P32 QUANTIFYING LEVELS OF PHYSICAL ACTIVITY IN PATIENTS WITH COPD: A US CROSS-SECTIONAL SURVEY

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Introduction and Objectives Physical inactivity can increase the burden of COPD and is a predictor of mortality and hospitalisations. There has been a paucity of data examining the relationship between physical activity and COPD treatment regimen. This study aimed to describe self-reported physical activity levels according to standard of care medication class (es) in COPD.

Methods Multicentre, cross-sectional, observational survey (Study: D5970R00003) conducted in the US. Patients (≥40 years) with a physician-confirmed diagnosis of COPD completed a questionnaire that included the Functional Performance Inventory-Short Form (FPI-SF) to assess physical activity (32 items/6 domains, rated from 1=*much* difficulty to 3=*no* difficulty). Investigators provided information on treatment history.

Results 1775 patients participated (71.9% Caucasian, 55.1% male, 87.1% current/ex-smokers, mean age 65.2 years, mean BMI 27.5 kg/m²). 14.8% of patients were classed as GOLD 2017 group A, 46.6% in group B, 2.6% in group C and 36.0% in group D. Activity impairment based on FPI-SF scores was seen in patients across all treatment classes (Table), with the greatest impairment observed in patients receiving triple therapy and in the FPI-SF domains requiring most physical activity ('maintaining the household' and 'physical exercise').

Conclusions Patients with COPD who required triple therapy tended to report the lowest levels of physical activity. Longitudinal studies are needed to evaluate the effect of bronchodilator treatment on the relationship between lung function, COPD symptom burden and physical activity.

P33 WHAT MATTERS TO PEOPLE WITH COPD? OUTPUTS FROM WORKING TOGETHER FOR CHANGE

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Introduction and Objectives There is little qualitative research into what matters to people with COPD, in terms of managing their condition and supporting their wellbeing. We used a co-production methodology not previously applied in COPD, Working Together for Change (WtFC), to undertake a service evaluation. We aimed to identify what is important to people with COPD and what services would address these issues. Evaluation of the process has been described.¹ Here we report the themes that emerged from WtFC that reflect what mattered to participants.

Methods WtFC began with 45 structured one-to-one discussions between an evaluator and participants identified from a GP list. We asked three questions: "What is working well in terms of your COPD care?", "What is not working well in terms of your COPD care?" and "What is important to you?" Responses were analysed using quality improvement methods in two co-production workshops involving COPD patients and carers (including some of the one-to-one participants), local health care professionals and voluntary sector organisations. Responses were themed by all participants working together with an expert facilitator. The group agreed a label for each theme and participants voted on the most important themes under the heading "What's not working."

Results The themes in each category are presented in Table 1. The six most important themes for "What's not working" were: "I don't think the right hand knows what the left hand is doing", "I can't get appointments when I want them", "I'm not treated as a person", "I can't do what I want to do", "I'm anxious and depressed" and "I can't eat well".

Abstract 32 Table 1 Physical activity by COPD treatment class

Current COPD treatment ^a	Functional Performance Inventory-Short Form domain, mean score ^b (SD)							
	Patients n (%)	Total (32 items)	Body care (5 items)	Maintaining household (8 items)	Physical exercise (5 items)	Recreation (5 items)	Spiritual activities (4 items)	Social interaction (5 items)
All	1743 ^c (100.0)	2.1 (0.68)	2.5 (0.67)	1.8 (0.83)	1.7 (0.81)	2.4 (0.77)	2.1 (1.16)	2.1 (0.88)
Short-acting bronchodilator	140 (8.0)	2.3 (0.65)	2.7 (0.51)	2.2 (0.78)	1.9 (0.80)	2.6 (0.73)	2.1 (1.16)	2.2 (0.89)
Mono long-acting bronchodilator	195 (11.2)	2.2 (0.68)	2.6 (0.70)	2.0 (0.80)	1.8 (0.79)	2.5 (0.78)	2.1 (1.17)	2.1 (0.89)
Dual long-acting bronchodilator	153 (8.8)	2.2 (0.65)	2.6 (0.69)	1.9 (0.80)	1.8 (0.78)	2.6 (0.67)	2.0 (1.22)	2.2 (0.83)
ICS/long-acting bronchodilator	648 (37.2)	2.2 (0.66)	2.6 (0.63)	1.9 (0.81)	1.7 (0.82)	2.5 (0.80)	2.2 (1.13)	2.2 (0.86)
Triple therapy	535 (30.7)	1.9 (0.67)	2.4 (0.72)	1.5 (0.81)	1.4 (0.74)	2.3 (0.75)	2.0 (1.18)	1.9 (0.86)
Other^d	72 (4.1)	2.2 (0.67)	2.6 (0.59)	2.0 (0.92)	1.8 (0.92)	2.6 (0.65)	2.1 (1.15)	2.2 (0.90)

^aMono long-acting bronchodilator includes treatment with a LAMA or LABA. ICS/long-acting bronchodilator includes treatment with ICS and a LAMA or LABA. Dual long-acting bronchodilator includes treatment with a LAMA and a LABA. Triple therapy is treatment with ICS, a LAMA and a LABA.

