HEALTH STATUS AND QUALITY OF LIFE IN IDIOPATHIC PULMONARY FIBROSIS (IPF) DIAGNOSIS

Although there was a trend towards a higher frequency of fatigue in sarcoidosis compared with healthy volunteers, no such relationship was seen in IPF. In healthy volunteers, no measures of dyspnoea or disease severity (spirometry abnormality, immunosuppression use or extrapulmonary disease) were associated with fatigue scores. In IPF increasing dyspnoea scores were associated with increased fatigue scores (p < 0.001).

Conclusions Both sarcoidosis and IPF patients suffer with high levels of fatigue, although the sarcoidosis cohort showed a trend towards greater frequency of severe fatigue compared with IPF. In IPF patients increasing fatigue was associated with worsening dyspnoea, suggesting an association with disease progression, but no similar relationship was seen in sarcoidosis. This suggests that fatigue in sarcoidosis occurs independently of common markers of disease activity, whereas it occurs as a sequelae of progressive disease in IPF.

Discussion This methodological approach to item generation will enhance the content validity of the IPF-PROM instrument. Items generated to date will be modified further by 80 patients from 4 UK centres and 20 ILD physicians participating in 3 rounds of a Qualtrics Delphi survey. This study is ongoing.

FATIGUE PULMONARY FIBROSIS AND SARCOIDOSIS: EFFECT OF SEVERITY

Patients felt a blame culture exists, whereby others felt that IPF is self-inflicted, like COPD, particularly when a patient was denied the chance to smoke. Patients were uncertain about how to deal with their future. There was a high expectation for their physician to explain the trigger for developing IPF. There was a national transplant agency. Patients with IPF were asked to record a personal account of their experience on a hand-held camera. Face to face interviews with patients were conducted in their home. Carers were also interviewed to add an alternative perspective.

Methods This was a cross-sectional questionnaire study of patients with sarcoidosis and IPF. Questionnaire data was analysed to investigate health status, QOL, and symptom prevalence (fatigue, depression and sleepiness). Comparison of scores between groups, and an analysis of the effect of markers of disease severity.

Results Questionnaires were administered to 235 participants; 82 healthy volunteers, 76 sarcoidosis patients and 77 IPF patients. IPF patients had statistically higher St George’s Respiratory Questionnaire (p = 0.034) and Epworth Sleepiness Scale scores (p = 0.003) than sarcoidosis patients, but there was no difference in mean fatigue scores. When stratified by questionnaire scores (Table 1), including pathological fatigue levels, no statistical difference was seen between IPF and sarcoidosis, although there was a trend towards a higher frequency of ‘severe fatigue’ in sarcoidosis. Fatigue scores correlated strongly with quality of life scores (King’s Brief Interstitial Lung Disease score and St George’s Respiratory Questionnaire) in both IPF (r = 0.615 and 0.659 respectively) and sarcoidosis (r = -0.529 and 0.502). In sarcoidosis, no measures of dyspnoea or disease severity (spirometry abnormality, immunosuppression use or extrapulmonary disease) were associated with fatigue scores. In IPF increasing dyspnoea scores were associated with increased fatigue scores (p < 0.001).

Conclusions Both sarcoidosis and IPF patients suffer with high levels of fatigue, although the sarcoidosis cohort showed a trend towards greater frequency of severe fatigue compared with IPF. In IPF patients increasing fatigue was associated with worsening dyspnoea, suggesting an association with disease progression, but no similar relationship was seen in sarcoidosis. This suggests that fatigue in sarcoidosis occurs independently of common markers of disease activity, whereas it occurs as a sequelae of progressive disease in IPF.

Discussion This methodological approach to item generation will enhance the content validity of the IPF-PROM instrument. Items generated to date will be modified further by 80 patients from 4 UK centres and 20 ILD physicians participating in 3 rounds of a Qualtrics Delphi survey. This study is ongoing.

M267 HEALTH STATUS AND QUALITY OF LIFE IN IDIOPATHIC PULMONARY FIBROSIS AND SARCOIDOSIS: EFFECT OF FATIGUE

Introduction and Objective Sarcoidosis and Idiopathic Pulmonary Fibrosis (IPF) are two common forms of interstitial lung disease. Sarcoidosis frequently causes extra-pulmonary disease whereas IPF specifically affects the lungs. Fatigue is a common feature of sarcoidosis, but an association between fatigue and disease activity on fatigue, was undertaken.

