characteristics and outcomes of this patient group. Bronchiectasis patients with S. maltophilia were identified from microbiology records and demographic data was recorded from electronic patient information. Comparisons were made to a previously prospectively collected dataset of bronchiectasis patients without S. maltophilia growth.

There were 174 patients with S. maltophilia and bronchiectasis. Intravenous and oral antibiotics were taken by 38.7% and 48.1% of the cohort respectively in the 2 months prior to the first S. maltophilia culture. Patients were followed up for a median of 6 (2–11) years and the mortality was 28.7%. Infection resolved (3 negative sputa) in 119/174 patients, however treatment did not significantly affect resolution. Failure of resolution was however significantly associated with mortality (p < 0.001) (Figure 1). In the year prior to S. maltophilia culture, 12.7% grew non-tuberculosis mycobacterium (NTM). In comparison with a separate bronchiectasis cohort, those with S. maltophilia had a lower FEV1 (59.2% vs 68.4%) and there was more immunodeficiency as the underlying aetiology (10.3% vs 2.38%).

Persistent S. maltophilia has a poor outcome in bronchiectasis. It may act as a marker of disease severity and the requirement for antibiotics, and acquisition frequently follows antibiotic use. It was also associated with the isolation of NTM. The resolution of infection is common but is not related to treatment directed against the organism, however persistent infection is associated with increased mortality.

Introduction Bronchiectasis can cause significant complications and severely impact on patients’ quality of life. The majority of patients can be managed by medical therapy. Although lung resection is a less popular option, it is still reserved for a small number of patients with refractory symptoms, antibiotic-resistant bacteria or complications. The BTS guideline recommends: “Lung resection surgery may be considered in patients with localised disease in whom symptoms are not controlled by medical treatment”. However, the lack of a clear referral framework means respiratory physicians may have missed valuable opportunities to discuss the option of surgery. Thus, we aim to raise awareness about this option among physicians. At a tertiary bronchiectasis clinic, we investigated the proportions of patients with resectable disease and whether appropriate surgical referrals were made. Development of a referral framework was later proposed.

Methods This is a retrospective study assessing all patients under the care of the bronchiectasis clinic at Queen Elizabeth Hospital Birmingham. The collected data included clinic letters, CT scan and spirometry reports. Based on surgical criteria, we developed
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A pathway to identify potential candidates for surgery. Their clinic letters were reviewed to determine whether the surgical option had been considered. A literature review was undertaken to identify key factors needed to develop a referral framework.

Results Among 381 patients identified, 19 patients were excluded having insufficient data and 30 having undergone previous lung resection. In the remaining 322 patients (Figure 1), 89 patients had localised disease, were fit, with adequate respiratory reserve. In this group, we further identified 8 patients (2% of study population) who were potential candidates for surgery. Following a discussion at the Midland Bronchiectasis Network meeting with input from experienced thoracic surgeons, a referral framework was generated to assist physicians in identifying potential candidates.

Conclusions We identified 8 patients who could benefit from surgery. Although they constitute a small proportion of the study population (2%), the result suggests respiratory physicians may be under-referring patients for surgery. A referral framework is introduced to assist physicians in referring appropriate patients to a surgical team.

Clinical Characterisation of Idiopathic Pulmonary Fibrosis

Introduction and objectives The last comprehensive survey of UK respiratory disease epidemiology was the British Thoracic Society’s 2006 Burden of Lung Disease report. We performed an analysis covering 2004–2012. Findings pertaining to IPF are presented here.

Methods Prevalence and incidence rates were estimated from a primary care database (the Health Intelligence Network) representing ~5 per cent of the population, using a broad range of primary care codes considered to encompass the IPF definition. Mortality figures were derived from official government statistics. For international mortality comparisons and numbers of hospital admissions/inpatient bed-days we used WHO data.

Results An estimated 32,500 people in the UK live with IPF, a prevalence rate of about 50/100,000. This is more than double NICE’s 2015 estimate of 15–25 per 100,000. There are around 6,000 new cases diagnosed/year, greater than previous estimates of around 5,000. Overall, 5,300 people/year die from IPF, slightly more than the previous commonly accepted estimate of 5,000. There are nearly 9,000 admissions/year for IPF, accounting for around 1.3% of all admissions due to lung disease and 1.4% of all hospital bed days, despite IPF affecting less than 0.25% of people who have had a lung disease diagnosis. IPF is 50% more common in men, and killed 60% more men than women from 2008–2012. In this period 13,974 men and 8,624 women died from IPF, broadly in line with previous estimates. Incidence increases with age, around 85% of diagnoses being made in people aged over 70. Prevalence is highest in Northern Ireland, north-west England, Scotland and Wales. IPF is least common in London. Incidence is not influenced by measures of deprivation.

Conclusions Although rare, IPF is considerably more common than previously recognised and represents a small but significant burden on NHS hospital services.