Poster sessions

13.4 (range 2–40). 44 (38%) were still smoking and 17 of these accepted referral to cessation services. 27 of the other 125 smokers assessed but not thought to have COPD also accepted referral.

Case finding using this method in people already attending primary care clinics has a high yield (1 in 5) takes little time and deserves wider adoption.

REFERENCES

M21 SPACE TO BREATHE: A NEW HOSPICE BASED PALLIATIVE CARE, RESPIRATORY AND PSYCHOLOGY PROGRAMME FOR PATIENTS WITH SEVERE COPD AND THEIR CARERS

Gore JM, Brophy CJ, Greenstone MA. How well do we care for patients with end stage chronic obstructive pulmonary disease? Thorax 2000; 55:1000

M22 THE CHRONIC OBSTRUCTIVE PULMONARY DISEASE ASSESSMENT TOOL (CAT) IN PATIENTS ADMITTED TO HOSPITAL FOR EXACERBATION


10.1136/thoraxjnl-2013-204457.432

Background The COPD assessment tool (CAT) measures health status and is responsive to change with pulmonary rehabilitation and out-patient exacerbations of COPD (AECOPD). This study established i) CAT score at AECOPD hospital admission, ii) change during recovery and iii) CAT in relation to other outcome measures of COPD severity at stability.

Methods Consenting patients presenting to hospital with a clinical diagnosis of AECOPD self-completed the CAT and answered detailed history. Length of stay (LOS) was recorded. At four week follow-up assessment, the CAT score, MRC dyspnoea score, spirometry and six-minute walking distance (6MWD) were measured.

Results Of 133 patients recruited at admission, there were 5 inpatient deaths, all with a high (>20) CAT on admission. Median LOS per admission CAT category was CAT10–20: 2.5 days; CAT21–30: 4 days; CAT31–40: 5 days. 89 subjects were reassessed at 4 weeks and 72 had a clinical diagnosis of COPD confirmed, Table 1. In these subjects, the mean (95%CI) change in CAT score from admission was -7 (-9, -5), p < 0.001. Whilst 61/72 had a high CAT score on admission, there remained 39/72 with high score at follow-up. CAT score at follow-up was related to 6MWD, r = 0.34, p < 0.01 but not to age or forced expiratory volume in one second (FEV1)% predicted.

Conclusion Despite marked improvement in CAT score with recovery from an AECOPD requiring hospital admission, a large proportion persist with high CAT scores at 4 weeks indicating poor health status. The CAT score offers prognostic information and adds another dimension to the COPD assessment.

REFERENCES

Abstract M22 Table 1. Results for the 72 patients with confirmed COPD.

<table>
<thead>
<tr>
<th>Gender</th>
<th>Age (years)</th>
<th>Length of Stay (days)</th>
<th>6MWD (m)</th>
<th>FEV1</th>
<th>MRC</th>
<th>Admission CAT score Mean (SD)</th>
<th>Follow-up CAT score Mean (SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>68 (48–86)</td>
<td>3 (1–20)</td>
<td>140 (5–420)</td>
<td>46 (16)</td>
<td>4 (1–5)</td>
<td>28 (7)</td>
<td>21 (8)</td>
</tr>
<tr>
<td>Female</td>
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</tbody>
</table>

M23 COPD EXACERBATIONS OF LONGER DURATION WORSENS HEALTH RELATED QUALITY OF LIFE

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Introduction Patient’s quality of life is related to the frequency of COPD exacerbations [Seemungal et al AJRCCM 1998: 157: 1418–1422]. There is increasing interest in reducing the duration of exacerbations but little evidence that this benefits patient’s quality of life.
Methods We analysed data from 384 patients in the London COPD cohort collected between 1995 and 2012. Patients completed diary cards recording respiratory symptoms. Exacerbation onset was defined as the first of two days of 2 major symptoms (increased breathlessness, sputum volume or purulence) or 1 major and 1 minor symptom (cold, increased cough, increased wheeze, sore throat). Recovery was defined as the first of two symptom free days and exacerbation duration was defined as the period between onset and recovery.

Patients completed the St. George’s Respiratory Questionnaire (SGRQ) annually when clinically stable. To avoid bias with repeated measures, exacerbation recovery and SGRQ total scores were averaged. FEV1% predicted was measured at recruitment.

Results The 384 COPD patients (246 male); mean age 68.6 years (SD 8.4), FEV1 % predicted 45.8% (16.6) and FEV1/FVC 45.8% (12.2) with 122 patients (32.1%) still smoking at recruitment. There were 3498 exacerbations (median annual rate = 2.13 (IQR 1.0–3.2)).

The median exacerbation duration was 10 days (IQR 6–18). Exacerbation duration was not available for 350 (10.0%) exacerbations as no symptoms were recorded and for a further 109 (3.1%) where the patient continued to recorded symptoms post exacerbation for 100 days or more.

In a multiple linear regression model, total SGRQ score increased by 0.20 units/1 day increase in exacerbation duration (95% CI 0.008–0.39; p = 0.041) after allowance for FEV1% predicted and exacerbation frequency. The results suggest that halving the duration of 4 exacerbation events from 10 to 5 days will produce a 4 unit change in the total SGRQ score.

Conclusion Shorter exacerbations are associated with improved quality of life. More research is needed on acute interventions designed to ameliorate exacerbations.

In the present study, 74% of deaths occurred in patients admitted from institutional care (mortality 35%), non-institutional care 9% (p = 0.002) and/or those with dementia (mortality 36%), without dementia 11% (p = 0.006).

Conclusions Compared to the BTS national audit, the proportion of patients with severe pneumonia is higher (49% v 30%) and mortality lower (16.5% v 21.2%). Both dementia and admission from institutional care were associated with high mortality rates. Among patients with low or intermediate risk CURB65 scores the mortality of those with CAP without COPD was lower than we previously found in pAECOPD, confirming that the underestimation of mortality risk by CURB65 in pAECOPD was not attributable to less effective clinical care.

REFERENCES