Discussion US-FNAC is well tolerated and can be safely performed opportunistically by respiratory physicians during outpatient visits. The diagnostic yield is high and comparable with previous published series. Its incorporation into the lung cancer pathway can facilitate prompt diagnosis and staging without more invasive investigations.

REFERENCE

1. Fultz PJ, Feins RH, Strang JG *et al.* Detection and diagnosis of nonpalpable supraclavicular lymph nodes in lung cancer at CT and US. *Radiology* 2002;222:245–51.

M14 ROLE OF ENDOBRONCHIAL ULTRASOUND-GUIDED TRANSBRONCHIAL NEEDLE ASPIRATION IN DIAGNOSIS OF ISOLATED MEDIASTINAL LYMPHADENOPATHY (IML)

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Introduction and Objectives The recognition of endobronchial ultrasound-guided transbronchial needle aspiration (EBUS-TBNA) as an important diagnostic modality has been increasing in recent years, particularly following establishment of its use in lung cancer. Mediastinoscopy is considered as the gold-standard investigation for isolated mediastinal lymphadenopathy (IML), despite the invasiveness of the procedure and need for general anaesthesia.

We present a retrospective clinical data in a large tertiary centre for respiratory medicine to evaluate to the role of EBUS-TBNA in establishing a diagnosis of IML and therefore avoiding more invasive techniques such as mediastinoscopy.

Methods Retrospective analysis identified 249 patients undergoing EBUS-TBNA between August 2009 and July 2013, of whom 72 were found to have IML. All patients had CT or PET-CT prior to undergoing EBUS-TBNA. In patients where EBUS-TBNA failed to produce diagnosis, they received clinical and radiological follow up for upto 6 to 12 months or were considered for mediastinoscopy as per clinical needs.

Results Of the 72 patients, 50 were male and 22 were female. For all patients, histological diagnosis was unknown prior to EBUS-TBNA. Confirmed pathological diagnosis was gained in total of 27 patients including 17 cases of sarcoidosis, 8 cases of malignancies, 1 case of tuberculosis and 1 case of ectopic thyroid tissue. Of the 8 confirmed malignancies 2 were adenocarcinoma, 2 were non-small cell carcinoma,1 was squamous cell carcinoma,1 was metastatic prostate carcinoma,1 was metastatic breast carcinoma and 1 was Chronic Lymphoid Lukaemia (CLL). No diagnosis was achieved in 40 patients while sample was insufficient in 3 cases and 2 were false negative (bronchoalveolar carcinoma and sarcoidosis). In all 72 patients, no significant complications were reported. Of the 40 undiagnosed cases, 29 patients were followed up clinically and radiologically and discharged as appropriate while remaining 11 are still under follow up. No patient has been referred for mediastinoscopy.

Conclusions Already established as a safe and minimally-invasive diagnostic technique in pulmonary medicine, EBUS-TBNA provides an alternative for diagnosis of patients presenting with IML. The increasingly successful use of EBUS-TBNA in place of mediastinoscopy and CT-guided biopsy undoubtedly merits further attention in the consideration of investigation of mediastinal lymphadenopathy.

M15 NEBULISED BRONCHODILATORS PRE-BRONCHOSCOPY IN PATIENTS WITH OBSTRUCTIVE LUNG DISEASE: DOES IT HELP?

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Background Patients with Chronic obstructive pulmonary disease (COPD) and asthma may be at higher risk of complications during bronchoscopy. Previous guidelines have recommended that all patients with asthma receive nebulised bronchodilators pre procedure. At our research centre, we changed our practice in January 2012; since this date we administer nebulised salbutamol to all patients with COPD and asthma pre-bronchoscopy.

Aims We examined research bronchoscopy records from asthma and COPD patients with and without nebulised bronchodilators to determine tolerance of procedure, complications and adverse events, sedation used and success of obtaining samples. We have also examined the overall safety of research bronchoscopies.

Abstract M15 Table 1. Summary of patient demographics, tolerance and saline inserted for BAL.

	COPD			Asthma		
	No Pre-Procedure Neb (n=38)	Pre-Procedure Neb (n=37)	P value	No Pre-Procedure Neb (n=32)	Pre-Procedure Neb (n=33)	P value
Sex (M/F)	22/16	26/11		20/12	18/15	
Age (yrs)	63.2 (5.7)	63.0 (6.1)	ns	44.3 (12.9)	40.8 (10.8)	ns
Pack Yrs*	39.9 (10.2 - 82.8)	42.0 (14.5 - 98.8)	ns			
ACQ*				1.3 (0.1 - 3.0)	1.4 (0.3 - 4.6)	ns
FEV1 (L)	1.7 (0.4)	1.9 (0.5)	0.07	2.9 (1.0)	2.7 (0.8)	ns
FEV1 (%)	61.3 (13.5)	63.7 (11.1)	ns	83.7 (20.4)	80.7 (20.4)	ns
Poor Tolerance	7.9%	10.8%	ns	6.3%	9.1%	ns
BAL (ml)*	480.0 (240.0 - 480.0)	420.0 (0.0 - 480.0)	0.06	480.0 (0.0 - 480.0)	480.0 (0.0 - 480.0)	ns

*denotes median (range)