burden with 40% having moderate airflow obstruction and 46% having quality of life impairment. We are continuing to recruit further practices. Subsequent work will examine whether using this algorithm Results in earlier identification of COPD in a cost-effective manner and an improvement in quality of life for patients.

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P29

CLINICAL CHARACTERISTICS AND MANAGEMENT OF PATIENTS WITH AN INACCURATE DIAGNOSIS OF CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD) IN PRIMARY CARE; RESULTS FROM THE WELSH NATIONAL COPD PRIMARY CARE AUDIT

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10.1136/thoraxjnl-2017-210983.171

Introduction Spirometry is required to make a clinical diagnosis of COPD, confirming persistent airflow limitation. However, studies suggest that making the correct diagnosis of COPD in primary care can be challenging. We sought to evaluate the clinical characteristics and management in primary care of patients registered with COPD but with incompatible spirometry, compared to patients with spirometry compatible with COPD.

Methods This analysis used data from the Welsh national COPD primary care audit, which prospectively collected data of patients, registered with COPD from 61% of GP practices in Wales covering January 2014-March 2015. Patients registered with COPD but with incompatible spirometry (post-bronchodilator forced expiratory lung volume in 1 s (FEV₁)/forced vital capacity (FVC) ≥ 0.70) were compared to COPD patients with compatible spirometry (FEV₁/FVC < 0.70).

Results In total, 8957 patients registered with COPD were evaluated, 2255 (25%) had incompatible spirometry, 6702 had compatible spirometry. There were no differences in age (71 ± 10 vs 70 ± 11 years) or asthma co-diagnosis (13.1% vs 13.1%), between these respective groups, but patients with incompatible spirometry had a higher body mass index (29.41 ± 6.69 vs 27.04 ± 5.94 kg/m², $p < 0.001$) and were more likely female (48.8% vs 45.6%, $p = 0.009$). There were also differences in smoking status (14.3% vs 8.6% never-smokers, $p < 0.001$), and spirometry [(FEV₁/FVC: 0.78 vs 0.55, $p < 0.001$), (FEV₁% predicted: $72 \pm 18\%$ vs $58 \pm 18\%$, $p < 0.001$)], but similar levels of breathlessness (MRC: 2.52 ± 0.94 vs 2.55 ± 0.98 , $p = 0.17$) and exacerbation frequency (6.86 ± 7.5 vs 7.3 ± 8.8 , $p = 0.05$). Despite incompatible spirometry, 30.4% of these patients received long acting beta agonist (LABA) therapy, 51.7% inhaled corticosteroids (ICS), 73% long acting muscarinic antagonist (LAMA), and 74.6% combined inhaled LABA/ICS therapy. Furthermore, there were no differences for LAMA (73% vs 73%, $p = 0.99$) or LABA/ICS

(76.7% vs 74.3%, $p = 0.37$) use in patients with incompatible spirometry *with* or *without* a diagnosis of asthma respectively, although more patients with asthma received LABA (38.9% vs 29.1%, $p = 0.001$) and ICS (57.1% vs 50.8%, $p = 0.05$) therapies.

Conclusions Patients without persistent airflow limitation diagnosed incorrectly with COPD, are symptomatic and receiving inappropriate pharmacological therapies. These data suggest that a breathlessness pathway may be helpful to aid diagnosis and management of such patients seen in primary care.

P30

A SERVICE EVALUATION TO ASSESS THE ACCURACY OF THE GOLD STANDARD FRAMEWORK PROACTIVE INDICATOR GUIDANCE (GSF PIG) IN PREDICTING 12 MONTH MORTALITY IN PATIENTS WITH A DIAGNOSIS WITH CHRONIC OBSTRUCTIVE PULMONARY DISEASE

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10.1136/thoraxjnl-2017-210983.172

Background Patients with a diagnosis of chronic obstructive pulmonary disease (COPD) have a limited life expectancy and poorer quality of life, which can manifest with a high symptom burden especially towards the end of life. The benefits of offering palliative care to this patient group is well known but they frequently have poorer outcomes and worse access to palliative care services and symptom management. Knowing when to instigate appropriate palliative care in this group is challenging due to prognostic uncertainty. The Gold Standard Framework (GSF) is recommended for use in primary care settings with this patient group to predict 12 month mortality, it is stated to be accurate in 70% of cases, however there is little evidence to support this. This study aims to evaluate the effectiveness of this tool in predicting 12 month mortality in patients with a diagnosis of COPD.

Method Retrospective data from one community respiratory service in the North West of England, was collected between January 2013 and January 2016, of patient's deemed to be entering the last 12 months of life by triggering the GSF tool. The length of time on the palliative register until either death or January 2107, when data analysis commenced, was reviewed. All the data utilised in this evaluation was routinely collected by the service.

Results Of the 448 patients included in this evaluation only 122 died within 12 months, meaning the GSF was accurate in predicting 12 month mortality in 27% of cases included in this review ($n = 448$). Sub group analysis of the different GSF triggers and routinely collected data hints at the possible importance in pulmonary rehabilitation to reduce mortality (OR 0.1079 (95%CI 0.0674–0.1726 $p < 0.0001$)) with gait speed potentially being an early prognostic indicator (p -value 0.008).

Conclusion This study suggests that in this cohort the GSF PIG is not an accurate predictor of 12 month mortality in patients with a diagnosis of COPD to the suggested 70%. It does hint at the importance of PR and gait speed in prognostication.