underwent large volume aspirations for symptom control. 3 indwelling catheters (IPC) and 2 intercostal drains were placed for treatment refractory effusions. There was one pleural space infection in 6 months, related to an IPC. There were 3 deaths at 12 months, none related to pericarditis/myocarditis.

Conclusions Pleural effusions occur in approximately a third of patients with pericarditis/myocarditis and are predominantly bilateral. Treatment refractory cases require pleural intervention: aspirations, drains and IPCs are all viable options. Limitations of this study are its retrospective nature, manual searching techniques and incomplete data related to values such as CRP. Our sample size is also too small to infer meaningful data on aetiology, pleural fluid biochemistry and gender predominance. A prospective study is thus warranted.

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P196 PNEUMOTHORAX AND CARDIAC DEVICE IMPLANTATION: A 10 YEAR RETROSPECTIVE REVIEW FROM A SINGLE CENTRE IN THE NORTH EAST OF ENGLAND

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Introduction In patients undergoing pacemaker (PPM) implantation or cardiac resynchronization, pneumothorax incidence was 1–6%, and commoner in women over 80 years of age with chronic obstructive pulmonary disease (COPD).^{1 2} No local review has ever been performed. We sought to add to the literature and inform local practice.

Methods Local Caldicott approval was sought for a review of cardiac device implantations from the local cardiological database. Those identified as being complicated by a pneumothorax on radiology reports were analysed further with basic demographics, pleural interventions and outcomes. Continuous variables are presented as mean ($\pm$ range) and categorical variables as percentages where appropriate.

Results 2056 implantation episodes from Jan 2010-Dec 2020 were reviewed. 70 pneumothoraces (3.4%) were identified, all related to PPM insertion. Mean age was 68.1 years (17–97), 39 were female, and 31 male. All pneumothoraces were on the side of the PPM (3 right, 67 left). 36 pneumothoraces were small, and 34 large according to British Thoracic Guidance criteria. 56 patients with minimal symptoms (30 were large pneumothoraces) were observed initially, with 5 requiring intercostal drainage (ICD) due to enlargement of pneumothorax and progressive symptoms. 14 pneumothoraces were treated with ICD as 1st line treatment: mean age was 78 years (69–89) and 8 had concurrent COPD. 5 pneumothoraces were large and all patients had significant symptoms. All pneumothoraces resolved within 6 weeks on follow up radiographs. There was no associated mortality.

Conclusions Pneumothorax rates following cardiac device implantation are low. Irrespective of size, such iatrogenic pneumothoraces with minimal symptoms can often be observed with adequate safety netting. Limitations of this study are its retrospective nature and manual searching techniques. Specific reasons for causing a pneumothorax such as excessive lead manipulation were unable to be identified retrospectively. A prospective study is thus warranted.

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P197 SECONDARY SPONTANEOUS PNEUMOTHORAX: EXAMINING THE EQUIPOISE

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Introduction and Objectives Current BTS guidelines recommend intercostal chest drain (ICD) for management of large secondary spontaneous pneumothorax (SSP) on the presumption that needle aspiration (NA) is less likely to be successful.¹ This premise has been challenged by a randomised control trial (RCT) by Thelle et al, which found NA halved the length of hospitalisation with fewer complications compared to ICD in patients with SSP.² We conducted a study to examine current views on management of SSP in the UK.

Methods Respiratory and emergency healthcare staff were invited, via personal email and via social media, to complete an online survey. The composed of 5 questions on a clinical vignette of a symptomatic patient with large (>2cm at hilum) SSP with no signs of respiratory compromise.

Results There were 70 responders: 64% from emergency medicine and 23% respiratory medicine. 47% were consultant grade; 44% doctors in training. 64% stated they would manage this patient with an ICD; 26% with NA; 7% with conservative care. For responders who choose ICD, the main factor influencing their decision was current clinical guidelines (64%), followed by higher anticipated success rate with chest drain (24%); familiarity of chest drain (8%) and concerns about patient safety (4%). Clinicians would be more likely to choose NA if the patient had minimal symptoms (57%), if there was a smaller pneumothorax (72%) or if there was patient preference for NA (59%), and less likely with greater severity of lung disease (60%). Most responders (89%), when presented with the Thelle et al study, would consider taking part in an RCT of NA versus ICD in SSP.

Abstract P197 Figure 1