Abstract P60 Table 1 Effects of IND/GLY on PROs in men and women compared with other comparators at Week 26

Parameters	IND/GLY vs SFC		IND/GLY vs GLY		IND/GLY vs TIO		IND/GLY vs PBO	
	Men	Women	Men	Women	Men	Women	Men	Women
TDI total scores	0.46	0.65	0.23	1.31	0.51	1.39	0.66	2.51
	(0.06, 0.85)*	(−0.12, 1.43)	(−0.23, 0.68)	(0.52, 2.10)†	(0.05, 0.97)*	(0.63, 2.15)‡	(0.05, 1.26)*	(1.52, 3.51)τ
SGRQ total scores	−0.93	−1.93	−1.36	−2.83	−2.51	−1.83	−2.27	−6.82
	(−2.53, 0.66)	(−4.92, 1.06)	(−2.57, −0.14)*	(−4.91, −0.75)†	(−3.72, −1.31)τ	(−3.90, 0.24)	(−4.59, 0.06)	(−10.6, −3.01)‡
Symptom scores (total) via e-diary	−0.37	0.06	−0.34	−0.40	−0.39	−0.62	−0.22	−0.31
	(−0.82, 0.09)	(−0.60, 0.73)	(−0.60, −0.08)†	(−0.82, 0.02)	(−0.65, −0.13)†	(−1.05, −0.19)†	(−0.79, 0.35)	(−1.30, 0.68)
Rescue medication use	−0.14	−0.03	−0.66	−1.22	−0.53	−1.13	−0.66	−1.12
	(−0.45, 0.17)	(−0.74, 0.67)	(−0.89, −0.43)τ	(−1.66, −0.78)τ	(−0.76, −0.30)τ	(−1.56, −0.69)τ	(−1.03, −0.29)‡	(−1.84, −0.40)†

*p < 0.05; †p < 0.01; ‡p < 0.001; τp < 0.0001; data presented as LSM (95% confidence interval); e-diary, electronic diary; IND/GLY, indacaterol/glycopyrronium (110/50 μg once daily); LSM, least square mean; PBO, placebo; PRO, patient-reported outcome; SFC, salmeterol/fluticasone (50/500 μg twice daily); SGRQ, St. George's Respiratory Questionnaire; TDI, transition dyspnoea index; TIO, tiotropium (18 μg once daily)

pooled analysis of 6 randomised trials from the IGNITE programme showed a lower baseline dyspnoea index (greater dyspnoea) and higher baseline St. George's Respiratory Questionnaire (SGRQ) total scores (worse health related quality of life) in women compared with men[1]. Here, we report the treatment impact in patient-reported outcomes (PROs) in men and women by further investigating data from the aforementioned pooled analysis.

Methods Six trials of 24 to 62 weeks duration (ENLIGHTEN, SHINE, ILLUMINATE, ARISE, SPARK and LANTERN) from the IGNITE programme were included. Effects of IND/GLY on PROs, such as transition dyspnoea index (TDI) and SGRQ total scores, symptoms scores via electronic diary and rescue medication use, were assessed, compared with salmeterol/fluticasone (SFC), glycopyrronium (GLY), tiotropium (TIO) and placebo (PBO) in both men and women with moderate to very severe COPD.

Results Data from 6108 patients were pooled and analysed (men, n = 4719; women, n = 1389). Overall, IND/GLY showed better improvement in dyspnoea and health status at Week 26 compared with other treatments. Although, there was some variability, the effect size was generally larger in women compared with men (Table). In addition, a higher percentage of women than men treated with IND/GLY achieved the minimal clinically important difference (MCID) from baseline in TDI and SGRQ total scores versus other comparators. Similarly, there was a greater reduction of rescue medication use in women than in men that received IND/GLY versus other treatments (Table). The reduction of symptom scores in the e-Diary with IND/GLY was comparable in both genders (Table).

Conclusions IND/GLY demonstrated superior improvement in dyspnoea and health status in both men and women with COPD compared with SFC, GLY, TIO and PBO. Furthermore, the efficacy of IND/GLY in terms of PROs was found to be better in women than in men and IND/GLY could be considered as a start-up treatment vs monotherapy for women with COPD. If confirmed in further studies these data may support gender differences in PROs response to bronchodilator therapy.

REFERENCE

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P61 COMMUNITY OXYGEN PRESCRIPTIONS AND DNACPR DISCUSSIONS IN STOCKPORT; AN OPPORTUNITY TO IMPROVE END OF LIFE CARE PLANNING?

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Introduction Many patients who are prescribed home oxygen are symptomatic from progressive, life-limiting disease. The GMC recommends "if cardiac or respiratory arrest is an expected part of the dying process and CPR will not be successful, making and recording an advance decision not to attempt CPR will help to ensure that the patient dies in a dignified and peaceful manner".[1] In addition, patients who are at risk of death or declining are identified on the gold standard framework (GSF) and future care planned according to their wishes.[2]

Objectives To investigate whether patients prescribed oxygen in the community had Do Not Attempt CPR (DNACPR) discussed and recorded; and secondly to investigate the length of time these patients were on oxygen and had DNACPR discussed/recorded prior to death.

Methods Patients who died between January and June 2016 on home oxygen were identified from the Stockport Home Oxygen Service records. The Stockport Health Record (SHR) and GP practices were consulted to find patients' primary diagnoses and DNACPR status.

