3. Introduction of specific LA fields on our online bronchoscopy reporting system.

Bronchoscopy and EBUS reports were re-audited following each intervention (total 19 cases).

Results Maximum recommended dose of midazolam in ≥ 70 yrs (3.5mg), was exceeded in 19% of EBUS cases and 5% of bronchoscopy cases pre-intervention. Following virtual teaching, 0% exceeded maximum recommended dose.

Maximum recommended dose of fentanyl (50mcg) was exceeded in 22% of EBUS and 4% of bronchoscopy cases pre-intervention. Following virtual teaching, maximum dose was exceeded in 1.6% of EBUS and 0% of bronchoscopies.

Pre-interventions, 1% and 2% lidocaine use was correctly documented in 17% of procedures and instillagel use was correctly documented in 33% of procedures. Following poster implementation, 1% lidocaine use was correctly documented in 75% of procedures, 2% lidocaine use was correctly documented in 88% of procedures and instillagel use was correctly documented in 60% of procedures. Following LA-field implementation, 1% lidocaine use was correctly documented in 91% of procedures, 2% lidocaine use was correctly documented in 91% of procedures, and instillagel use was correctly documented in 66% of procedures. (figure 1)

Conclusions Virtual teaching for bronchoscopists increased awareness of safe PSA, thus reducing previously exceeded recommended doses of sedatives. Implementation of a bronchoscopy suite poster, and specific recording fields for LA, has improved documentation practices. Methods introduced continue to be used in our trust's bronchoscopy suite.

REFERENCE

1. BTS Quality Standards for Diagnostic Flexible Bronchoscopy in Adults (2014) [https://www.brit\[1\]thoracic.org.uk/document-library/clinical-information/bronchoscopy/bts-quality-standards-for-flexible\[1\]bronchoscopy-2014](https://www.brit[1]thoracic.org.uk/document-library/clinical-information/bronchoscopy/bts-quality-standards-for-flexible[1]bronchoscopy-2014)

P125 AUDIT OF COMPLICATIONS OF PERCUTANEOUS CT GUIDED LUNG BIOPSIES CARRIED OUT AT ROYAL ALEXANDRA HOSPITAL AND INVERCLYDE ROYAL HOSPITAL IN 2019 AND 2020

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Background Percutaneous CT guided lung biopsy (PCLB) is used for histological diagnosis of pulmonary disease and is preferred to surgical biopsy due to its fewer complications.

The British Thoracic Society (BTS) recommend that operators audit their practise to calculate complication rates to inform patients about risks. Complication rates should be similar to, or lower than those from the national survey: pneumothorax (20.5% of biopsies), pneumothorax requiring chest drain (3.1%), haemoptysis (5.3%), and death (0.15%).

Aims This audit aims to calculate whether the complication rates of percutaneous CT guided lung biopsy were acceptable when compared to the aforementioned BTS guidelines.

It also aims to ascertain what risk factors there may be for developing a more severe pneumothorax as a consequence of the procedure.

Methods 153 patients had a PCLB at Royal Alexandra and Inverclyde Royal Hospitals. Their biopsy reports and follow up chest X-rays were reviewed for evidence of haemoptysis, pneumothorax, air embolus, or death. Their immediate

discharge letters were used to view their hospital stay lengths and to see which patients needed a chest drain inserted during their stay.

Each patient's lesion diameter and the distance that the biopsy needle travelled through the chest wall to reach the lesion were measured.

Complication rates were calculated and compared with the quoted rates. Potential risk factors for a severe pneumothorax were assessed.

Results Pneumothorax rate was 21.6%.

Pneumothorax requiring a chest drain rate was 7.2%.

Haemoptysis rate was 10.5%.

No deaths were reported as a consequence of the procedure.

Patients that developed a pneumothorax requiring a chest drain were on average 4 years older. They had an average 0.6cm greater distance travelled by the needle to the lesion and were 0.4 cm smaller in diameter.

Conclusions Complication rates were acceptable when compared to BTS guidelines.

Older age, smaller lesions, and lesions further from pleura are risk factors for a serious pneumothorax.

P126 AMBULATORY PNEUMOTHORAX WITH THE PLEURAL VENT IN A DGH IN THE NORTH EAST OF ENGLAND

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Introduction Ambulatory pneumothorax management saves inpatient days and is feasible with the Rocket pleural vent (PV) at the expense of higher rate of complications in primary spontaneous pneumothorax (PSP) (RAMPP study¹). The HiS-Pec study² in secondary spontaneous pneumothorax (SSP) showed that PV was probably dangerous. We have a local service with strict inclusion criteria (WHO PS 0–2, ambulant patients) using the PV.

Methods We retrospectively analysed all pneumothoraces managed with a PV from March 2018-April 2021.

Results 50 patients were identified. Table 1 shows the characteristics of 32 patients with PSP and 16 patients with SSP managed with the PV. The other 2 patients were iatrogenic

Abstract P126 Table 1

	PSP	SSP
Number	32	16
Mean age (years)	30.9	61.5
Mean number of days PV in situ	5.9	4.5
Current tobacco smokers	17	1
Current marijuana smokers	11	0
Ex-smokers	0	15
Never smokers	14	0
Number with Respiratory comorbidity	2	16
<i>Description of comorbidity</i>		
Previous pneumothorax	2	2
COPD	0	12
Asbestosis	0	1
Non specific fibrotic lung disease	0	1
Lung cancer	0	1
Rheumatoid lung disease	0	1