

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.

REFERENCE

1. Early F, Winders S-J, Reddy SM, Ralphs JE, Fuld JP. Co-production to inform clinical commissioning in COPD: An evaluation of working together for change. *Eur J Pers Cent Healthc* 2017;5(1):111–119.

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

¹ZL Borrill, ¹JL Hoyle, ¹L Brown, ²R Booton, ²P Crosbie, ²M Evison. ¹*Pennine Acute Hospitals NHS Trust, Manchester, UK;* ²*University of South Manchester University Hospitals NHS Trust, Manchester, UK*

10.1136/thoraxjnl-2017-210983.176

Introduction Isolated mediastinal and/or hilar lymphadenopathy (IMHL) is a common indication for EBUS-TBNA. Causes of IHML 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 IHML 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 IHML 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.

REFERENCE

1. Evison M, Crosbie PAJ, Morris J, et al. A study of patients with isolated mediastinal and hilar lymphadenopathy undergoing EBUS-TBNA. *BMJ Open Res* 2014;1:e00040. doi:10.1136/bmjresp-2014-000040

Abstract P34 Table 1

	Low risk	High risk	All patients
Total	86	212	298
Pathological diagnosis achieved	2	96	98
Sarcoidosis	0	46	46
NSCLC	1	16	17
TB	1	14	15
SCLC	0	8	8
Non 1° lung cancer	0	5	5
Lymphoma	0	7	7
Other granulomatous disorder	0	2	2
False negative	0	57	57
Sarcoidosis	0	46	46
NSCLC	0	2	2
TB/NTM	0	3	3
Non 1° lung cancer	0	1	1
Lymphoma	0	4	4
Reactive lymphadenopathy	84	59	143
Negative predictive value	100%	49.1%	71.5%

P35 A SINGLE CENTRE PROSPECTIVE ANALYSIS OF THE EFFECT OF NEEDLE GAUGE ON EBUS-TBNA SENSITIVITY AND SAFETY

FR Millar, J Gates, A Kumar, MK Menon, RB Banka. *Department of Respiratory Medicine, King George Hospital, Barking, Havering and Redbridge NHS Trust, London, UK*

10.1136/thoraxjnl-2017-210983.177

Introduction EBUS-TBNA is the current gold standard technique for lymph node sampling in mediastinal lymphadenopathy. Traditionally our trust has used size 21 gauge needles for all EBUS-TBNA cases, however recently we have used 19 gauge needles in an effort to increase diagnostic yield. We present preliminary Results from a small, randomised, single centre study assessing the sensitivity and safety of 19 gauge EBUS needles versus 21 gauge EBUS needles in EBUS-TBNA.

Methods Patients attending for EBUS-TBNA were prospectively randomised to either 19 gauge or 21 gauge groups. Samples were sent for analysis and the pathologist was blinded to the needle size used. The primary outcomes measured were positive sampling of lymphoid tissue and diagnostic sampling. Complications including severe bleeding and pneumothorax were included in the analysis.

Results A total of 61 patients were enrolled in the study, with 32 assigned to the 21 gauge group and 29 assigned to the 19 gauge group. The average age was 57.5+/-6.8 years and 53.2 +/-5.4 for the 21 gauge and 19 gauge groups respectively ($p \geq 0.05$). In the 21 gauge needle group lymphoid tissue was obtained in 27 of the 32 cases (84.38%), whereas the 19 gauge needle group lymphoid tissue was obtained in 25 of 29 cases (86.2%) ($p \geq 0.05$). Diagnostic sampling was obtained in 20 of the 32 (62.5%) cases in the 21 gauge needle group versus 19 of the 29 cases in the 19 gauge group (65.5%) ($p \geq 0.05$). None of our patients in either cohort suffered severe bleeding or pneumothorax.

Conclusions/Limitations Currently our study has shown no significant difference in either sensitivity or safety between 19 and 21 gauge EBUS-TBNA. However we recognise that as yet our study is under powered and continued enrolment of patients is required to obtain valid Conclusions Given that size 21 gauge needles confer a significant cost saving (£7800 per annum) our trust are likely to continue using these needles if our preliminary Results are confirmed.

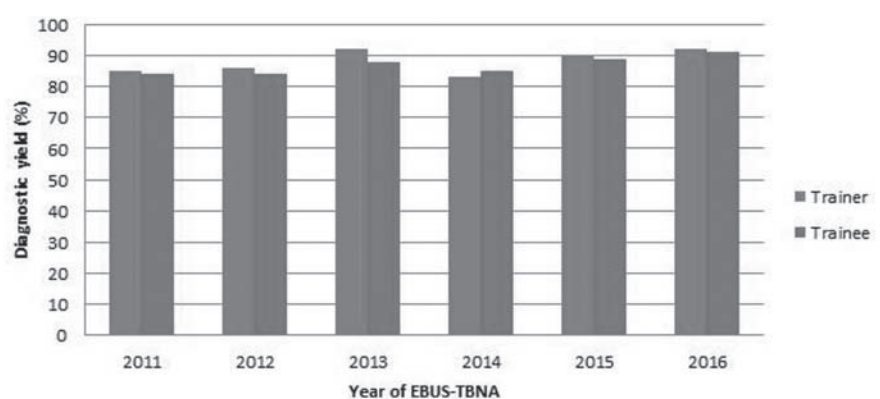
P36 EBUS-TBNA DIAGNOSTIC YIELD CAN BE MAINTAINED WHEN PERFORMED BY A TRAINER SUPERVISING A SECOND OPERATOR TRAINEE

¹A Gupta, ²D Nicoara, ²A Sajeed, ²RK Panchal, ²M Tufail, ²J Bennett. ¹University Hospitals of Leicester, Leicester, UK; ²Glenfield Hospital, Leicester, UK

10.1136/thoraxjnl-2017-210983.178

Introduction Endobronchial ultrasound-guided transbronchial needle aspiration (EBUS-TBNA) facilitates diagnosis of hilar and mediastinal lymphadenopathy. The procedure usually requires two operators; one guiding the bronchoscope and other undertaking needling for biopsy. British Thoracic Society Quality Standards recommend a diagnostic yield of 88%. Increased training and experience has been shown to improve diagnostic yield over time.¹ Services face a potential conflict between delivering a high quality service, as evidenced by high diagnostic yield, and training specialty registrars. Our EBUS-TBNA trainers have trained 35 trainees since 2011. We evaluated EBUS diagnostic yield at a tertiary centre with procedures carried out by trainer and trainee operators.

Methods Retrospective analysis of two operator EBUS-TBNA procedures from March 2011 to December 2016 was carried out. Data was collected on gender, age, procedure date and clinicians



Abstract P36 Figure 1 Diagnostic yield of EBUS-TBNA for trainers vs trainees from 2011–2016.