 years (n, %)	2 (1.4%)	0	-

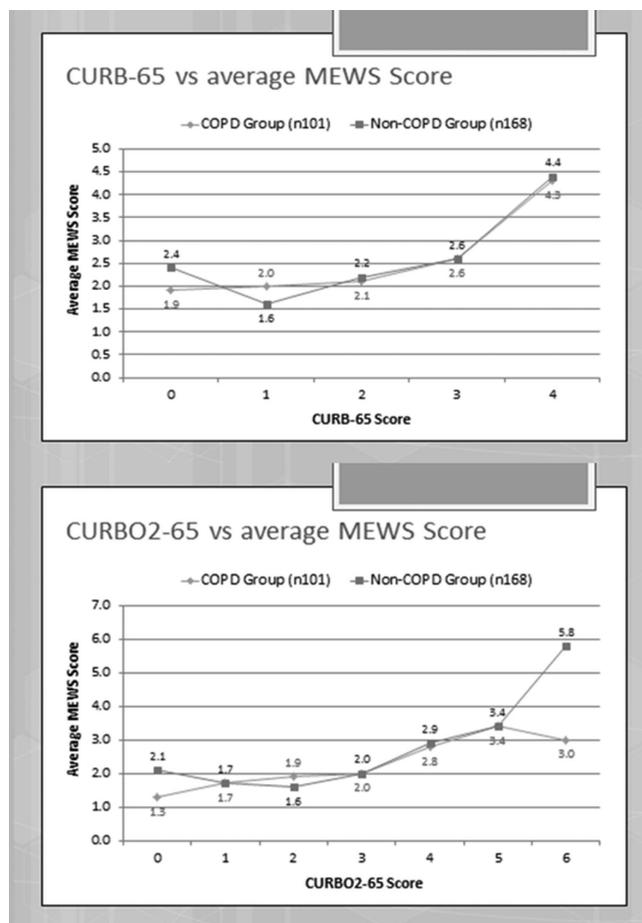
P246 CURBO2-65 HAS BETTER CORRELATION THAN CURB65 WITH MODIFIED EARLY WARNING SCORING SYSTEM (MEWS)

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Introduction For patients admitted to hospital with pneumonia, CURB65 (confusion, Urea>7, Respiratory Rate>30 and Blood Pressure<90/60) is used to assess severity of the pneumonia (1). MEWS is a score which informs about the physiological status of a patient thus about the patients overall clinical status. One would anticipate CURB65 to be correlated to MEWS however there is no evidence to support correlation particularly on admission. The body's capability to maintain adequate oxygenation when affected by pneumonia is of paramount importance. Oxygen was originally excluded from CURB65 due to non-statistical significance for predicting mortality. We felt CURB65 may not correlate with MEWS on admission hence introduced a new score incorporating oxygen to CURB65 score - CURBO2-65. COPD patient's with SATS <88% or Non-COPD with <94% would score 1 and any patient receiving supplemental oxygen to maintain their SATS in desired range would score 1. The maximum score for oxygenation is 2 and maximum score on CURBO2 65 is 7 instead of 5 as in CURB65.

Method We retrospectively analysed all pneumonia patients (COPD and Non-COPD) admitted to hospital for 2 consecutive months (December 2012 and January2013). Data was collected



Abstract P246 Figure 1.