Results 43 patients (mean age 73.8 ± 1.8) were identified. The overall median (range) length of time on home oxygen was 191 (5–3617) days. 14 (32.6%) had a community DNACPR form present or discussed 60.7 ± 24.4 days (mean ± sem) prior to death.

Most common diagnoses were COPD (n = 19), malignancy (n = 14), ILD (n = 5) and other eg CF, PE (n = 3). Results for these groups are shown in Table 1.

Conclusion Patients are prescribed home oxygen for many reasons and for variable amounts of time. For many the prescription represents a deterioration in their health. In our cohort of patients only 32.6% had DNACPR discussed/present at death, and median survival after initiation of oxygen was only 191 days.

Abstract P61 Table 1 Length of time on home oxygen and DNACPR status by disease group. (– represents too few n numbers to calculate)

	Overall	COPD	Malignancy	ILD	Other
N	43	19	14	5	3
Patient age (mean ± sem)	73.8 ± 1.8	78.3 ± 1.6	67.0 ± 4.0	73.0 ± 4.8	74.3 ± 6.7
Time on oxygen in days (median, range)	191 (5–3617)	562 (10–1432)	16.5 (5–210)	450 (150–636)	172 (8–3617)
Patients with DNACPR (%)	32.6%	42.1%	28.6%	40.0%	0
Length of time DNACPR prior to death in days (mean ± sem)	60.7 ± 24.4	75.0 ± 45.1	–	–	0

We propose that the prescription of home oxygen can be used as a trigger for discussion of a community DNACPR form. As well as planning for their death, the hope is that this discussion can also prompt planning for the final weeks and months of life, such as wills, advanced directives and preferred place of care.

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P62 AVOIDING INAPPROPRIATE PRESCRIBING OF HIGH DOSE INHALED CORTICOSTEROID COMBINATION INHALERS – IS THE MESSAGE GETTING THROUGH?

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Introduction In the UK, over a third of asthma patients are treated at BTS step 4 or 5[1] with similar suggestions of over use of high dose inhaled corticosteroids (ICS), equivalent to ≥1000 micrograms beclomethasone dipropionate, in patients with COPD.[2] This has resulted in the highest dose ICS (HDICS-licensed daily dose equivalent to 2000micrograms beclomethasone dipropionate) with long-acting $Beta_2$-agonist combination inhalers consistently appearing in the top five costliest drugs to the NHS. The London Respiratory Team have shared their concerns regarding the potential harm and waste associated with this practice; hence, many prescribing initiatives have been implemented to optimise ICS use through appropriate step down or ICS withdrawal. However cost-saving interventions such as generic prescribing have also been implemented.

Aims To ascertain whether any reduction in spend on HDICS combinations is due to treatment optimisation or generic switches.

Methods Monthly prescription cost analysis data available from the NHSBSA website (http://www.nhsbsa.nhs.uk) for the latest 15 months were analysed for the quantities prescribed and associated cost (Net Ingredient Cost) of all of the HDICS combination inhalers currently available.

Results In 2015–16, the monthly spend on all HDICS combination inhalers fell from around £20million/month to £18million/month, and number of items fell from around 400,000/month to 365,000/month. By the last quarter, the switch from high cost HDICS combinations to lower cost ones accounted for 15% of all HDICS combinations, saving around £0.75million/month.

Conclusion The message around inappropriate use of high dose ICS is beginning to filter through. Savings have been made from both switching to lower cost HDICS combination products and reduction in total numbers prescribed. Some of these saving will be offset by some patients being prescribed lower cost, lowerz ` dose ICS combinations.

However the reduction in high dose prescribing is less than 10% of the total number prescribed. Given the extent of overuse, further harm and waste reduction can be made by reviewing the appropriateness of high dose ICS combinations prescribing in asthma and COPD with can lead to significant cost savings and improve value.

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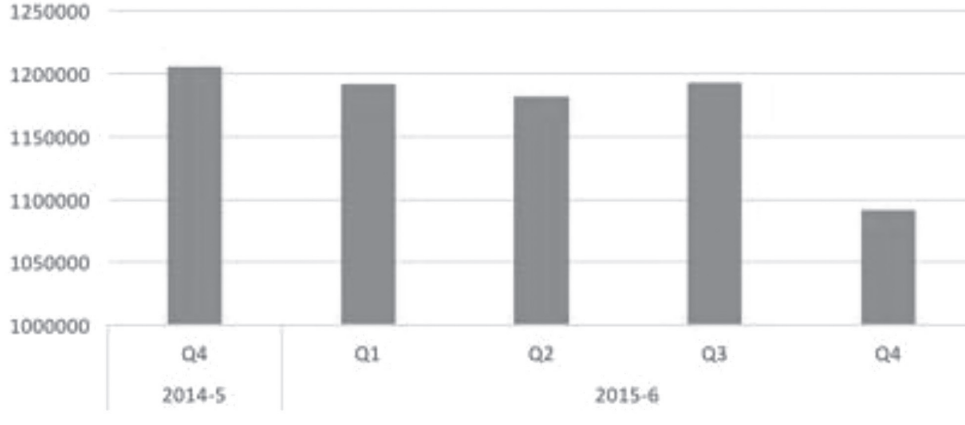

Abstract P62 Figure 1 High dose ICS combinations – Quarterly Quantiities