decreasing. 76 (20 PSP, 56 PSP) went for surgery at the index time with 5.3% recurrence (20% recurrence in those without surgery).

Conclusions This is the first known analysis of pneumothorax trends in a large trust in the North East of England. The data has limitations (size of pneumothorax, frailty (opting for thus conservative management not recorded), reliance on clinical coding and not all notes were available. Updated larger datasets should help elucidate trends better.

P5 CONSERVATIVE MANAGEMENT OF LARGE PRIMARY SPONTANEOUS PNEUMOTHORAX – AN INNER CITY, TERTIARY CENTRE EXPERIENCE

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10.1136/thorax-2023-BTSabstracts.157

Background Our centre introduced a pathway for the conservative management of large primary spontaneous pneumothorax (PSP) following increasing evidence to support this strategy in select individuals.1

Aims To evaluate our local centre experience of conservatively managing large PSP, the process and outcomes.

To identify any safety or operational concerns.

Methods Retrospect review of all pneumothorax referrals to pleural clinic from October 2020 – October 2022. Patients with large, unilateral PSP (≥2cm at level of hilar or ≥6cm combined measurement Collin’s method) were included for analysis.

Results 77 patients were referred with pneumothoraces during the 2-year period. 38 of which was primary (49%) with 15 77 patients were referred with pneumothoraces during the 2-year period. 38 of which was primary (49%) with 15

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the 2-year period. 38 of which was primary (49%) with 15

PSP (n=14)

<table>
<thead>
<tr>
<th>Large unilateral PSP (n=14)</th>
<th>Interventional management (n=5)</th>
<th>Conservative care (n=12)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age, mean yrs</td>
<td>29</td>
<td>29</td>
</tr>
<tr>
<td>% Male</td>
<td>79</td>
<td>80</td>
</tr>
<tr>
<td>% Right</td>
<td>71</td>
<td>80</td>
</tr>
<tr>
<td>% Positive smoking history</td>
<td>50</td>
<td>40</td>
</tr>
<tr>
<td>% previous pneumothorax</td>
<td>43</td>
<td>20</td>
</tr>
<tr>
<td>Pneumothorax size at hilum (mm), median (IQR)</td>
<td>25 (18)</td>
<td>32 (46)</td>
</tr>
<tr>
<td>Pneumothorax size at apex (mm), median (IQR)</td>
<td>63 (38)</td>
<td>88 (43)</td>
</tr>
<tr>
<td>Clinical outcomes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Length of hospital stay – days</td>
<td></td>
<td>0.02</td>
</tr>
<tr>
<td>Means/SD</td>
<td>4 ± 6.3</td>
<td>7 ± 8.7</td>
</tr>
<tr>
<td>Median (IQR)</td>
<td>1 (7)</td>
<td>3 (15)</td>
</tr>
<tr>
<td>Time to radiological resolution of pneumothorax – days</td>
<td></td>
<td>0.03</td>
</tr>
<tr>
<td>Means/SD</td>
<td>38 ± 30.6</td>
<td>26 ± 17.7</td>
</tr>
<tr>
<td>Median (IQR)</td>
<td>35 (30)</td>
<td>20 (32)</td>
</tr>
</tbody>
</table>

Conclusion • Conservative management of large PSP is safe, with those suitable for outpatient management experiencing a significant reduction in length of hospital stay at the expense of doubling time to radiological resolution.

• Patients not suitable for outpatient conservative management should be considered for pleural drainage over inpatient observation as little clinical advantage is conferred with the latter.

• History of previous pneumothorax may be a risk factor for failure of conservative management. Further research in this area could aid future risk stratification.

REFERENCE


P6 CURRENT MANAGEMENT OF PRIMARY SPONTANEOUS PNEUMOTHORAX IN A TEACHING HOSPITALS AND SUITABILITY FOR AN AMBULATORY PATHWAY

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10.1136/thorax-2023-BTSabstracts.158

Background Primary spontaneous pneumothorax (PSP) occurs predominantly in young adults. The 2010 BTS guidelines recommended management for stable patient is needle aspiration followed by chest drain insertion in case of failure. The
upcoming BTS guidelines recommend ambulatory management. We aimed to determine the current practices in managing patients with PSP and estimate the proportion of the patients who would have been suitable for ambulatory management.

**Method** We retrieved from hospital records all hospitalizations with discharge code of ‘pneumothorax’ between 2020–2022. We excluded cases with age outside 18 years to 54 years age bracket, and those with history of or imaging-proven underlying lung disease. We also excluded cases with traumatic or iatrogenic pneumothorax. For those who underwent drainage for PSP, we determined that the absence of all the following would mean suitability of ambulatory drainage: tension pneumothorax, bilateral disease, haemodynamic compromise at presentation or pregnancy.

