Conclusions Despite only a small number of patients meeting the criteria for NTM disease, each single positive NTM culture generates a cascade of further investigations and work for the mycobacterium service. As a minimum, multiple samples, radiology and symptom assessment are needed. For those NTM associated with more complex comorbid disease, this often needs to be repeated over many months.

P34 5-YEAR EXPERIENCE OF LATENT TUBERCULOSIS INFECTION (LTBI) MANAGEMENT PRE-IMMUNOMODULATORY THERAPY AT A TERTIARY HOSPITAL INFECTIOUS DISEASES UNIT IN THE UK

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A growing number of immunomodulatory therapies that can increase the risk of reactivating latent TB infection (LTBI) are being used. Accordingly a broader range of patients screened for LTBI and referred to TB clinics bring new challenges to chemoprophylaxis risk benefit assessment. We describe 5 years' experience of LTBI management in our infectious diseases TB clinic.

We collected retrospective case note data for all LTBI patients who were assessed for chemoprophylaxis in the clinic between 1/9/2015–30/9/2020. We recorded interferon gamma release assay (IGRA) and tuberculin skin test (TST) results, choice of LTBI chemoprophylaxis and completion rates, and alanine aminotransferase (ALT) levels during treatment. We compared these outcomes according to patient age and gender, referring specialty, current and planned immunomodulatory therapy.

367 patients (48% female) were diagnosed with LTBI, 188 (51%, 47% female) of whom were pre-immunomodulatory therapy and significantly older (median age 56.2 vs 32.6 p<0.0001). This group were also more likely to have had a negative/indeterminate QuantiFERON-TB Gold (QFT) (25.5% vs 4.1%, p<0.0001), as were the 95/188 of these on immunosuppressive therapy when QFT tested (41% vs 9%, p<0.0001). In total, 25 different immunomodulatory treatments were planned by 7 referring specialties for >20 different conditions; anti-TNF (87 patients, 46.3%), other biologic/small molecule inhibitors (SMI) (38, 20.2%), checkpoint inhibitors (21, 11.2%) and DMARDs (14, 7.4%). Oncology referrals and the range of different agents both increased over the period, while overall numbers were stable.

90/188 (48%) patients initiated chemoprophylaxis, 50 with isoniazid (H), 40 with rifampicin/isoniazid (RH). Those initiating chemoprophylaxis were significantly younger (median 48.7 vs 63.5 years old, p<0.0001). Patients with planned anti-TNF (49, 56%) were more likely to initiate chemoprophylaxis than for other biologic/SMI (15, 39%) or immune checkpoint inhibitor therapy (19, 6%). 16 (18%) patients had any rise in ALT, 5 (6%) >5 times the upper limit of normal. 67 (74%) completed chemoprophylaxis, 6 stopped early due to ALT rises. No differences in these outcomes were seen according to chemoprophylaxis agent, gender or age.

Fewer than half pre-immunotherapy LTBI patients commenced chemoprophylaxis, reflecting older age, QFT uncertainty and an increasing variety of biologics/SMIs.

P35 NECK NODE TB: PERSPECTIVE FROM THE RAPID ACCESS HEAD AND NECK CLINIC

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Background Lymph node TB is the commonest form of extra pulmonary TB and in particular, neck node TB (approximately 20% local data). The 'neck lump pathway' was interrogated to understand differential diagnosis with regards TB and other pathologies.

Aim To assess fine needle aspiration cytology (FNAC) in the Rapid Access Head and Neck Clinic (RAHNC) to facilitate patient assessment, next investigation and appropriate timely out-patient review.

Method A retrospective review of all referrals during the period 01/01/2019–01/12/2019 was undertaken to assess whether initial assessment with FNAC was sufficient to plan on-going management of active TB.

Results 203 neck lump referrals were reviewed in RAHNC (median time from referral 9 days, IQR 4–35) as their first 2 week wait appointment; median age 53 (IQR 35–65); male gender 111 (55%); non-Caucasian ethnicity 83 (41%).

All referrals had initial FNAC and 18 (9%) underwent a second (table 1). First FNAC was diagnostic in 76% of malignant neck lumps. Further histology for diagnosis of cancer and/or staging required in 28 (44%) and in all lymphoma patients. A significant number of benign conditions (27%) required surgical biopsy to exclude malignancy.

TB suspected in 17 (8%); median age 42 (IQR 31–51); non-Caucasian ethnicity 13 (76%); initial FNA consistent with TB cytology (7 granulomatous; 8 necrotising; 1 caseating inflammation; 1 pus). A single patient underwent a second FNA for TB culture. 5 (29%) required excision biopsy (3 confirmed TB; 2 lymphoma).

TB diagnosed in 14 (7%) with 64% culture positivity: 7 fully sensitive; 1 Isoniazid resistance; 1 Rifampicin mono-resistance; 3 culture negative; 2 culture not performed).

Median time from first attendance to TB treatment start 47 days (IQR 27–76). All persons started on TB therapy completed their intended regimen duration.

Conclusion The RAHNC effectively investigates neck lumps of varied pathologies. A single FNA may be sufficient to

Abstract P35 Table 1 Fine needle aspiration cytology (FNAC) result by diagnosis and requirement for further histological clarification

	Final diagnosis frequency (%)	1st FNAC diagnostic (%)	Further histological diagnosis required	Histology required for IHC/staging	
Head and neck cancer	45 (22)	61 (76)	37 (82)	8	20
Metastatic cancer	16 (8)		12 (75)	4	2
Lymphoma	19 (9)		12 (63)	7	19 (100%)
TB	14 (7)	11(79)		3	NA
Benign other	109 (53)	73 (67)		29 (27%)	NA

Abbreviations used: FNAC fine needle aspiration cytology; TB tuberculosis; IHC immunohistochemistry