breathing and we offer the facility to insert PICC lines and use surefusers. Our aim was to demonstrate the benefits of managing patients with infective exacerbations of bronchiectasis in the community.

Method We performed a retrospective analysis of 51 patient records. We looked at a number of clinical outcomes including length of stay, infection rates, culture rates and potential cost implications.

Results Patients managed through AHAH had shorter lengths of inpatient stays; 2.5 days compared to 9.1. The cost of an AHAH bed is £100/day and an acute medical bed is £280/day which Results in a saving of £1140 per patient per admission. Patients managed in the community were more likely to have their sputum cultured in accordance with BTS guidelines. We proved equivalence in rates of hospital acquired infections, readmissions and death. Patient satisfaction was significantly better in those managed in the community, 98% would recommend the service to family or friends compared to 83% of patients managed on an inpatient ward.

Conclusion Our Results demonstrate clear benefits of managing patients with exacerbations of bronchiectasis in the community, not only in terms of a reduction in hospital bed days and cost but also improved patient satisfaction. We believe that our AHAH service is a safe and beneficial clinical service which could be applied to other clinical conditions.

REFERENCE

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OUTCOMES OF PREGNANCY IN WOMEN WITH BRONCHIECTASIS

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Introduction The impact and outcomes of pregnancy in women with non-cystic fibrosis bronchiectasis are largely unknown.

Methods We performed a retrospective cohort study of pregnancy in women with bronchiectasis attending our centre between 2007–2017. In all cases the mother had been diagnosed with bronchiectasis prior to conception and was under close monitoring throughout the pregnancy. Baseline

descriptive statistics recorded included: maternal age at delivery, body mass index (BMI), disease aetiology, previous pregnancy, and baseline percentage predictive values for respiratory function 6 months prior to conception assessed using forced expiratory volume in 1 s (FEV₁) and forced vital capacity (FVC). Longitudinal statistics were recorded for outcome of pregnancy, mode of delivery, infection status, obstetric cholestasis and haemoptysis during pregnancy, and respiratory function at baseline (6 months prior to gestation), conception, delivery and 6 months postpartum. Statistical analysis was made using the Pearson's two-tailed correlations, with p-values of <0.05 considered as statistically significant.

Results There were 11 successful pregnancies in 10 women with bronchiectasis during the study period. In all cases pregnancy was well tolerated with no significant adverse events. Mean age was 33.9 (range 23.9–43.5). Evidence of negative investigations for cystic fibrosis was found in 9/10 patients. Mean baseline FEV₁ prior to pregnancy was 70.2%-predicted (SD 19.6) compared with 66.5% (SD 20) at delivery (p≥0.05) and 66.2% (SD 20.7) at 6 months after delivery (p≥0.05). FEV₁/FVC ratio at conception, delivery and at 6 months after delivery was 0.77 (SD 0.1), 0.75 (SD 0.1) and 0.73 (SD 0.1) respectively (p≥0.05). 60% of women had positive sputum cultures during pregnancy: *Pseudomonas aeruginosa* in 27.3%, *Haemophilus influenzae* 45.5%, *Staphylococcus aureus* 18.2%, *Streptococcus pneumoniae* 9.09% and coliforms 9.09%. Positive sputum microbiology was not correlated with any change in respiratory function or pregnancy outcomes.

Conclusion Pregnancy in women with non-CF bronchiectasis was largely well tolerated in our cohort. Larger studies are needed to determine the true impact of pregnancy on lung function in this population.

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SELF-MANAGEMENT FOR NON-CYSTIC FIBROSIS BRONCHIECTASIS: COCHRANE SYSTEMATIC REVIEW

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Background The aims of therapeutic management for non-cystic fibrosis (non-CF) bronchiectasis are: preservation of lung

Abstract P60 Figure 1 Pulmonary function in pregnant women with non-CF bronchiectasis.