Abstract S76 Table 1

<table>
<thead>
<tr>
<th>Site</th>
<th>Greenwich (%)</th>
<th>Nepal (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n = 86</td>
<td>n = 34245</td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;15</td>
<td>1.2</td>
<td>2.5</td>
</tr>
<tr>
<td>15–24</td>
<td>34.9</td>
<td>20.5</td>
</tr>
<tr>
<td>25–34</td>
<td>34.9</td>
<td>18.0</td>
</tr>
<tr>
<td>35–44</td>
<td>10.5</td>
<td>12.0</td>
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<tr>
<td>45–54</td>
<td>10.5</td>
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<tr>
<td>55–64</td>
<td>3.5</td>
<td>15.5</td>
</tr>
<tr>
<td>65+</td>
<td>4.7</td>
<td>12.0</td>
</tr>
</tbody>
</table>

| Other                 |               |             |
| Treatment completion  | 98            | 91          |
| TB/HIV co-infection   | 1.1           | 2.4         |
| MDR                   | 4.7           | 2.6         |

**Pre-treatment chest X-ray severity and its relation to bacterial burden in pulmonary tuberculosis**

S6 Murthy, S Chattejee, S Phillips, S Murray, D McHugh, SH Gillespie. University College London, London, UK; University College London Hospital, London, UK; MRC/ Clinical Trials Unit/UCL, London, UK; TB Alliance, New York, USA; University of St Andrews, St Andrews, UK

**Background**

Chest radiographs are commonly used for the diagnosis of tuberculosis and to assess the extent of disease. A relationship between the extent of disease as determined by smear grade and cavitation has been shown to predict 2-month smear results but little has been done to determine whether radiological severity reflects the bacterial burden at diagnosis.

**Design/methods**

Pre-treatment chest X-rays from 1837 subjects with smear positive pulmonary tuberculosis enrolled into the REMoxTB trial were retrospectively reviewed. Two clinicians blinded to clinical details using the Ralph et al scoring system

**Results**

Matching sets of data were available for 1422 subjects. The median severity score was 53.75/140 (IQR 32.03–66.25) and median time to culture positivity 117 h (4.88 days). CXR severity score was weakly correlated with time to positivity (Spearman’s correlation -0.20, p = 0.0001). Time to positivity was higher in those without cavitation (difference 23.7 h, p = 0.0001) and those with a low area affected (difference 12.1 h, p = 0.0001).

**Conclusions**

The radiological severity of pulmonary tuberculosis at diagnosis is weakly correlated with bacterial load as measured by TTP. This suggests that, in addition to bacterial burden, other factors such as immune response influence radiological appearances.

**Spoken sessions**

**S77**

**Pre-treatment chest X-ray severity and its relation to bacterial burden in pulmonary tuberculosis**

**S78**

**Do tuberculosis cases managed by clinicians with average annual caseloads below 10 have poorer treatment outcomes?**


**Introduction and objectives**

The 2007 Department of Health Tuberculosis Toolkit advises that clinicians should not be solely managing tuberculosis (TB) cases if their average caseload is less than 10 per year. A systematic evaluation of whether these guidelines are being followed, and how effective such a threshold is, has not been undertaken in the UK.

**Methods**

All UK TB cases notified 2003–2011 were extracted from Public Health England’s Enhanced Tuberculosis Surveillance system. Mean caseload for each clinician was calculated over the preceding year and three years by using case notification date. 12 month TB treatment outcomes were categorised as unfavourable or good/neutral.

**Results**

74,550 TB cases were notified 2003–11. The proportion of TB cases seen by a clinician who had a low caseload under 10 was analysed, then random effects logistic regression utilised to determine the relationship between caseload and treatment outcomes, adjusting for clustering by clinician and confounding.

**Conclusions**

Our analysis indicates that TB cases managed by clinicians with a caseload under 10 was analysed, then random effects logistic regression utilised to determine the relationship between caseload and treatment outcomes, adjusting for clustering by clinician and confounding.

**REFERENCES**


**S79**

**Cough prevalence and frequency in pulmonary tuberculosis**

RD Turner, AC Repossi, S Matsos, SS Birring, GH Bothamley. Homerton University Hospital NHS Foundation Trust, London, UK; IEETA, University of Aveiro, Aveiro, Portugal; King’s College London, London, UK

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**REFERENCES**

1. Ditah, Thorax 2008;63:440–446