

**ELSO** The ELSO database contains 78 patients (adult, 59; paediatric, 19) with pulmonary vasculitides who received ECMO. 43 had a diagnosis of Granulomatosis and Polyangiitis (GPA), whereas the remaining diagnoses included hypersensitivity angiitis, Goodpasture's syndrome and thrombotic microangiopathy. The median age was 23 yrs (IQR 16–47). The median duration of ECMO was 190hrs (IQR 146–282) and ICU survival was 82%. Twelve patients (15%) were reported to have thrombotic ECMO circuit complications.

**Conclusion** In this case series, ECMO offers an excellent survival rate in SRF due to ANCA-associated DAH. ELSO registry data supports this, suggesting that ECMO should be considered as supportive therapy in DAH with SRF not responsive to conventional therapy.

#### P279 REDUCTION IN DISEASE PROGRESSION WITH NINTEDANIB IN THE INPULSIS™ TRIALS

<sup>1</sup>V Cottin, <sup>2</sup>H Taniguchi, <sup>3</sup>HR Collard, <sup>4</sup>L Richeldi, <sup>5</sup>S Stowasser, <sup>6</sup>I Tschöpe, <sup>7</sup>R Schlenker-Herceg, <sup>8</sup>G Raghu. <sup>1</sup>Louis Pradel Hospital, University of Lyon, Lyon, France; <sup>2</sup>Tosei General Hospital, Aichi, Japan; <sup>3</sup>University of California San Francisco, San Francisco, California, USA; <sup>4</sup>University of Southampton, Southampton, UK; <sup>5</sup>Boehringer Ingelheim Pharma GmbH and Co. KG, Ingelheim Am Rhein, Germany; <sup>6</sup>Boehringer Ingelheim France S. A. S., Reims, France; <sup>7</sup>Boehringer Ingelheim Pharmaceuticals Inc., Ridgefield, Connecticut, USA; <sup>8</sup>University of Washington, Seattle, Washington, USA

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**Background** Nintedanib, an intracellular inhibitor of tyrosine kinases, is in development for the treatment of idiopathic pulmonary fibrosis (IPF). The INPULSIS™ trials were two replicate 52-week, randomised, double-blind, placebo-controlled Phase III trials that investigated the efficacy and safety of nintedanib 150 mg twice daily in 1066 patients with IPF. Declines in forced vital capacity (FVC)% predicted of >5% and >10% in patients with IPF have been proposed as indicators of disease progression and have been associated with reduced survival.

**Aim** To determine the effect of nintedanib on changes in FVC% predicted in the INPULSIS™ trials.

**Methods** The proportions of patients with absolute and relative declines in FVC% predicted of >5% and >10% at week 52 in each INPULSIS™ trial were determined in a post-hoc analysis.

**Results** In each trial, a significantly greater proportion of patients in the placebo group had an absolute decline in FVC% predicted of >5% compared with the nintedanib group. In INPULSIS™-1, a significantly greater proportion of patients in the placebo group had an absolute decline in FVC% predicted of >10% compared with the nintedanib group; the difference between groups in INPULSIS™-2 was numerically in favour of nintedanib but did not reach statistical significance. In each trial, significantly greater proportions of patients in the placebo group had relative declines in FVC% predicted of >5% and >10% compared with the nintedanib group.

**Conclusion** In the INPULSIS™ trials, nintedanib reduced the proportion of patients with IPF who experienced disease progression as measured by categorical FVC decline.

#### P280 EXTENDED CLINICAL EXPERIENCE WITH PIRFENIDONE DURING A NAMED PATIENT PROGRAMME FOR IDIOPATHIC PULMONARY FIBROSIS (IPF): INTERIM RESULTS

<sup>1</sup>H Parfrey, <sup>2</sup>N Chaudhuri, <sup>3</sup>MA Gibbons, <sup>3</sup>L Anning, <sup>4</sup>M Balkin, <sup>5</sup>S Cooper, <sup>5</sup>R Dew, <sup>4</sup>TM Maher. <sup>1</sup>Papworth Hospital NHS Foundation Trust, Cambridge, UK; <sup>3</sup>Royal Devon and

Exeter NHS Foundation Trust, Exeter, UK; <sup>4</sup>Royal Brompton and Harefield NHS Foundation Trust, London, UK; <sup>5</sup>pH Associates Ltd, Marlow, UK; <sup>2</sup>University Hospital of South Manchester NHS Foundation Trust, Manchester, UK

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**Introduction and objectives** From September 2011 to May 2013, pirfenidone was available in the UK in a named patient programme (NPP). We present results from an extension to a previous real-world study (Parfrey *et al.* Abstract S98, BTS Winter Conference 2012) now including longer follow-up and all patients enrolled in the pirfenidone NPP from 4 centres.

