carcinoid. In all of LC diagnosed by EBUS-TBNA, staging was achieved in the same procedure (8.1% N0, 5.4% N1, 67.6% N2 and 18.9% N3). EBUS-TBNA showed a sensitivity of 86%, specificity of 88.9%, PPV of 97.4%, and PNV of 57.1% for simultaneous diagnosis and staging in our setting.

Conclusions In our study EBUS-TBNA was useful to simplify the diagnosis and staging of LC, allowing both simultaneously in 77.1% of the patients and may be the preferred method for the initial approach after CT or PET/CT scan in this group of patients, in order to achieve faster diagnosis.

REFERENCES

P40 PREDICTORS FOR PNEUMOTHORAX FOLLOWING CT GUIDED BIOPSY (CTGB) FOR LUNG MASSES
Portsmouth Hospitals NHS Trust, Portsmouth, UK
10.1136/thoraxjnl-2017-210983.182

Background CTGB is widely used to sample lung masses. One of the important complications is pneumothorax which could potentially lead to a prolonged hospital stay. The aim of the study was to examine the prevalence and potential predictors associated with pneumothorax following CTGB.

Methods We retrospectively reviewed CTGB data over a two year period (August 2014 to July 2016) for all patients who underwent CTGB. The data collected included age, sex, comorbidities, smoking history, spirometry, performance status, presence of emphysema, thickness, depth of the needle, size of the lesion and lobe of the lesion.

Results 227 patients underwent CTGB with an overall diagnostic yield of 93.8% (213/227). The incidence of pneumothorax was 61/227 (26.9%). Of the patients with pneumothorax, 8/61 (13.1%) needed chest drain insertion with a median hospital stay of 4.5±2.1 days. There was no difference in diagnostic yield between both pneumothorax and the no pneumothorax group. Overall 89.2% (190/213) of the positive biopsies were malignant while 10.8% (23/213) were benign. There was no difference in the performance status, severity of airflow obstruction or lobe of the lesion between groups. Binary logistic regression analysis showed the size of the lesion as a determinant of developing pneumothorax (p=0.022). The risk of developing a pneumothorax was 27.1% for a lesion ≤10 mm and 18.7% for a lesion ≥20 mm.

Conclusion The incidence of pneumothorax following CTGB was 26.9% but only 3.5% of all patients undergoing CTGB had a chest drain inserted for their pneumothorax. While CTGB is a safe procedure with a good diagnostic yield one

Poster sessions
THE ROLE OF EBUS-TBNA IN ISOLATED INTRATHORACIC LYMPHADENOPATHY IN NON-NEOPLASIC PATIENTS – A COMMON DILEMMA IN CLINICAL PRACTICE
P39
1LM Santos, 2M Jacomelli, 3S de Morarco, 4V Ferreira. 1Pneumology Unit, Hospital das Clinicas, Faculdade de Medicina da Universidade de Sao Paulo, Sao Paulo, Brazil

Abstract P40 Table 1

<table>
<thead>
<tr>
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<th>Pneumothorax (n=61)</th>
<th>Pneumothorax (n=166)</th>
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<tbody>
<tr>
<td>Age (mean±SD)</td>
<td>71±29.8</td>
<td>69±20.3</td>
</tr>
<tr>
<td>FEV1% predicted</td>
<td>69±22.3</td>
<td>71±22.8</td>
</tr>
<tr>
<td>Smokers</td>
<td>145 (87.3%)</td>
<td>52 (85.2%)</td>
</tr>
<tr>
<td>Emphysema on CT</td>
<td>80 (48.2%)</td>
<td>32 (52.5%)</td>
</tr>
<tr>
<td>Needle depth (median±SEM)</td>
<td>8±1.9</td>
<td>11±1.9</td>
</tr>
</tbody>
</table>

Conclusion Isolated ITLN were mostly benign and reactive LN was the second most frequent cause. More than 70% of reactive LN by EBUS-TBNA were confirmed and the majority had no need for more invasive procedures. EBUS-TBNA showed to be a useful diagnostic procedure in isolated ITLN, with a great PPV, and its accuracy can be optimised by follow-up or minimal invasive procedures.