The median (range) number of coughs in 24h was 228 (43–1950) at baseline, 122 (20–704) at 1 month, and 81 (16–414) at 3 months (p=.002, Friedman's test). The median reduction in cough count at 3 months was 49.6%. There were improvements in all patient-reported outcomes. Azithromycin was well tolerated.

Conclusions In a non-controlled, open-label trial in people with sarcoidosis who reported a chronic cough, 3 months of treatment with azithromycin led to improvements in a range of cough metrics. Azithromycin should be tested as a treatment for sarcoidosis cough in a randomised placebo-controlled trial.

S125 ESTABLISHING PRESCRIBING HABITS AND COMPLICATION AWARENESS OF NITROFURANTOIN, AND THE IMPACT OF ADVERSE EFFECTS FOLLOWING PROPHYLACTIC PRESCRIPTION

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Introduction Nitrofurantoin (NF) is prescribed for urinary tract infections (UTIs). Associated adverse pulmonary and hepatic side-effects are known. Current monitoring guidelines[1] [2] lack specific recommendations for monitoring. This work formed part of a clinical effectiveness project to raise awareness of side effects of prophylactic NF and allow recommendations for monitoring.

Methods We undertook 1) Audit (1st-31st July 2020) of GP surgeries in local clinical commissioning group (CCG) who prescribed prophylactic NF and assessed their monitoring habits. (2) Assessment of GPs' and urologists' prescribing habits and awareness of complications associated with prophylactic NF. (3) Audit of patients diagnosed with nitrofurantoin-induced interstitial lung disease (NFILD) by our ILD center (2014–2020).

Results 503 patients in local CCG were prescribed prophylactic NF at time of audit. 265/503 were on prophylaxis for 0–2 years, 40% of these for >6 months to 2 years. Of those patients on NF >6 months to 2 years, 45% received no monitoring, 21% received both lung and liver monitoring, 20% received only liver monitoring and 14% received only lung. 238/503 patients were on prophylaxis for >2 years; in this cohort 20% received no monitoring, 44% received both lung and liver monitoring, 21% received only liver monitoring and 15% received only lung.

Of 125 questionnaire respondents prescribing prophylactic NF, 82% were GPs and 12% urologists. 47% followed CCG guidelines whilst 38% followed national guidelines. 58% were aware of liver complications and 72% aware of respiratory. However, 41% and 53% were never monitored for liver and lung complications respectively.

Our centre diagnosed 46 patients with NIILD. 80.4% were female, mean age 72 years. 70% were prescribed NF for recurrent UTIs and 58.7% were prescribed for >6 months. Of this cohort, 61% displayed resolution (complete/with minimal fibrosis) on HRCT following removal of NF, 16% developed fibrosis and 23% showed no interval change. There was no difference in subset analysis of those treated with steroids from those not.

Conclusion NF complications can bear significant impact on patient's health. Improving awareness and monitoring is crucial and must be addressed. Increased clarity of monitoring guidelines will circumvent side effects of NF.

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S126 THE PHARMACIST-LED ACCELERATED TRANSFER OF PATIENTS TO SHARED CARE FOR THE MONITORING AND PRESCRIBING OF IMMUNOMODULATORY THERAPY DURING COVID-19

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Introduction and Objectives Shared care allows for optimal local management of patients with support and guidance from the specialist secondary/tertiary care multidisciplinary teams. Implementing shared care for patients managed with immunomodulatory medicines by an interstitial lung disease (ILD) service was accelerated during the COVID-19 pandemic to minimise the risks associated with travelling to a specialist clinic for consultation, monitoring and supply of medication.

Methods Patients were deemed eligible for shared care if they had been prescribed a stable dose of immunomodulatory medication included in the shared care guideline for 3 months. The specialist pharmacist(s) sought permission from the patient and requests were sent to general practitioners (GPs) with a primary care decision form to be returned within 2 weeks. Reminders were sent for shared care responses not received within this timeframe. All patients that had shared care accepted were transferred to GP for the monitoring and supply of immunomodulatory therapy. All other patients were monitored remotely and had medications supplied via specialist centre.

Results Of 352 eligible patients, 350 agreed to requesting shared care with primary care providers for immunomodulatory medication(s). Acceptance of shared care was received for 226 patients (65%) and refusal for 17 patients (5%). The barriers to transferring care included no response from GP (104 patients, 30%), hospital only status of medicine under local Clinical Commissioning Group (CCG), patient deemed complex by GP and/or poor adherence.

Conclusions This study demonstrates how different healthcare providers worked together effectively to deliver high standards of integrated care, tailored to the individual needs of patients with ILD, during the COVID-19 pandemic. Uptake of shared care could be improved by direct communication pathways with GPs, increased education in the management of immunomodulatory medicine(s) for primary care providers and review of CCG categorisation of medicines included in the shared care agreement. Shared care may improve accessibility to medicines and reduce environmental impact. We suggest further studies to assess monitoring in primary care, patient feedback, impact on specialist clinic capacity and financial implications.