**Methods** Four centre, retrospective, cohort review of patient outcomes in the 24 months following pirfenidone initiation in the NPP. Discontinuation data were separately collected for all patients prescribed pirfenidone at the Brompton between Sept 2011 and May 2014.

**Results** Two hundred and eighteen eligible patients have been identified. Demographic data have been collected for 124 patients (78% male) and outcome data at 12 months from 58 patients. Mean ( $\pm$ S. D.) age at diagnosis was 67.1( $\pm$  8.1) years. Mean time from diagnosis to pirfenidone initiation was 27.7 ( $\pm$  30.6) months. At pirfenidone initiation, mean FVC was 69.3 ( $\pm$ 18.9)% predicted (with 27 (22.0%) patients having FVC >80% predicted); DLco was 40.3( $\pm$  13.8)% predicted. Following a 14-day titration period, 53 (93%) patients were receiving the recommended dose of 2403 mg/day pirfenidone. At 6 and 12 months; 47 (81%) and 44 (76%) patients continued to receive pirfenidone.

187 patients have been prescribed pirfenidone at the Brompton since Sept 2011. At 10 months following initiation 18.5% of these have discontinued pirfenidone with no further discontinuations beyond this time. For patients in the NPP with available paired baseline and 6 or 12 month FVC, mean decline in FVC% predicted over first 6 months of pirfenidone treatment was 3.2 ( $\pm$  7.9)%; over first 12 months 1.6( $\pm$ 12.0)%. One patient's FVC% predicted declined >10% in the first 12 months of treatment. Mean decline in DLco% predicted over first 6 months from pirfenidone initiation was 9.1( $\pm$  14.7)%; over first 12 months' treatment, 7.0( $\pm$  17.2)%.

**Conclusions** The high proportion of patients remaining on pirfenidone at 12 months suggests it is well tolerated and any tolerability issues tend to occur early in treatment. Lung function is largely preserved at 12 months following pirfenidone initiation. Longer-term observation of lung function and clinical outcomes will continue to determine the real-world benefits of pirfenidone.

## Smoking detection and cessation and non tobacco products

#### P281 SMOKING PREVALENCE AND STOP SMOKING INTERVENTIONS FOR PATIENTS ADMITTED TO AN EMERGENCY DEPARTMENT (ED) IN A BUSY, INNER CITY HOSPITAL

<sup>1</sup>R Thomas, <sup>1</sup>F Warden, <sup>2</sup>M Stern. <sup>1</sup>University of London Medical School, London, UK; <sup>2</sup>Department Respiratory Medicine, Whittington Health, London, UK

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**Introduction** ED admissions are 'teachable moments' to offer cessation advice to smokers. In this study, smoking prevalence and stop smoking interventions were investigated in patients

**Abstract P281 Table 1** Patient demographics and smoking characteristics

	Current Smokers n = 24	Ex Smokers n = 39	Never Smokers n = 38
<b>Age</b>			
mean±SD years	46.5 ± 17.5	55.5 ± 23.5	59.7 ± 22.3
<b>Male:Female</b>	13:11	21:18	11:27
<b>Pack years</b>			
mean±SD (range)	28.5 ± 25.4 (5–96)	17.9 ± 22.7 (5–90)	
<b>Cannabis (% of total)</b>	12.5%	0	0
<b>Mean±SD Number (range) of Previous Quit attempts</b>	2.4 ± 2.3 (1–10)	1.1 ± 0.5 range 1–3	

admitted to ED in a busy inner London hospital. The views of ED doctors on the value/appropriateness of offering smoking cessation advice in ED were canvassed with the aim of defining barriers to implementation of 'right care' for sick smokers.

**Methods** Proforma questionnaires guided interviews of ED patients and doctors. Patient demographics, smoking history (pack years, quit attempts, motivation to quit, smoking cessation advice/referral in ED) were documented. Doctors were asked about their views on ascertaining smoking status, offering brief advice and referral to quit smoking services to smokers in ED. All patients and staff were given an information sheet explaining the purpose of the questionnaires.

**Results** 101 patients were interviewed. 24/101(23%) were current smokers (3/24 12.5% also smoked cannabis), 39/101(39%) were ex-smokers and 38/101(37%) were lifelong non-smokers. Table 1 demonstrates that smokers were younger than ex- and never-smokers, never-smokers were predominantly female and 17/24 (71%) smokers had had multiple attempts to give up. In comparison, 36/39 (92%) ex-smokers gave up on their first attempt, with 33/39(85%) quitting without assistance. 13/24 (54%) smokers expressed a desire to quit yet only 4(17%) were asked/given advice about smoking by a doctor. 14 doctors (6 FYs, 4 CMT/SPRs, 4 consultants, 8/14 had had Stop Smoking training) were questioned. 14/14 agreed that smoking cessation was important; 8/14(57%) felt that ED was not an appropriate place to offer advice.

