The role of inhaled corticosteroids (ICS) in the long-term management of COPD is still unclear. Therefore, we performed a meta-analysis of the two-year studies published on this subject (Kersten et al: Am J Respir Crit Care 1995; 151: A463; Renkema et al: Chest 1996; 109: 1556-62. Patients with "asymptomatic features" were analyzed by isolating the original data. The effect on FEV1 was measured by a multiple repeated measurement technique in which time and drug effects were investigated. 95 (of the original number of 140) Patients treated with ICS (with 1500 μg beclomethasone, 5 with 1600 μg budesonide, and 8 with 800 μg beclomethasone) were included. 88 Patients treated with placebo were included (of the initially 144 patients). No baseline differences were observed (mean age 61 years, mean FEV1 = 45%pred.). Worsening of the disease was the drop-out reason in 4 patients of the ICS group vs. 9 of the placebo group (p = 0.11). The estimated two-year difference in the prebronchodilator FEV1 was +0.090L (95% confidence interval +0.037 to +0.143). In conclusion, this meta-analysis showed beneficial long-term effects of ICS on the FEV1.

When to perform arterial blood gases (ABG) in stable chronic obstructive pulmonary disease (COPD)?

In patients with stable COPD, there is no agreement on the FEV1 threshold above which ABG are unnecessary to identify patients who would require supplemental O2 therapy. The American Thoracic Society and French guidelines recommend to perform ABG when FEV1 is less than 50% predicted, whereas the European Respiratory Society recommends to perform ABG when FEV1 is less than 65% predicted. Several studies have shown a poor correlation between spirometry and Pa02. Several studies have shown a poor correlation between spirometry and Pa02. These data suggest that 55% would be an acceptable FEV1 threshold above which measurement of ABG are not necessary in stable COPD patients.

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2510 When to perform arterial blood gases (ABG) in stable chronic obstructive pulmonary disease (COPD)?

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2511 Survey of prescription of long term oxygen therapy outside guidelines

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Guidelines for the prescription of long term oxygen therapy (LTOT) have been published but many surveys have found a large proportion of patients prescribed LTOT to have arterial oxygen pressure above guideline thresholds. We have surveyed prescribers of LTOT to patients enrolled in the ANTADOR (French National Respiratory Home network) Observatory. 2081 questionnaires were send to prescribers identified by 20 regional associations asking if they ever prescribed LTOT to stable COPD patients with Pa02 ≥ 60 mmHg and asking them to mark any of 9 suggested situations or "other reason" for such prescription, 654 replies have been received. The mean age of doctors was 43.5 ± 7 yr. and 81% were respiratory physicians. 117/164 (7.8%) had never prescribed LTOT at PaO2 ≥ 60 mmHg. The remaining 537 marked a median of three options. 154 marked 5 options or more. The commonest motives for prescription outside guidelines were: "nocturnal desaturations" (38%), "polymtrophy hypotension" (33%), and "reputant clinical right heart failure" (34%). 172 (31%) doctors ticked at least three these situations together. In contrast the options of prescription "in response to demand by the patient" or "familial" were only chosen 40 times. 309 prescribed for "effort desaturations", 215 for dyspnea, 193 for "repeat hospitalization", 127 for "poly-cythaemia". We conclude that physicians prescribe LTOT outside guidelines for objective rather than subjective reasons of perceived severity of disease and trials of efficacy of LTOT in these circumstances are required.

2512 Assessment of domiciliary oxygen therapy effectiveness by means of arterial blood gas analysis at home and long-term oximetry in patients with COPD

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Aim: 1. To assess if domiciliary oxygen therapy (DO) in COPD patients, is effective to reach, breathing oxygen, a resting PaO2 ≥ 60 mm Hg and a CT < 15% during DOX and/or SOX. Sensitivity of oximetric recording = 90%.

2. To assess the resting breathing oxygen, PaO2 ≥ 60 mm Hg and a CT < 15% during DOX and/or SOX. Sensitivity of oximetric recording = 90%.

3. To analyse the sensitivity of the home oximetry in detecting patients with a resting breathing oxygen, PaO2 > 60 mm Hg.

Methods: 73 clinically stable COPD patients, FEV1 < 50% predicted, without other heart, pleural, lung pathologies that have been using DO for at least 1 year (55 COPD patients, 8 patients with chronic hypoxemia with different etiologies and 10 patients with chest pathology). All patients were asked to mark any of 9 suggested situations or "other reason" for such prescription. 654 replies have been received. The mean age of doctors was 43.5 ± 7 yr. and 81% were respiratory physicians. 117/164 (7.8%) had never prescribed LTOT at PaO2 ≥ 60 mmHg. The remaining 537 marked a median of three options. 154 marked 5 options or more. The commonest motives for prescription outside guidelines were: "nocturnal desaturations" (38%), "polymtrophy hypotension" (33%), and "reputant clinical right heart failure" (34%). 172 (31%) doctors ticked at least three these situations together. In contrast the options of prescription "in response to demand by the patient" or "familial" were only chosen 40 times. 309 prescribed for "effort desaturations", 215 for dyspnea, 193 for "repeat hospitalization", 127 for "poly-cythaemia". We conclude that physicians prescribe LTOT outside guidelines for objective rather than subjective reasons of perceived severity of disease and trials of efficacy of LTOT in these circumstances are required.