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.

REFERENCES

- 1 End of life care: When to consider making a Do Not Attempt CPR (DNACPR) decision. http://www.gmc-uk.org/guidance/ethical_guidance/end_of_life_DNACPR_decision.asp.
- 2 Gold Standards Framework. <http://www.goldstandardsframework.org.uk/>.

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 5¹ 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 Beta₂-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, lower 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.

REFERENCES

- 1 Covvey J, et al. Is the BTS/SIGN guideline confusing? A retrospective database analysis of asthma therapy. *Prim Care Respir J* 2013;**22**(3):290–5.
- 2 White P, et al. Overtreatment of COPD with inhaled corticosteroids—implications for safety and costs: cross-sectional observational study. *PLoS One* 2013;**8**(10): e75221.

Abstract P62 Figure 1 High dose ICS combinations – Quarterly Quantities

P63

SALVAGE LUNG VOLUME REDUCTION SURGERY AFTER FAILURE OR COMPLICATIONS OF ENDOBRONCHIAL TREATMENT WITH ONE-WAY VALVES FOR SEVERE EMPHYSEMA

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Introduction Endobronchial lung volume reduction with one-way valves (ELVR), in combination with staged unilateral VATS lung volume reduction surgery (LVRS), multiplies the options of treatment for emphysema. No experience has yet been reported in literature of the use of LVRS after failure of ELVR. We aimed therefore to review our current series.

Methods 7 consecutive patients (3 male, age 68, 59–76) had successful Chartist assessment and ELVR, and subsequently underwent salvage LVRS following failure or complications of primary procedure. All patients were suitable candidates for either approach according to our criteria (average RV/TLC 67 range 56–77, FEV1 32% range 25–38, DLCO 32%, range 24–55), with 4 patients classifying as moderate to high risk for LVRS and the rest as moderate or low. They were offered both options and opted for ELVR on the assumption of reduced risks and shorter hospitalisation. Valves were not removed prior to LVRS, except in one case who was also the first chronological patient in our series.

Results Delayed collateral ventilation with no lobar collapse and no functional improvement at any time was observed in 3 patients. The remainder had lobar collapse with initial improvement: of these, 1 developed ipsilateral pneumothorax with persisting air leak leading to LVRS, 2 developed contralateral upper lobe compensatory hyperinflation (1R, 1L) and 1 ipsilateral lower lobe compensatory hyperinflation.

No significant morbidity or 30-day/in-hospital mortality. Median length of stay after LVRS was 11 days (4–34), slightly longer (19 days, 4–34) for patients who were operated for contralateral hyperinflation or whose EBV was removed prior to

VATS (no valve in situ on the operated side). Duration of drainage was also longer in these patients compared to the whole group, 18 (6–30) vs. 8 (5–30) days. Average EQ-5D score was 49.7 (18.9–71) six months after LVRS, vs. 42 (18.9–81.4) preoperatively, with only one patient reporting further deterioration.

Conclusion ELVR can be considered as a trial of LVR not precluding salvage LVRS. Removal of endobronchial valves prior to surgery seems unnecessary and may actually be protective against excessive postoperative air leak. Occurrence of compensatory hyperinflation may suggest that single-stage bilateral ELVR could also be considered.

Sleep Apnoea and Non-invasive Ventilation

P64

MULTIPLE DIMENSIONS OF EXCESSIVE DAYTIME SLEEPINESS

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Introduction Sleepiness is a subjective symptom, often reported by patients with sleep disorders. We investigated subjective measures of sleepiness, as measured by the Epworth Sleepiness Scale (ESS), and correlated this to objective observations, as recorded by the mean sleep latency (MSL). We related our findings to affect, fatigue, emotion, mood, and quality of life.

Patients and methods Patients referred to a tertiary referral centre for sleep disorders were assessed regarding their sleep complaint, excessive daytime sleepiness (EDS), sleep routine and night-time symptoms. Age, gender and BMI were recorded. The ESS (0–24 points), the Stanford Sleepiness Scale (SSS; 0–8 points), the Samn-Perrelli fatigue scale (SPS; 0–7 points), the Global Vigour and Affect Scale (GVS and GAS 0–10 points, respectively), the Hospital Anxiety and Depression Scale (HADS-A and HADS-D 0–21 points, respectively), and the Positive and Negative Affect Schedule (PAS and NAS 10–50 points,

Abstract P63 Figure 1