Abstract S91 Table 1

		2EHRZ/4HR	2MHRZ/2MHR	2EMRZ/2MR	p value
ALT RESULT	n [◇]	634	649	634	***
	Median peak value as xULN (IQR)	0.83 (0.56–1.35)	0.78 (0.53–1.23)	0.73 (0.51–1.09)	0.046 [†] 0.000 [‡]
	Median time to peak value in arm (days)	28 (14–84)	28 (14–84)	55 (14–84)	0.972 [†] 0.017 [‡]
	No with peak ≥3 xULN (%)	41 (6.5%)	35 (5.4%)	25 (3.9%)	0.130
	No with peak ≥5 xULN (%)	20 (3.2%)	18 (2.8%)	14 (2.2%)	0.580
	No with peak ≥10 xULN (%)	7 (1.1%)	2 (0.3%)	3 (0.5%)	0.204 [§]
AST RESULT	n	639	654	635	***
	Median peak value as xULN (IQR)	1.02 (0.73–1.48)	0.93 (0.68–1.45)	0.90 (0.68–1.28)	0.026 [†] 0.000 [‡]
	Median time to peak value in arm (days)	52 (14–84)	28 (14–84)	55 (13–84)	0.160 [†] 0.917 [‡]
	No with peak ≥3 xULN	46 (7.2%)	41 (6.3%)	27 (4.3%)	0.074
	No with peak ≥5 xULN	21 (3.3%)	17 (2.6%)	12 (1.9%)	0.292
	No with peak ≥10 xULN (%)	8 (1.3%)	5 (0.8%)	5 (0.8%)	0.668 [§]
	No of liver-related withdrawals	11 (1.7%)	7 (1.1%)	4 (0.6%)	0.178

[◇]Some patients not included due to missing ALT results

[†] Isoniazid arm against standard therapy

[‡] Ethambutol arm against standard therapy

[§] Fisher's exact test

Predicting Risk in Pleural Disease

S92 NON-MALIGNANT PLEURAL EFFUSIONS (NMPE): A PROSPECTIVE STUDY INTO 355 CONSECUTIVE UNSELECTED PATIENTS

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Introduction and objectives Non-Malignant Pleural Effusions (NMPE) have an estimated annual incidence of 200,000 in the UK.¹ They are often secondary to underlying organ dysfunction, with congestive heart failure (CHF) the leading cause. CHF itself carries a high mortality risk, with 28% of patients with New York Heart Association (NYHA) class IV dying within a year.² Despite this, information on baseline characteristics, prognostic features and mortality in NMPE is sparse. Our aim is to determine the mortality rates in NMPEs in a prospective observational trial.

Methods We recruited 784 consecutive patients presenting to a pleural service, between 03/2008 and 03/2015, with an undiagnosed pleural effusion. Further analysis was conducted on the 355 patients with NMPE.

Pleural biochemistry, cytology, thoracic USS and chest radiograph were performed. Echocardiogram, CT scans, radiological-guided biopsy and medical thoracoscopy were undertaken as

clinically indicated. Patients were followed-up for a minimum duration of 12 months with final diagnosis decided by independent review by 2 respiratory consultants. Survival data was calculated from study entry to death. Surviving patients were censored on 07/2016.

Results Of the 784 patients, 355 (45%) were diagnosed with a NMPE. These patients had a mean age of 68 (SD17) with 69% of patients male. Patients with CHF (HR 4.7 CI: 2.3–9.5) had a 50% 1-year mortality and a mean age of 79. Renal failure (HR 5.2 CI: 2.1–12.9) and liver failure (HR 4.8 CI: 1.9–11.8) patients had 1-year mortality rates of 31% and 25% respectively (HR c/w inflammatory pleuritis). Bilateral effusions (HR 2.6 CI 1.7–3.9) and transudative effusions (HR 3.1 CI: 2.2–4.3) were associated with a worse prognosis in patients with NMPE, with a 57% and 44% 1-year mortality respectively.

Conclusion This is the largest prospectively collected series in patients with NMPE, demonstrating that those secondary to organ dysfunction have an extremely high 1-year mortality. The presence of a pleural effusion in patients with CHF is a marker of severe disease, almost doubling the mortality risk compared to patients with NYHA class IV CHF.

REFERENCES

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