course and history of long term survivors and we describe characteristics and outcomes of all lung transplant recipients who have survived greater than 20 years at our centre.

**Results** Twenty-one (16.2%) out of a possible total of 121 transplant patients survived at least 20 years with an overall median survival of 21.3 (range 20.1–24.9) years. The mean age at transplantation was 31.8 ± 9.9 years and 13 (61.9%) were male. The most common indication for transplantation in the group was Cystic Fibrosis (33.3%); heart-lung and bilateral lung transplant operations were equally the most commonly performed.

The median six-minute walk distance (6MWD) was 600m (range 419–785m). The median time to the development of BOS was 9.7 years. At time of evaluation, 2 (10%) patients had BOS score 0, 3 (14%) BOS 1, 6 (29%) BOS 2 and 10 (48%) BOS 3.

The total number of rejections requiring augmentation with corticosteroids was 30 episodes in 21 patients with an average of 1.4 (range 0–3) episodes per patient. Eighteen patients had at least one episode of rejection needing corticosteroids.

No patient developed symptomatic ischaemic heart disease; systemic hypertension was found in 19 (90.5%) patients. Two (9.5%) patients developed post-transplant lymphoproliferative disease. Four patients developed other malignancies, 3 of which were skin cancers and 1 renal cancer.

All 4 cases of diabetes post transplantation occurred in patients with Cystic Fibrosis. Eight patients received replacement therapy as a result of ciclosporin toxicity and four underwent renal transplantation.

**Conclusion** Twenty-one (16.2%) patients in our cohort survived 20 years. Although nearly all patients developed an element of CLAD, exercise tolerance was preserved as judged by 6MWD. Hypertension was common and renal failure remained the most problematic complication of immunosuppression.

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**Abstracts P244 Figure 1** Survival Functions

The indication for transplantation was COPD and IPF in all. The cause of death was BOS in 9/14, malignancy in 2/14 and pulmonary embolism, stroke and bleeding in the others. When compared with 50 single lung transplant recipients aged 60–64, we did not find any statistically significant differences in survival (p value 0.158) (see figure 1), cause of death and reason for transplantation.

**Conclusion** We have shown from our limited data that patients aged 65 and over have very similar outcomes to their younger counterparts. Hence, age whilst still important should not be a deterring factor when referring patients for lung transplant assessment. It would also be important to examine longer term outcomes and complications such as rates of renal dysfunction, hypertension, rejection and admissions into hospital. As the number of patients aged 65 and older receiving lung transplant increases, we should be able to gather more effective data.