intracellular IL-17A. Infected animals also developed peribronchial B220+ cellular foci.

In mediastinal LNs following infection, PA-specific responses were dominated by B220+ CD19+ CD43+ CD23-B5+ cells expressing and producing IL-17A and IL-22 as well as PA-specific IgM but not IgG. This PA-specific B1 response was not seen in the thoracic lymph nodes of sterile-head treated animals. In splenocytes, there was a pre-existing B cell response to PA with identical features. Peritoneal B1a cells isolated from untreated controls also produced IL-17A, IL-22 and anti-PA IgM following infection, confirming the existence of pre-existing B1 cells that can respond to PA. In μMT animals, chronic colonisation rates, bacterial burden and neutrophil inflammation did not differ from WT littersmates. However, classical PA-specific Th17 responses dominated following infection in μMT animals, suggesting alternative compensatory IL-17 sources acting in the absence of B cells.

Conclusions In chronic pulmonary PA infection, innate-like B1 cells migrate to the site of infection and are a novel source of pro-inflammatory IL-17 cytokines.

Lung cancer: reasons to be cheerful

S106 “REASONS TO BE CHEERFUL”–DATA FROM YEAR 8 OF THE NATIONAL LUNG CANCER AUDIT


Introduction The National Lung Cancer Audit, now in its 8th year, is run jointly by the Royal College of Physicians and The Information Centre for health and social care, and is commissioned by the Healthcare Quality Improvement Partnership (HQIP). Over this period, the audit has collected rich data of increasing quality and has charted improving standards of care for patients, as well as persistent variation across organisations which in most cases is independent of case-mix.

Methods Although several other countries also submit data to the audit, this abstract presents provisional results for England only for patients first seen in 2012.

Results 31,003 patient records were submitted with the audit, this abstract presents provisional results for England and outcomes for patients with pre-treatment IIIA disease using the National Lung Cancer Audit (NLCA) 2008–2011.

Background Surgery for lung cancer patients with mediastinal lymph node involvement (N2 disease) remains controversial. In one study (Albain 2009), progression-free (but not overall) survival was higher for patients who received induction chemo-radiotherapy followed by lobectomy but post operative mortality was high in pneumonectomy patients. We describe treatment and outcomes for patients with pre-treatment IIIA disease using data submitted from England to the National Lung Cancer Audit (NLCA) 2008–2011.

Methods Patients with pre-treatment staging of T1–3, N2, M0 were included. Small cell cancer, mesothelioma and carcinooid were excluded. The extent and histological nature of pre-treatment N2 disease is not recorded in the NLCA. Survival analyses were performed according to treatment received.

Results 6,775 of 98,403 (6.9%) patients met the inclusion criteria. 2,669 (39%) patients had either chemotherapy or radiotherapy recorded and 2,250 (33%) patients had no treatment recorded. 948 (14%) patients received chemotherapy and radiotherapy however radiotherapy treatment intent was recorded as curative in only 12%. 907 (13%) patients had surgery recorded as part of their treatment plan. Of these, 70% had post operative pathological nodal status recorded (25% N0, 14% N1, 30% N2). Median survival following surgery for the 271