**Results** The search retrieved 160 hospital episodes. 53 admissions (for 43 patients) met the inclusion criteria. Of these 43 patients, 33 (76.74%) were males, the median age was 28 (23–36) years and 27 (62.79%) were smokers. 44 of 53 (83.01%) PSP episodes required drainage with chest drain, the first intervention in 43 episodes and needle aspiration in 1 episode. The median length of hospital stay for all patients with PSP was 2.8 days (1–5 days) and 3.3 days (2–6 days) for patients who required drainage. Out of the total 44 episodes requiring drainage, 36 (81.81%) met the suitability criteria for ambulatory management. Reasons for ineligibility for ambulation were haemodynamic instability (n=4), pregnancy (n=2), and bilateral pneumothorax (n=2).

**Conclusion** The recommendation of 2010 BTS guidelines for needle aspiration in PSP was not routinely followed. A substantial proportion of patients with PSP requiring drainage can be managed on ambulatory/outpatient basis. These results will be the basis for starting an ambulatory pathway locally.

To evaluate website reliability, the Journal of American Medical Association (JAMA) and DISCERN benchmark criteria were applied. To evaluate readability, 10 standardised tools were utilised including the Flesch-Kincaid Reading Ease Score. To evaluate website content, a novel, self-designed 10-part questionnaire was utilised to assess whether information deemed essential by the authors was included.

Website authorship and year of publication were also noted.

**Results** The mean JAMA score was 1.82+/–1.22 out of 4, with only nine websites achieving all four reliability criteria. There was a moderate correlation between JAMA scores and year of website publication (r=0.548, p<0.001) indicating that newer websites were more reliable than older websites. The mean readability score was 15.43+/–9.76 which corresponded to a 13th-14th school grade standard. Only four websites noted alternative treatment options.

**Conclusions** Most websites were written above the 6th-grade reading level recommended by the US Department of Health and Human Services. Furthermore, the exclusion of essential information regarding pneumothorax surgery from websites highlights the current gaps in online information. These findings emphasise the need to create and disseminate comprehensive, reliable websites on pneumothorax surgery that enable patients to make informed health decisions.

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**P7**

**AN EVALUATION OF THE CONTENT, READABILITY, AND RELIABILITY OF PUBLICLY AVAILABLE WEB-BASED INFORMATION ON PNEUMOTHORAX SURGERY IN IRELAND**

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10.1136/thorax-2023-BTSabstracts.159

**Introduction** The internet is increasingly a first port of call for patients introduced to new treatments. Unfortunately, many websites are of poor quality, thereby limiting patients’ ability to make informed health decisions. No study to date has evaluated online information regarding pneumothorax surgery. Knowledge regarding same may allow physicians to recommend appropriate websites to patients and supplement remaining knowledge gaps.

**Objective**

1. To evaluate the content, readability, and reliability of online information regarding pneumothorax surgery.

**Methods** 11 search terms including ‘Pneumothorax Surgery’, ‘Pleurectomy’, and ‘Pleurodesis’ were each entered into Google, Bing, and Yahoo. The top 20 websites found through each search were screened, yielding 660 websites.

Only free websites designed for patient consumption that provided information on pneumothorax surgery were included. This criterion excluded 581 websites, leaving 79 websites to be evaluated.

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**P8**

**MY PNEUMOTHORAX JOURNEY. A PRIMARY SPONTANEOUS PNEUMOTHORAX PATIENT INFORMATION RESOURCE**

1C Craig, 2M Aloushehata, 2Penman, 3J Robinson, 2M Antony, 1M Evison, 1M Harris.

1Manchester University NHS Foundation Trust, Manchester, UK; 2University Hospital of North Midlands NHS Trust, Stoke on Trent, UK; 3West Midlands Academic Health Science Network, Birmingham, UK

10.1136/thorax-2023-BTSabstracts.160

**Introduction** On the back of recent randomised trials, there has been a paradigm shift in the management of primary spontaneous pneumothorax (PSP), towards conservative and ambulatory treatment options.

Due to the clinical equipoise between different options, it is important that patients are actively involved in the management plan and have appropriate information resources available at the time to aid decision making. It is important to ensure patients are involved in the production of such information resources – Patient and Public Involvement and Engagement (PPIE).

Therefore, the aim of this project was to co-produce patient information resource on PSP and related treatment options.

**Methods** Pleural physicians and nursing staff from Manchester University NHS Foundation Trust and University Hospital of North Midlands NHS Trust worked in collaboration with the West Midlands Academic Health Science Network (WMAHSN) and NHS England Accelerated Access Collaborative (AAC).

The initial draft leaflet was discussed with patients from both hospital sites via a focus group and online survey for