+2SD and +3SD respectively) and expressed as% of the available data for each age group. Change in BMI between ages was recorded as deviation by ≥±1 centile over time.

**Results** Data was collected for 52 patients (76% PB, 12% PCD, 12% PB and PCD; 52% male). Z-scores revealed that most individuals were of a healthy BMI (>80%). There was no undernutrition at any of the age points except at age 7 (5%). There was higher frequency of overweight at ages 3 & 15 (12% and 16%). Obesity levels were low compared to the general population (age3:4%, age5:0%, age7:2%, age9&11:3%, age15:7%). The frequency of children crossing down ≥1centiles was most pronounced between age 3 to 5 years (60%, n=23). Between the ages of 7–9, 9–11 and 11–15 most children had no major change in BMI (58%, 66% and 41%) but went up ≥1centiles in around a third (30%, 24%, 37%).

**Conclusion** Most children had healthy weight for height. However, between age 3–5 a high portion showed a decline in nutritional status that may be linked with clinical respiratory symptoms at the time and needs further exploration. An increase in BMI is most notable in teenage years that may or may not be related to their respiratory health and early intervention is indicated. BMI may also not be the most sensitive indicator of nutritional undernutrition in this age group.

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**Poster sessions**

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**‘I still haven’t found what I’m looking for’ – Cancer diagnosis: imaging and bronchoscopy**

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**EVALUATION OF PATIENT EXPERIENCE OF A SELF-REFERRAL CHEST XRAY SERVICE PILOTED IN AREAS OF GREATER MANCHESTER**

1S Taylor, 2D Brickhill, 1L Brown, 1L Dunn, 4M Edson, 1L Gallowan-Davison, 2S Grundy, 1E Harris, 1S Lyon, 2A Smith, 2N Rehan. 1The Christie NHS Foundation Trust, Manchester, UK; 2Northern Care Alliance NHS Foundation Trust, Manchester, UK; 3Manchester Foundation Trust, Manchester, UK; 4Manchester University NHS Foundation Trust, Manchester, UK; 5Greater Manchester Cancer Alliance, Manchester, UK

**Introduction** Increasing the uptake chest X-rays (CXRs) in patients with the common symptoms of lung cancer might lead to a stage-shift towards early diagnosis of lung cancer. However, symptomatic patients experience numerous barriers to accessing CXRs. A self-referral CXR (SRCXR) service was launched in July 2022 allowing symptomatic members of the public to attend for a CXR at one of three Greater Manchester (GM) hospitals without the need for a primary care appointment (if specific criteria were met). Outcomes of this pilot service have been published previously. This project aims...
to understand patient motivations for attending the service to determine how uptake could be increased and to facilitate service expansion.

**Methods** Deductive thematic content analysis of semi-structured qualitative interviews with a sample of attendees.

**Results** Fifty-one attendees were interviewed. Respondents were from a wide range of age groups and postcodes within the included areas. The majority of participants were female (57%) and White British (94%). Overall, participants ‘couldn’t fault the service’ and would recommend it to others. Most participants heard about the service through word of mouth and advertisement (35%) or through their GP surgery (22%). The majority (86%) attended due to a concerning health issue (i.e. cough or chest complaints). Twenty-two percent had tried to see their GP but were unable to get an appointment. Qualitative findings are interpreted within the Health Belief Model (figure 1). Demographic factors may influence engagement. Some forms of advertising may be more suitable to people of different ages, concerns were raised that social media ‘may not reach older people’. Ethnicity barriers such as language or cultural issues were also highlighted. If the chest Xray self-referral service wasn’t available, most participants would contact their GP, but highlighted the difficulties, e.g. contacting the surgery, long waits for appointments/referrals. Others would not have done anything if this service was not available.

**Conclusion** This work provides assurances that the GM SRCXR service is providing a good experience of care and helping to break down barriers to accessing CXRs in patients with the common symptoms of lung cancer and provides guidance for future service enhancements.

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**Abstract P71 Table 1** Comparison of diagnostic accuracy between MDT decisions and Herder scores

<table>
<thead>
<tr>
<th></th>
<th>MDT decision to investigate for all patients</th>
<th>MDT decision to investigate in patients with Herder &gt;10–70%</th>
<th>Herder score alone</th>
<th>Herder score alone ≥10% ≥70%</th>
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</thead>
<tbody>
<tr>
<td>Accuracy</td>
<td>79.7%</td>
<td>82.4%</td>
<td>66.7% 67.3%</td>
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</tr>
<tr>
<td>Sensitivity</td>
<td>88.2%</td>
<td>81.5%</td>
<td>96.5% 67.1%</td>
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<tr>
<td>Specificity</td>
<td>69.1%</td>
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<tr>
<td>Positive predictive value</td>
<td>78.1%</td>
<td>84.6%</td>
<td>63.1% 72.2%</td>
<td></td>
</tr>
<tr>
<td>Negative predictive value</td>
<td>82.5%</td>
<td>80%</td>
<td>87% 62.2%</td>
<td></td>
</tr>
</tbody>
</table>

