Abstract P219 Table 1

Study Data n=11	Baseline Pre-modafinil	Day 10 modafinil 200 mg/day	Day 40 Modafinil 200 mg/day	Improvement At 40 days	4 week NIV[2]	Improvement After 4 weeks Of NIV	1 year study of NIV [3]	Improvement At 1 year
Mean Arterial PaO_2 kPa On air (range)	5.8 (4.3–7.3)	6.7 (4.1–8.1)	7.67 (5.5–9.3)	+1.87 kPa	7.5	+1.7	7.0	+2.4
Mean Arterial $PaCO_2$ kPa On air(range)	8.6 (6.5–13.4)	6.7 (5.2–8.0)	5.9 (5.0–6.3)	−2.7 kPa	7.5	−0.7	7.2	−1.35
Mean daytime saturations on air (range)	75% (58–89)	85% (65–92)	90% (79–95)	15%	No data	No data	No data	No data
Mean overnight saturations on air (range)	72% (58–86)	79% (67–89)	83% (68–91)	+11%	79%	0%	No data	No data
Mean FEV-1 (%)	28%	30%	32%	+4%	31%	+6%	25%	−1%
Mean FVC (%)	48%	45%	53%	+5%	No data	No data	54%	No data

saturations by +11%. FEV-1 and FVC improved by +4%–5% which may reflect reduced acidosis on ventilatory muscles. Compared with studies of nocturnal nasal ventilation, modafinil equalled the effects of NIV and tolerance was excellent. It could provide a cheaper and more effective alternative for patient unable to use long term NIV in HRF.

REFERENCES

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Danger at work: occupational lung disease and asthma

P220 PROFILING OF OCCUPATIONS AND EXPOSURES OF PATIENTS DIAGNOSED WITH OCCUPATIONAL RESPIRATORY DISEASES AT A UK REGIONAL REFERRAL UNIT

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10.1136/thoraxjnl-2017-210983.362

Introduction Patients with suspected work-related respiratory symptoms are referred to tertiary NHS clinics in the UK for diagnosis of an occupational lung disease. Analysis of diagnosis data provides an opportunity to understand the profile of occupations and workplace exposures.

Methods The study population comprised 500 patients who were referred to a tertiary occupational respiratory unit (Heart of England NHS Foundation Trust, UK) and diagnosed with an occupational respiratory disease. The 500 cases were randomly selected from a database of 2400 patients diagnosed over the period 2010–2015. Information on patients included: occupation (current), industry type, gender, diagnosis and date of diagnosis. The occupation titles were first reviewed and then coded (using CASCOT) at the four-digit level using SOC 2000. The automated assigned codes were accepted where percentage match was ≥50%, the remainder of jobs coded manually using information on industry type. A UK general population JEM (ACEJEM) was then linked to the assigned SOC codes. The job coding was conducted independently of knowledge of diagnosed lung diseases.

Results Job titles and diagnosis were available for 497 patients. 73% of the job titles were coded automatically. The most common diagnosis was asthma 141 (28%), pleural plaques 119 (24%) and pneumoconiosis 81 (16%). 402 (81%) of the patient jobs were allocated to three of nine main SOC occupational groups; 'skilled trade occupation', 'process, and machine operators' and 'elementary occupations'. Over 89% of asthma and pneumoconiosis cases were exposed to vapours, gases, dust or fumes (VGDF). Of the asthma cases the highest proportion were exposed to dusts (81%, 114/141) and mineral dusts (66%, 93/141), and assigned as exposed to moderate or high level of dust exposure. Only 29% of the asbestosis cases were assigned as exposed to fibres. The most common 4 digit code for asthma was 5241 (Electricians and electrical fitters), followed by 5315 (carpenters and joiners).

Conclusion The use of a general population JEM and coding of patient jobs enables a standardised approach to understanding the nature of occupations and workplace exposures for different lung disease. The approach overcomes the reliance on patient recall of workplace exposures.

P221 SILICOSIS AND MYCOBACTERIUM DISEASE: IS IT A PROBLEM IN THE UK?

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10.1136/thoraxjnl-2017-210983.363

Introduction and objectives An association between silicosis and mycobacterium disease is well reported globally particularly amongst gold miners.[1] The rate of mycobacterium infection in silicosis cases in the last 15 years in the UK is unclear. The aim of this study was to establish the frequency of either