Methods This was a cross-sectional questionnaire study of patients with sarcoidosis and IPF. Questionnaire data was analysed to investigate health status, QOL, and symptom prevalence (fatigue, depression and sleepiness). Comparison of scores between groups, and an analysis of the effect of markers of disease severity.

Results Questionnaires were administered to 235 participants; 82 healthy volunteers, 76 sarcoidosis patients and 77 IPF patients. IPF patients had statistically higher St George’s Respiratory Questionnaire (p = 0.034) and Epworth Sleepiness Scale scores (p = 0.003) than sarcoidosis patients, but there was no difference in mean fatigue scores. When stratified by questionnaire scores (Table 1), including pathological fatigue levels, no statistical difference was seen between IPF and sarcoidosis, although there was a trend towards a higher frequency of ‘severe fatigue’ in sarcoidosis. Fatigue scores correlated strongly with quality of life scores (King’s Brief Interstitial Lung Disease score and St George’s Respiratory Questionnaire) in both IPF (r = 0.615 and 0.659 respectively) and sarcoidosis (r = -0.529 and 0.502). In sarcoidosis, no measures of dyspnoea or disease severity (spirometry abnormality, immunosuppression use or extrapulmonary disease) were associated with fatigue scores. In IPF increasing dyspnoea scores were associated with increased fatigue scores (p < 0.001).

Conclusions Both sarcoidosis and IPF patients suffer with high levels of fatigue, although the sarcoidosis cohort showed a trend towards greater frequency of severe fatigue compared with IPF. In IPF patients increasing fatigue was associated with worsening dyspnoea, suggesting an association with disease progression, but no similar relationship was seen in sarcoidosis. This suggests that fatigue in sarcoidosis occurs independently of common markers of disease activity, whereas it occurs as a sequelae of progressive disease in IPF.

Discussion This methodological approach to item generation will enhance the content validity of the IPF-PROM instrument. Items generated to date will be modified further by 80 patients from 4 UK centres and 20 ILD physicians participating in 3 rounds of a Qualtrics Delphi survey. This study is ongoing.

FATIGUE PULMONARY FIBROSIS AND SARCOIDOSIS: EFFECT OF SEVERITY

Patients felt a blame culture exists, whereby others felt that IPF is self-inflicted, like COPD, particularly when a patient was denied the chance to smoke. Patients were uncertain about how to deal with their future. There was a high expectation for their physician to explain the trigger for developing IPF. There was a national transplant agency. Patients with IPF were asked to record a personal account of their experience on a hand-held camera. Face to face interviews with patients were conducted in their home. Carers were also interviewed to add an alternative perspective.

Methods This was a cross-sectional questionnaire study of patients with sarcoidosis and IPF. Questionnaire data was analysed to investigate health status, QOL, and symptom prevalence (fatigue, depression and sleepiness). Comparison of scores between groups, and an analysis of the effect of markers of disease severity.

Results Questionnaires were administered to 235 participants; 82 healthy volunteers, 76 sarcoidosis patients and 77 IPF patients. IPF patients had statistically higher St George’s Respiratory Questionnaire (p = 0.034) and Epworth Sleepiness Scale scores (p = 0.003) than sarcoidosis patients, but there was no difference in mean fatigue scores. When stratified by questionnaire scores (Table 1), including pathological fatigue levels, no statistical difference was seen between IPF and sarcoidosis, although there was a trend towards a higher frequency of ‘severe fatigue’ in sarcoidosis. Fatigue scores correlated strongly with quality of life scores (King’s Brief Interstitial Lung Disease score and St George’s Respiratory Questionnaire) in both IPF (r = 0.615 and 0.659 respectively) and sarcoidosis (r = -0.529 and 0.502). In sarcoidosis, no measures of dyspnoea or disease severity (spirometry abnormality, immunosuppression use or extrapulmonary disease) were associated with fatigue scores. In IPF increasing dyspnoea scores were associated with increased fatigue scores (p < 0.001).

Conclusions Both sarcoidosis and IPF patients suffer with high levels of fatigue, although the sarcoidosis cohort showed a trend towards greater frequency of severe fatigue compared with IPF. In IPF patients increasing fatigue was associated with worsening dyspnoea, suggesting an association with disease progression, but no similar relationship was seen in sarcoidosis. This suggests that fatigue in sarcoidosis occurs independently of common markers of disease activity, whereas it occurs as a sequelae of progressive disease in IPF.