(%): 75(69.7–78.5)) and 13 LD-Controls (10M/3F, age: 66 (62–72), FEV₁%pred(%): 60(52.8–74.5), FEV%FVC(%): 52 (45–57)) were studied. At least one of the respiratory depression indicators was detected in all 20 participants with OUD (Table1). Overall, there was a greater frequency of significant respiratory depression in both OUD groups compared to controls, most commonly ETCO₂>6.5kPa (p=0.021;Table1). NRDI was significantly higher in LD-Controls than OUD-LD (217(43.7–504.5) min⁻¹ and 148.5 (35–172.6) min⁻¹, respectively (p<0.01)), but there was no significant difference between OUD and HC (87.6(51.7–115.3) min⁻¹ and 76.9 (52.8–164.2) min⁻¹, respectively (p=0.7)).

Conclusions Respiratory depression is frequently present in OUD patients with comorbid COPD and significantly more severe than in opioid-naïve controls. Further studies are required to determine the association between respiratory depression and overdose risk.

Please refer to page A193 for declarations of interest related to this abstract.

COVID-19: clinical features and risk

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CHARACTERISING ANOSMIA IN HOSPITALISED PATIENTS WITH COVID-19

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Introduction Anosmia is one of the core symptoms of COVID-19, but its significance in hospitalised patients has not been extensively studied.

Aims Our aim was to characterise anosmia experienced by hospitalised COVID-19 patients, assessing whether subjective reporting correlated with examination findings which were quantified using our novel scoring system. We also looked to explore possible association between severity of anosmia and clinical outcomes, as well as whether severity correlated with comorbidities.

Method Over a two-month period we combined reported history of anosmia with olfactory nerve examination when assessing patients hospitalised with COVID-19. Examination included scoring patients on their ability to recognise distinctive smells of coffee, vinegar, clove, vanilla and mint from disguised bottles. A numerical grading system was established scoring severity of anosmia for each smell, with a total score calculated for each patient (table 1). Co-morbidities of all patients were noted and all were followed up at discharge to monitor whether they were admitted to intensive care (ICU) and whether they developed complications of COVID-19.

Results 46 patients were included, 33 (72%) of whom were male. Examinations were either performed at admission in the Emergency Department or on medical wards shortly afterwards. 16 (35%) patients were later admitted to intensive care. Mean length of stay was 21 days (SD 18.8). Coffee was the smell most often identified with a mean score of 1.09 (SD 1.13). Vinegar was least identified with a mean score of 1.8 (SD 0.89). There was a significant difference in patients' reporting of anosmia symptoms, compared to our objective assessment. 96% of patients (30 of 31) who reported no anosmia actually had objective evidence of anosmia on

Abstract P86 Table 1 Anosmia scoring system developed

Score for each smell	Meaning
0	Able to identify the smell correctly
1	Able to identify the smell but it doesn't smell right
2	Unable to identify the smell
3	Total anosmia
Total scores per patient	Definition
0–4	Mild anosmia
5–10	Moderate anosmia
11–15	Severe anosmia

examination (test of proportion, p<0.001). Severity of anosmia was not significantly associated with upper respiratory tract symptoms, ICU admission or development of complications from COVID-19. There was no correlation between severity of anosmia and presence of pre-existing comorbidities. **Conclusion** A significant proportion of patients studied were not aware they had anosmia. This has implications for pandemic management going forward when people are required to self-report this symptom and suggests potential benefit in formal examination of the olfactory nerve.

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CLINICAL CHARACTERISTICS OF COVID-19 PATIENTS WITH PULMONARY EMBOLISM IN 1ST AND 2ND WAVES

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Introduction and Objectives Multiple studies have demonstrated increased risk of pulmonary embolism (PE) in COVID-19. Our study at a major NHS Trust examined the clinical characteristics, attributes and outcomes of PE in COVID-19, which have infrequently been explored in literature.

Methods We performed a retrospective cohort study of COVID-19 patients with PE diagnosed on CT pulmonary angiogram (CTPA) over 2 months in 1st and 2nd waves (April 2020 and January 2021). Data collected from electronic health and imaging records included patient demographics, D-dimers, oxygen requirements, clinical outcomes, thromboprophylaxis/treatment and PE attributes on CTPA.

Results We identified 76 COVID-19 patients with PE (mean age 62.2 years, 69.7% male, 40.8% Caucasian). Patients experienced prolonged periods of COVID-19 symptoms prior to PE diagnosis - 19.6 day symptoms in 1st wave (n = 16, 21.9%) compared to 15.2 days in 2nd wave (n = 57, 78.1%). Average D-dimer was highly elevated (mean = 11576 ng/mL). 43 (56.5%) patients had high oxygen requirements - 21 (27.6%) required ≥10 litres/min via mask, 13 (17.1%) required non-invasive ventilation and 9 (11.8%) were intubated and ventilated. 22 patients (28.9%) were admitted to intensive care and 11 patients (14.5%) died. On admission, 48 patients (63.2%) were started on treatment dose enoxaparin (high PE suspicion) and 12 (15.8%) had intermediate (prophylactic) dose enoxaparin. PEs were largely treated with 3–6 months of rivaroxaban (n = 43, 56.6%) or apixaban (n = 7, 9.2%). 65.5% (n = 49) of patients had bilateral PEs; largest sizes being segmental (n = 32, 42.1%), subsegmental (n = 17, 22.4%), lobar (n = 16, 21.1%), main pulmonary artery (n = 5, 6.6%) and saddle (n = 5, 6.6%). 15 patients (19.7%) had evidence of right heart strain on CTPA.