Methods Patients screened in 2016 by our Secondary Care service using NICE-recommendations were included. Those aged 16–65 had an Interferon Gamma Test (QuantiFERON) and those aged 0–16 a Mantoux Test (reported as positive if ≥ 5 mm). Results were then stratified by the TB incidence in their country of birth and by age.

Results 345 patients were offered screening, and 235 patients attended (68%). 44 patients (19%) were found to have LTBI and none had active TB. The Results are displayed in Table 1. 120 patients (51%) were in the Strategy-recommended group, which had the lowest LTBI-positivity rate (10%). Restricting screening to just this group would have resulted in 32 of the 44 LTBI cases (72%) being ‘missed’. The LTBI-positivity rate was high in the younger and older age groups from the ≥ 150 cases/100,000 countries (25% and 33% respectively), and 1/3 of those screened in the age 16–35 group from the 40–150 cases/100,000 countries tested positive, the majority being Romanian.

Conclusions The LTBI rate in New Entrants is high in groups not currently widely screened. Broadening the programme to include patients from a wider age range and from countries with a TB incidence of $\geq 40/100,000$ would achieve higher LTBI detection and aid National TB control.

REFERENCES

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Abstract P170 Table 1 LTBI screening results stratified by TB incidence in the country of birth and by age range (shaded cells indicate the Strategy-recommended screening group results)

Age range (n=235 patients)	TB rate 40-150/100,00 (n=72 patients)	TB rate $\geq 150/100,000$ (n=163 patients)
0-15 years	Screened = 1	Screened = 16
	Positive = 1(100%)	Positive = 4(25%)
16-35 years	Screened = 52	Screened = 120
	Positive = 15(29%)	Positive = 12(10%)
36-65 years	Screened = 19	Screened = 27
	Positive = 3(16%)	Positive = 9(33%)

Pulmonary vascular disease: monitoring and managing

P171 ARE THE EUROPEAN SOCIETY OF CARDIOLOGY PULMONARY HYPERTENSION GUIDELINE RISK ASSESSMENT CRITERIA ASSOCIATED WITH 12-MONTH MORTALITY?

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Background The European Society of Cardiology (ESC) guidelines for management of pulmonary hypertension (PAH)

advocate comprehensive assessment of patients to determine prognosis and to guide treatment decisions, using a set of risk assessment criteria based on expert advice. These criteria are coded Red (high), Amber (medium) and Green (low). It is unclear whether these criteria are associated with short term survival.

Aim To determine whether red/amber/green risk status according to ESC guidelines is associated with 12 month mortality.

Methods This was a “snapshot” observational study using routinely collected clinical data for patients eligible for targeted drug treatment at a regional centre, under shared care with a national centre. All data available at the latest visit within the study period were collated, including demographics, echocardiogram and right heart catheterisation data. Data are reported as mean/median/count/%. Characteristics of deceased and surviving patients were compared using Mann-Witney U-test. Association with 12 month mortality was assessed using Receiver Operator Characteristics (ROC) curve analysis.

Results Routinely collected clinic data were available for 104 patients, echocardiograms for 88 and right heart catheter data for 68. 25% were male, mean age 68.2 years. 45.2% had connective tissue disease-associated PAH, 32.7% inoperable chronic thromboembolic PH, 18.3% Idiopathic PAH. 101 were on treatment, of which 35.6% were on monotherapy, 51.0% on dual oral therapy, 9.6% on intravenous treatments. Baseline data are shown in the table. 25% had one red criterion, 14.4% had two and 8.6% had three or more. 19 patients died in the 12 month follow-up period, 6 of whom had no red criteria. Deceased patients were older ($p=0.015$) and had shorter walking distance ($p=0.003$). Risk criteria were worse for symptom progression, WHO functional class, walking distance and for the overall number of red criteria. ROC-curve analysis showed that symptom progression (c-statistic 0.695, $p=0.048$), walking distance (0.748, $p=0.012$) and the overall number of red flags (0.710, $p=0.033$) were the only elements associated with 12 month mortality.

Conclusions The ESC risk assessment criteria are associated with 12 month mortality in this cohort when all criteria are collated. Further work in a large cohort is needed to confirm the clinical utility of these criteria.

Abstract P171 Table 1

	Median/%	Red flags, n(%)
Symptom progression	N/A	11 (10.6)
NT-proBNP (ng/L)	60.5	2 (1.9)
WHO functional class	N/A	13 (12.5)
6 min walk distance (m)	295	28 (28)
Echo RA area (cm ²)	17.5	5 (7.4)
Right heart catheter (any criterion)	N/A	13 (19.1)

P172 PRE-OPERATIVE INSIGHTS FROM CARDIOPULMONARY EXERCISE TESTING IN PATIENTS WITH PULMONARY ARTERIOVENOUS MALFORMATIONS

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