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.

Abstract P260 Figure 1

Conclusions Survival rates for our unit are higher than the national average. An increase in oncological treatments for stage IV patients appears to have contributed to the significant improvement in survival for these patients.

P261 IMPACT OF PHYSICIAN-LED ULTRASOUND-GUIDED TISSUE SAMPLING IN SUSPECTED LUNG CANCER

R Patel, R Reddy, M Naeem, A Singh, Y Vali. *Kettering General Hospital, Kettering, UK*

10.1136/thoraxjnl-2017-210983.403

Introduction and Aim Patients with suspected lung cancer require a prompt histological diagnosis to help plan treatment. Respiratory physicians traditionally obtain samples via bronchoscopy and ultrasound (USS)-guided pleural aspiration. Other sampling methods usually rely on interventional radiology and are often a source of delay. In 2014, Kettering General Hospital developed a range of USS-guided procedures performed by physicians in an ambulatory care setting.¹ These bedside procedures offered at the initial consultation,² include sampling of supraclavicular lymph nodes, lung/pleural-based lesions, subcutaneous and bone metastases. This study aims to evaluate the impact of these techniques on histological diagnosis and demand for bronchoscopy and interventional radiology. **Methods** All patients with suspected lung cancer in the 12 months from January 2016 were reviewed and the histological diagnosis rate was compared to that of 2013 using cancer databases. We identified the method for tissue sampling, and for patients who underwent supraclavicular node sampling, we looked at whether the lymphadenopathy had been reported on by the CT radiologist. Neck ultrasound was carried out if the physician identified any supraclavicular lymphadenopathy on review of CT imaging.

Results 238 lung cancers were diagnosed in 2016, with a histology positive rate of 77.2% (Table 1). 51 physician-led bedside ultrasound-guided procedures (excluding pleural fluid aspiration) were carried out in 2016. For those with histology, this comprises 23.8% of histological diagnoses. Of the 23 who underwent sampling of a supraclavicular lymph node,

only eight (34.8%) had the nodes mentioned in the CT report. The number of bronchoscopy procedures fell 26.8% and CT guided biopsies fell 19.1%.

Conclusion The introduction of these novel physician-led bedside procedures appears to have improved the rate of histological lung cancer diagnosis whilst reducing demand on bronchoscopy and interventional radiology. This study also suggests physicians should seek out supraclavicular lymphadenopathy unless the CT radiologist has commented on their absence. This may reduce the need for more invasive procedures.

REFERENCES

- Reddy R, Naeem M, Tsaknis G. S31 safety and yield of physician led ultrasound guided transthoracic lung/pleural biopsies. *Thorax* 2015;70:A23.
- Reddy R, Vali Y, Naeem M. P78 tackling emergency lung cancer admissions. *Thorax* 2016;71:A126-A127.

Abstract P261 Table 1

	2013	2016
Number of confirmed lung cancer (histology positive)	195 (135)	238 (185)
Histological diagnosis rate	69.2%	77.7%
USS-guided sampling of supraclavicular nodes (Histology positive)	0	23 (19)
USS-guided lung biopsy (Histology positive)	0	21 (18)
USS-guided sampling of bony/subcutaneous metastases (Histology positive)	0	7 (7)
Number of bronchoscopy procedures	183	134
Number of CT guided biopsy procedures	63	51

P262 PULMONARY BENIGN METASTASIZING LEIOMYOMA: AN SINGLE-INSTITUTION CASE SERIES

¹K Chandarana, ²V Rizzo, ¹EJ Caruana, ¹AG Dawson, ¹S Rathinam, ¹A Nakas. ¹Glenfield Hospital, Leicester, UK; ²Belfast Health and Social Care Trust, Belfast, UK

10.1136/thoraxjnl-2017-210983.404

Introduction Pulmonary benign metastasizing leiomyoma (BML) is a rare and often asymptomatic presentation of