Conclusions This paper supports a move away from the traditional follow-up duration of 5 years by proposing a reduced programme of yearly scans in years 1,2 and 4 for stage 1 disease, and years 1–3 for stage 2 and 3 disease. Patients who are free of disease at this point could be discharged from the clinic accepting a 1.6% annual rate of metachronous disease. More investigation is warranted on the optimal framework for surveillance within the first 2 years post-surgery.

REFERENCE

1. Kamalatharan G, Moorcroft C, Shah R, Taggart S. P76 when is it safe to discharge resected stage 1a/1b NSCLC from the clinic? *Thorax* 2014;69(2):A109–A.

Abstract P258 Figure 1 Graph showing rates of recurrence by stage of disease when metachronous disease was not included as an event of interest.

P259 PURSUIT OF TISSUE: ARE WE DOING PATIENTS A DISSERVICE?

RM Williams, HE Davies. *Llandough University Hospital, Cardiff, UK*

10.1136/thoraxjnl-2017-210983.401

Background Whilst pursuit of a histological diagnosis in patients with suspected lung cancer (LC) and good performance status (PS) is indisputable, the advent of novel anti-cancer agents is making us re-examine our approach in patients with poor performance status. NICE guidelines advocate use of anti-cancer therapies in patients with PS 0–1 (37.1% of LC patients locally); (NICE 2011); this contrasts with National Lung Cancer Audit recommendations concerning optimal pathological diagnosis rates ($\geq 80\%$) (NLCA 2017). Our work evaluates local pathological confirmation rates in patients with poor performance status (3–4) and its impact on patient care.

Method All new LC diagnoses over a 12 month period were identified and data collated retrospectively through the CAN-ISC database and electronic record system. Analysis of whether pathological confirmation impacted on the MDT's treatment plan was undertaken.

Results Overall, 277 patients were diagnosed with LC over the 12 month period. 89 patients (32%) had a PS of 3–4 at diagnosis. The MDT treatment plan for 77% of this group was specialist palliative care or active monitoring; chemotherapy was recommended for 15 patients – 1 received it.

Pathological confirmation was obtained in 38% of PS 3–4 patients (43% adenocarcinoma); it influenced management in 43% of these. Histocytological diagnoses were achieved in 4 patients of PS 4 through a variety of invasive investigations; some unscheduled (pathological fracture fixation), others reflecting diagnostic uncertainty.

Discussion Historically LC patients with a poor performance status received best supportive care and securing a tissue diagnosis was unnecessary. With the advent of personalised treatment and novel therapies, traditional views may need re-examining. Our data demonstrates that, whilst more patients with a poor PS may be considered suitable for anti-cancer therapy, very few receive it. Target driven practice with an unmitigated pursuit of a pathological diagnosis in poor PS patients may be associated with adverse clinical sequelae and waste of valuable resource. Scheduled tests in this population should be considered on an individual basis and involve early MDT discussion. This said, whilst pressure to reach recommended pathological confirmation rates goals remain variables on which hospital LC MDTs are measured; this blanket approach to gaining tissue is likely to continue.

P260 SURVIVAL IMPROVES IN STAGE IV LUNG CANCER PATIENTS

¹B Matata, ¹M Shaw, ²J Maguire, ²M Ledson. ¹Research Unit, Liverpool Heart and Chest Hospital, Liverpool, UK; ²Liverpool Lung Cancer Unit, Liverpool, Anfield, UK

10.1136/thoraxjnl-2017-210983.402

Introduction Liverpool is an area of high socioeconomic deprivation, with more than twice the national incidence of lung cancer. In order to benchmark our survival performance at the Liverpool Lung Cancer Unit (diagnosing about 400 new cases/year) we wanted to compare our Units performance against national figures (32% 1 year survival, and 10% 5 year survival). We were also interested in determining if our survival rates had changed over time.

Methods We conducted a retrospective analysis of data for all patients diagnosed over a period of 9 years. All analyses were conducted on the entire dataset stratified on the basis of 3 years' time intervals (2007–2009; 2010–2012; 2013–2015). Demographic data were analysed and compared using descriptive statistics. Survival analysis was conducted by Kaplan Meier survival plots and log-Rank tests. P-values less than 5% were considered statistically significant.

Results 3710 patients were diagnosed, with a mean age of 71.3, 52.5% male. Performance state (PS) 0=15%, 1=29.4%, 2=22.2%, 3=19.8%, 4=6.4%. Stage at diagnosis 1=19.7%, 2=6.6%, 3=23.3%, 4=41.3%. There was no significant change in numbers, age, PS, histological subtypes and stage over the 3 time periods. However, a survival rate of 40% and 16% was observed for 1 year and 5 years respectively, which is higher than the national average (figure 1). In addition, there was an increase in survival for patients diagnosed in latter time period compared with the earlier time periods. Interestingly, only stage IV patients showed significant improvement in survival for 2013–2015 ($p < 0.001$), a pattern that strongly correlated with an increased oncological treatments (both chemotherapy and radiotherapy) 41.7% vs 57.0% ($p < 0.001$). The differences in survival for stage IV patients did not relate with any significant change in age, gender, histological subtype or PS.