**Conclusion** 1/4 of patients attending A+E are smokers. Over 1/2 are motivated to quit but are not offered smoking-cessation advice during admission. Despite ED staff regarding Stop Smoking as valuable treatment, there is a perception that ED is an inappropriate setting to broach the issue of quitting. Smokers tended to be younger and had multiple unsuccessful attempts to quit compared to older ex-smokers who mainly quit on the first attempt. Offering support to quit during the first attempt is the most effective way to achieve permanent cessation. ED attendance should therefore be prioritised for targeted stop smoking interventions.

**P282 A PROSPECTIVE STUDY TO DETERMINE THE ACCURACY OF SELF-REPORTED SMOKING HABITS IN PATIENTS WITH TUBERCULOSIS**

AL Carver, R Whitfield, MR Soobratty, GV O'Donovan, G Grove, GF Cope, HJ Millburn. King's College London, London, UK

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**Background** Smoking is an independent risk factor for tuberculosis infection, disease and mortality. It is therefore important

that clinicians can identify patients who are actively smoking in order to provide optimal care. The reliability of self-reported smoking habits is often questioned but the development of biochemical assays that measure the nicotine metabolite cotinine, allow for an objective assessment of smoking status. Here we assess the accuracy of self-reported smoking habits in patients with tuberculosis by comparing these with urinary cotinine levels.

**Methods** Patients were recruited from two London tuberculosis clinics. Self-reported smoking habits were obtained from an interviewer administered questionnaire. Urinary cotinine levels were measured using a SmokeScreen® test kit (GFC Diagnostics, Oxfordshire, UK), a semi-quantitative colorimetric assay.

**Results** One hundred patients attending clinic for treatment of active tuberculosis or latent tuberculosis infection completed the study (Table 1). Nineteen reported using tobacco and had either smoked or chewed tobacco the day before testing, the quantity of which was representative of a standard day's consumption. Duration of smoking ranged from 3 to 40 years with a mean of 13.4+10.5 and a median of 10.0. Eight further patients recorded stopping smoking between a few days and 6 years prior to testing, with a mean cessation period of 2.0+2.1 years. Two of these had later started chewing tobacco.

Although nineteen patients reported either smoking or chewing tobacco, a further six patients' urine tested positive for cotinine, i.e. 24% of tobacco users failed to report its use (Table 1). Furthermore, nine patients produced the colour change indicating heavy smoking (11–15/day) and ten patients produced a result indicating very heavy smoking (>16/day), although only two reported smoking 11–15 cigarettes the previous day and a further two must have chewed an equivalent amount of tobacco. This corresponds to 79% of heavy to very heavy tobacco users under-reporting its use.

**Conclusion** Discrepancies exist between objective and subjective assessments of smoking habits amongst patients with TB which may be attributable to an under-reporting of tobacco use, suggesting further avenues of research in this patient cohort.

**P283 CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD) CASE-FINDING AND TOBACCO DEPENDENCE ON LONG STAY PSYCHIATRIC WARDS**

<sup>1</sup>D Hughes, <sup>1</sup>M Jeanneret, <sup>1</sup>F Johansson, <sup>1</sup>K Sherring, <sup>2</sup>L Restrck. <sup>1</sup>Camden and Islington NHS Foundation Trust, London, UK; <sup>2</sup>Whittington Health, London, UK

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**Introduction and objectives** 42% of UK tobacco smoked is consumed by people with mental disorders.<sup>1</sup> Smoking prevalence, and the proportion of highly-dependent smokers, are increased in patients with severe mental illness (SMI) and smoking is the main cause of high premature mortality in this group.<sup>1</sup> The prevalence of COPD, a disease with >85% smoking-attributable deaths, in psychiatric in-patients is unknown and patients with SMI are less likely to have physical-health-checks and treatment.<sup>1</sup> We hypothesised that COPD is under-diagnosed and under-treated in in-patients with SMI.

**Methods** Case notes review and a structured smoking/respiratory assessment, using NICE COPD guidance with spirometry/oximetry,<sup>2</sup> were performed for in-patients with SMI over 1 month on three long-term psychiatric wards in an inner-city mental health trust.

**Results** Patient demographics are shown in the Table.

## Corrections

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R Thomas, F Warden, M Stern. P281 Smoking prevalence and stop smoking interventions for patients admitted to an emergency department (ED) in a busy, inner city hospital. *Thorax* 2014;69(Suppl 2):A196. doi: 10.1136/thoraxjnl-2014-206260.399

The author names should read:

Williams H,<sup>1</sup> Thomas R,<sup>1</sup> Stern M<sup>2</sup>

<sup>1</sup>University College London Medical School, London, UK

<sup>2</sup>Department Respiratory Medicine, Whittington Health, London, UK



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