^bPatients rated how difficult each activity was for them to perform on a three-point scale: 1=*much* difficulty, 2=*some* difficulty, 3=*no* difficulty. If patients did not perform an activity (either for health reasons or by choice), the item is not included in the mean for that domain.

^cNumber of patients with completed Functional Performance Inventory-Short Forms

^dOther treatments included, but were not limited to: ICS, short-acting bronchodilators in combination with other treatments, and phosphodiesterase-4 inhibitors or oral corticosteroids alone or in combination with other treatments.

COPD, chronic obstructive pulmonary disease; ICS, inhaled corticosteroids; LABA, long-acting β_2 -agonist; LAMA, long-acting muscarinic antagonist; SD, standard deviation.

Conclusions What mattered to people with COPD encompassed not just health-related issues but also meaning, purpose and relationships. This underlines the importance of a patient-centred and holistic approach to delivering healthcare. This co-production process provided a non-clinical setting in which the patient voice could be heard and provide a meaningful input for health service planning.

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Abstract P33 Table 1 Themes derived from patient statements. Figures in brackets refer to the number of statements within the theme. Themes in bold were voted as the most important themes in the “what’s not working” category

	What’s working	What’s not working	What’s important for the future
Health care and professional support	Clinical support (11)	I don’t think the right hand knows what the left hand is doing (12)	I want help in all respects from public services (12)
	Good access (9)	I can’t get appointments when I want them (4)	I would like good clinical and professional support from professionals with the right knowledge (6)
	Medication (6)	I’m not treated as a person (4)	I want to be seen by my own doctor when I need it, on time (3)
	Great staff (4)	I’m confused by conflicted advice (3)	I would like more organised exercise (3)
Quality of life	Feeling safe (4)	I’m angry when there are errors (3)	
	Listening and understanding practitioners (4)	I feel rushed (2)	
	Complementary support (1)	I was ill informed (2)	
		I haven’t had enough physiotherapy (2)	
Social support	Looking after myself and others (13)	I can’t do what I want to do (16)	I want to stay independent for ever (10)
	Keeping independent/busy/well (12)	I live in fear (6): fear of breathlessness and the future	I want to stay in my own home (9)
		I don’t have enough energy (6)	I want to be mobile (7)
		I’m anxious and depressed (5)	I would like to stay as healthy as possible to achieve my aspirations (6)
Amenities		I can’t eat well (4)	I need help to stay confident (6)
		I feel like I’m begging (3)	
		I’ve lost my mojo (3)	
		I don’t have enough money (2)	
Social support		I feel like a burden (2)	
		I am lonely (2)	
		I keep forgetting things (1)	
	Family and friends support (11)		I value family support (3)
Amenities	Communication (2)		I want to be able to maintain my social network (2)
	Transport (2)		
	Location (1)		

Interventional procedures in respiratory disease

P34 PROSPECTIVE VALIDATION OF A RISK STRATIFICATION MODEL FOLLOWING NEGATIVE EBUS-TBNA IN ISOLATED MEDIASTINAL AND/OR HILAR LYMPHADENOPATHY

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Introduction Isolated mediastinal and/or hilar lymphadenopathy (IMHL) is a common indication for EBUS-TBNA. Causes of IMHL include granulomatous and malignant disorders or reactive lymphadenopathy due to associated comorbidity (eg emphysema, cardiac failure). A previous study developed a risk stratification model following a negative EBUS-TBNA for IMHL to guide future sampling/surveillance⁰⁻¹. We conducted a prospective validation of this model.

Methods Consecutive patients undergoing EBUS-TBNA for IMHL at two large EBUS centres in Greater Manchester underwent prospective risk stratification immediately prior to EBUS. Low risk was defined as the presence of at least one comorbidity known to be associated with IMHL AND largest lymph node diameter less than 20 mm, short axis. EBUS-TBNA pathology, Results of any subsequent lymph node sampling and a minimum of six months clinical-radiological follow-up were used to define the final diagnosis in each case.

Results 298 patients (mean age 58.4 years) with IMHL underwent EBUS-TBNA between September 2013 and December 2016 (table 1). Pathological diagnosis of malignancy or granulomatous disease was established by EBUS-TBNA in 98 patients. Of the 200 patients with negative EBUS-TBNA, 143 were ultimately diagnosed with reactive lymphadenopathy, and 57 patients categorised as false negative (46 with sarcoidosis). In the 200 patients with a negative EBUS, all 84 patients prospectively classified as low risk were subsequently diagnosed with reactive lymphadenopathy (NPV 100%). All patients with false negative EBUS were initially classified as high risk (PPV 48%). Only 2/86 patients classified as low risk pre EBUS had a pathological diagnosis at EBUS-TBNA (lung cancer and TB).

Conclusions The risk stratification model following negative EBUS in IMHL has been validated across two EBUS centres demonstrating an excellent NPV. It may provide a simple tool to aid decision making following negative EBUS for IMHL, questioning the role of further sampling or surveillance in such cases. The use of this model as a pre-test decision aid to possibly avoid EBUS-TBNA in low risk patients is a topic for debate and further research.

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