Yorkshire Thoracic Society (YTS) and the North-East Thoracic Society (NETS).

The survey was Internet-based and accessible from laptop, tablet and smartphone.

A total of 91 members undertook the survey with approximately half completing all 17 questions. There was an equal division of the sexes. Two thirds were aged between 30 and 50. Just over half were consultants and a further quarter junior doctors in training. Nurses and physiotherapists made up the remainder. There was an even split between teaching and district general hospital practice.

Half of the respondents felt that less than a quarter of their patients were troubled by cough. The majority did not use the guideline recommended definition of 8 weeks cough. 3 investigations, chest x-ray, spirometry, and full blood count, were routinely performed. CT thorax, sputum microbiology, FeNO and allergy testing much less so, with very few performing bronchoscopy, bronchial challenge, or oesophageal testing. The most common therapies used were proton pump inhibitors, carboceistine and nasal corticosteroids. Opiates, with the exception of morphine were rarely prescribed. Neuromodulators were not used by two thirds of the respondents. Only morphine, proton pump inhibitors, and nasal corticosteroids were considered by the majority to be effective. The most common treatment strategy was for 8 – 12 weeks and then continuous if the patient relapsed.

Chronic cough was considered a ‘disease in itself’ by 50/60 respondents. The mechanism was thought to be dysregulation of the cough reflex via ATP and P2X3 receptors by the majority. Oesophageal dysmotility was considered rare.

One third had not read any guidelines, most had received some training but over half would attend a course.

These findings indicate that whilst clinical investigation adheres to guidelines, prescribing is not evidence based. There is a need and desire for further training in this disease.

Please refer to page A293 for declarations of interest related to this abstract.

Results Ten studies; 6 in IPF (n=271 patients), 2 in ILDs including IPF (n=294 patients), 1 in CTD-ILD (n=1 study, 11 patients) and 1 in sarcoidosis (n=21 patients) were included. Definitions for persistent cough included self-reported chronic cough, stable cough frequency for >4 weeks and cough for >8 weeks, with some studies requiring additional criteria such as refractory cough, 24-hour cough count of >10/15 coughs per/hour and/or cough severity VAS >40mm. Cough severity VAS (n=8 studies, mean range=38.8–73.4/100mm) and cough counts (n=4 studies) were the most frequently used cough measures, and the LCQ (n=7 studies, mean range=11.0–15.3/21), SGRQ (n=4 studies, mean range=57.2–57.4/100) and CQLQ (n=2 studies, mean range=56.5–60.5/112) were the most frequently used impact/HRQoL measures. Four studies assessed concurrent/baseline associations between cough and impact/HRQoL measures, including three trials in IPF where cough severity VAS was negatively correlated with SGRQ, LCQ and/or CQLQ scores, in one of which cough counts were negatively correlated with LCQ scores, and an observational cohort study in ILD where cough severity VAS had an independent negative impact on SGRQ scores. Additionally, in a cross-sectional study in ILD, 31% of patients ranked cough as the worst symptom. None of the studies examined the HCRU/economic burden of cough.

Conclusions Our study highlights the heterogeneity in assessing cough and its impact in IPF and other ILDs. The findings confirm the negative impact of cough on HRQoL in IPF, with indications of a similar impact in other ILDs. Our synthesis underscores the need for standardised assessment, along with dedicated studies, particularly in non-IPF ILDs and on the economic burden of cough.

Please refer to page A293 for declarations of interest related to this abstract.

P222 THE IMPACT OF COUGH AND DYSPNOEA ON ANXIETY AND DEPRESSION IN IDIOPATHIC PULMONARY FIBROSIS

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Introduction Idiopathic pulmonary fibrosis (IPF) is a debilitating, life-limiting fibrotic lung disease. Cough and breathlessness are among the most commonly reported symptoms and confer negative psychological burden, yet its exact relationship with anxiety and depression remains unknown. We aimed to determine the severity of mood disorders in individuals with IPF and assess the association with symptom burden.

Methods We prospectively recruited incident cases of IPF into an observational study (ethics reference 20/EE/0261). Hospital Anxiety and Depression Scales were collected at baseline and repeated at 12 months (subscales for HADS-A and HADS-D, range 0–21; higher scores depicting worse quality of life). Dyspnoea-12 (range 0–36), Leicester Cough Questionnaires (LCQ, range 3–21) and cough visual analogue scales (VAS, range 0–100mm) were also recorded. Demographic data and lung function were collected.