This work is a pilot study as part of a sixth form Biology extended essay, all participants signed a written consent form.

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P121 DOES METHACHOLINE CHALLENGE TEST IMPROVE ASTHMA DIAGNOSTIC CERTAINTY IN CHILDREN AGE 5–16YR?

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Introduction Current UK guidance (NICE) for diagnosing asthma in children 5–16yrs involves sequential lung function testing in a complex algorithm (spirometry; bronchodilator reversibility if spirometry shows obstructions; FeNO; PEFv). This results in three diagnostic outcomes: asthma, not asthma or suspect asthma, with children requiring at least 2 positive tests to be assigned a diagnosis of asthma. Bronchial challenge testing (BCT) is not currently recommended in children but is in adults when there is diagnostic uncertainty.

We hypothesised that methacholine BCT (BCTmeth) is feasible in children >5 years and that the results can reduce the number of children labelled 'suspect asthma'.

Methods Children aged 5–16 years with suspected asthma (symptoms of wheeze, cough, breathlessness) were referred into the RADicA (Rapid Access Diagnostics in Asthma) Study. All attempted lung function testing (spirometry with bronchodilator reversibility, FeNO, PEFv and BCTmeth). Using the NICE algorithm, participants were assigned as asthma, not asthma or suspect asthma. BCTmeth were classed as positive when PD20 was <0.20mg, and children's asthma status was reassessed with this result.

Results 53 children (mean age 9.5yr [SD 3.4]; 25 male) attempted all tests. 8 children (mean age 8.75yrs [SD 3.6]; 4 male) did not complete BCTmeth; 2 children's baseline spirometry was classed as obstructed prior to BCTmeth, 1 had taken salbutamol prior to BCTmeth and 5 had inconsistent baseline spirometry, these were excluded from further analysis.

Abstract P121 Table 1 Number of children classed as asthma, not asthma and suspect asthma before and after BCTmeth

	Using NICE lung function algorithm N (%)	Using NICE lung function algorithm AND BCTmeth N (%)
Asthma	7 (15.5%)	13 (28.8%)
Not asthma	29 (64.4%)	30 (66.6%)
Suspect asthma	8 (17.7%)	1 (2.2%)
Missing evidence	1 (2.2%)	1 (2.2%)
Total	45	45

45 children (mean age 9.5yrs [SD3.4], 21 male) successfully completed BCTmeth; of these children 20 had a positive test (PD20 <0.15mg-0.199mg). 1 child was unable to complete FeNO and/or PEFv (positive BCTmeth) and classed as 'missing evidence'. Using the NICE algorithm, 7 children were diagnosed with asthma (5 positive BCTmeth) and 29 without asthma (7 positive BCTmeth). Of the 8 children with suspect asthma; 6 had a positive BCTmeth and could be given a diagnosis of asthma, 1 had a negative test and was reclassified as not asthma and 1 had a borderline result (PD20 0.214mg) so remained in the suspect asthma group.

Conclusion BCTmeth is feasible with 85% of children successfully completing the challenge. Assessing airway hyperresponsiveness with BCTmeth reduced diagnostic uncertainty in children.

P122 AN EVALUATION OF THE TRANSITION SERVICE BETWEEN PAEDIATRIC AND ADULT REGIONAL SEVERE ASTHMA CARE IN LEEDS

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Introduction Over one million children have asthma in the UK and a recognised need for support transitioning into adult services. Poor transition with uncoordinated processes risks disengagement from services, and poorer health outcomes. Transition processes are embedded for children with diabetes and transplantation, but less established for severe asthma. We aim to explore the patient experience of transition for young people with severe asthma and evaluate the impact of a transition service in reducing emergency department (ED) presentations with asthma.

Methods A questionnaire containing Likert scale and free text questions was developed based on the 'ready, steady, go'¹ programme. This was given to patients aged 14–15 years attending asthma transition clinic.

ED records for the years 2016–2018 were reviewed to identify patients aged 16–19 that presented with asthma symptoms. These data were cross-referenced with the registry of patients known to the transition service and demographic data was analysed.

Results 9 patients completed questionnaires, with two thirds of respondents reporting confidence about the transition process. All respondents reported good knowledge of their condition and treatment. Key themes that emerged were concerns about potential limits asthma may place upon their future achievements and a desire for understanding of management of their asthma during the transition process.

During the years analysed for ED attendances, none (0%) of the 17 children who underwent transition through the service presented to the emergency department with asthma. During that time, 131 young people (mean (SD) age 17.5 (0.7) years, 56% female) presented to the emergency department with asthma who were not known to the transition service.

Conclusion The transition service for young people with severe asthma is successful in preventing emergency department attendances with asthma symptoms. We have identified a need to expand the transition service to young people not already known to the regional severe asthma service.

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P123 DON'T FORGET YOUR PE KIT – IMPROVING THROMBOLYSIS DECISION MAKING IN A DISTRICT GENERAL HOSPITAL (DGH)

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Introduction Multiple patients with massive/submassive pulmonary emboli (PE) were admitted in a short timeframe to a DGH. Inconsistency in management was noted, prompting discussion surrounding thrombolysis decisions.

Methods All PE-related admissions to the Cardiac Monitoring Unit (CMU) between 2016–2020 were reviewed. Thrombolysis decision, relevant test results and outcomes were recorded and their concordance to local and national recommendations and guidelines were analysed.

Junior doctors were surveyed. Confidence in PE management was assessed, they were asked to select the appropriate management option for 5 clinical scenarios and if a 'bundle' would aid decision-making.

Results 57 patients were admitted over 4 years. 14 had a massive PE and 33 patients had a submassive PE. Of these, 12 (85.7%) and 17 (51.5%) were thrombolysed respectively. Departmental echocardiograms were organised within 24 hours in 74% and follow-up echocardiograms performed in 54%. The pooled mortality at 1 year was 21% with no significant difference between those thrombolysed and those not.

The survey, to which 22 junior doctors responded, demonstrated that 73% described themselves as 'very' or 'fairly' confident in managing massive/submassive PE. There was disparity in case management with the polar options of 'thrombolysis' and 'subcutaneous anticoagulation' being chosen at least once in each scenario.

All respondents supported a bundle. A consent form, information sheet and decision-making flowchart were created with stakeholder input and published locally.

Conclusion We show mostly guideline-concordant practice with the exception of echocardiogram follow up. Variability in opinion amongst juniors, despite perceived confidence, was observed. Bundle creation with respondent and consultant input standardises management and prompts escalation to seniors early to negate overconfidence in complex situations.

P124 IMPROVING SAFE SEDATION PRACTICES IN BRONCHOSCOPY AT A DISTRICT GENERAL HOSPITAL

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Introduction Procedural sedation and analgesia (PSA) practice varies, with minimal standardisation in bronchoscopy. The British Thoracic Society published Quality Standards in 2014 to ensure high standards of care for all patients undergoing bronchoscopy.

Aims

- Identify areas for improvement in PSA
- Increase PSA awareness amongst bronchoscopists
- Improve use of safe recommended doses of sedation agents
- Improve clarity of documentation

Methodology We performed a retrospective review of 113 bronchoscopy and 59 endobronchial ultrasound (EBUS) reports (September 2019–September 2020). May 2020 was excluded due to COVID19.

Three interventions were implemented:

1. Virtual local departmental teaching to raise awareness of safe PSA.
2. Implementation of a bronchoscopy-suite poster detailing local anaesthetic (LA) dose conversions.

Abstract P124 Figure 1 Correct documentation of LA agents