**Introduction** Suspicious lung nodules on CT are typically investigated with a 18F-FDG PET-CT scan and a Herder score is calculated to guide management. BTS guidelines recommend that nodules with a score under 10% should be offered surveillance and over 70% surgery. However, for a score between 10 to 70%, management decisions are left to the multidisciplinary team (MDT), influenced by the patient’s risk and preference. Our aim is to evaluate the outcomes of PET-CT scans performed within a lung cancer screening (Targeted Lung Health Check [TLHC]) programme to assess the utility of the Herder score in decision making.

**Methods** A retrospective analysis was performed of 18F-FDG PET-CT scans performed between August 2018 and December 2022 for patients with solid nodules >300mm³ and Brock score>10% from West London TLHC programme. Patients who either had a biopsy or completed 12 months of surveillance scans were included in the analysis. The FDG activity of each nodule was classified using definitions from the BTS guidelines and a Herder score calculated. The accuracy of decision making by the MDT as well as using Herder scores at threshold of 10% and 70% were assessed.

**Results** 186 patients underwent a PET-CT scan for a suspicious nodule. 33 patients were excluded owing to loss to follow-up, awaiting a 12-month surveillance scan or being discharged after PET-CT scan; 153 subjects were included in the final analysis. The mean age was 68.6 years (range 56 to 76) with 76 female subjects and 104 ex-smokers. The mean size of nodules was 17.4mm (range 7.7 to 30mm). 85 out of 153 nodules (55.5%) were malignant. Sensitivity, specificity, positive and negative predictive values for identifying malignant nodules are outlined in table 1.

**Conclusion** An MDT decision to further investigate nodules using a combination of the Herder score between 10–70% as well as imaging and clinical factors provided the greatest overall diagnostic accuracy compared to Herder alone.

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**Poster sessions**

**P71** THE UTILITY OF THE HERDER SCORE FOR GUIDING DIAGNOSTIC INVESTIGATIONS OF NODULES IN LUNG CANCER SCREENING

1L Chan, 1EC Bartlett, 5S Swindan, 1A Tana, 1K Wechalekar, 1S Padley, 1CA Ridge, 1B Rawal, 1SR Daisai, 1Addis, 1JL Gamer, 1PL Shah, 1A Devarah. 1Royal Brompton Hospital, London, UK; 2National Heart and Lung Institute, Imperial College, London, UK

**Introduction** Suspicious lung nodules on CT are typically investigated with a 18F-FDG PET-CT scan and a Herder score is calculated to guide management. BTS guidelines recommend that nodules with a score under 10% should be offered surveillance and over 70% surgery. However, for a score between 10 to 70%, management decisions are left to the multidisciplinary team (MDT), influenced by the patient’s risk and preference. Our aim is to evaluate the outcomes of PET-CT scans performed within a lung cancer screening (Targeted Lung Health Check [TLHC]) programme to assess the utility of the Herder score in decision making.

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**P72** THE ROLE OF THE HISTORICAL CLINICAL AND IMAGING DATA IN TARGETED LUNG HEALTH CHECK SCREENING REVIEW MEETINGS

1,2,3G Dixon, 1N Rash, 1BC Buckley, 1A Edye, 1MV Masani, 2,3A Bibby. 1Royal United Hospitals Bath NHS Foundation Trust, Bath, UK; 2North Bristol NHS Trust, Bristol, UK; 3Academic Respiratory Unit, University of Bristol, Bristol, UK; 4InHealth, High Wycombe, UK

**Introduction** The Somerset, Wiltshire, Avon and Gloucester (SWAG) Cancer Alliance are undertaking a Phase 3 Pilot in the National TLHC programme. SWAG covers a population of 2.6 million with an estimated 366,500 eligible participants. Weekly Screening Review Meetings (SRM) are undertaken to review actionable cases. The SWAG SRM has established access to local PACS imaging databases to enable review of relevant historical imaging. TLHC participant data were captured for participants in the West Bath and Bridgewater regions between August 2022 and June 2023. SRM outcomes were scrutinised and pathway changes were categorised. Actionable incidental findings were downgraded according to additional available clinical information and historical imaging. Pulmonary nodules follow up recommendations were downgraded on the basis of historical imaging.

**Results** 3133 screening participants underwent a baseline low dose CT scan. 874/3133 (27.9%) participants were discussed in an SRM with 95/874 (10.9%) undergoing pathway change.