

risk for OSAS, and in this study, about 50% were diagnosed with OSAS, with one third starting NIV. However, more than a third of the patients are still waiting for the PSS to be performed, and only a small percentage repeated the PSS after the institution of NIV. Additionally, two-thirds are proposed for bariatric surgery, but only a small percentage have done the surgery. These data show that there is a significant prevalence of undiagnosed OSAS and the importance of POPC in diagnosing and instituting therapy and avoiding peri and postoperative complications. However, the current difficulty in performing PSS and subsequent diagnosis and monitoring of OSAS is equally noticeable.

Keywords: *Obstructive sleep apnea syndrome. Surgery.*

PC 008. LONG-TERM MAINTENANCE STRATEGIES AFTER PULMONARY REHABILITATION: PERSPECTIVES OF PEOPLE WITH CHRONIC RESPIRATORY DISEASES, INFORMAL CARERS AND HEALTHCARE PROFESSIONALS

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Introduction: Pulmonary rehabilitation (PR) is an effective intervention for people with chronic respiratory diseases (CRD). Benefits tend however to fade after 6 to 12 months. Community-based maintenance strategies might be a valuable opportunity to sustain PR benefits. However, the views of different stakeholders on this topic were not yet explored.

Methods: People with CRD, informal carers and healthcare professionals were recruited using purposive sampling and snowballing techniques. Focus groups were conducted with each stakeholder group using a semi-structured guide. Data were transcribed verbatim and thematically analysed.

Results: Twenty-nine people with CRD (24% female, median 69 years), 5 informal carers (100% female, median 69 years) and 16 healthcare professionals (75% female, median 36 years) were included. Three themes were identified: "Maintaining an independent and active lifestyle" which revealed common strategies adopted by people with CRD, such as walking or house chores to maintain an active lifestyle independently; "Intrinsic motivation and professional and peer support" which showed that motivation, group-based activities and having the support of a healthcare professional are key elements to maintain benefits, and that "Access to information and partnerships with city councils' physical activities" were necessary steps to take in the future to consider the preferences of patients and sustain active lifestyles.

Conclusions: This study suggests that motivation, professional and peer support are key elements to maintain the benefits of PR in people with CRD, and that different physical activity options (independent or group activities) considering peoples' preferences, should be available through partnerships with the community, namely city councils.

Keywords: *Chronic respiratory diseases. Maintenance strategies. Pulmonary rehabilitation. Physical activity.*

PC 009. DOMICILIARY PULMONARY REHABILITATION PROTOCOL: WHAT IS RECOMMENDED?

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Introduction: Pulmonary rehabilitation (PR) consists in an individualized intervention for patients with chronic respiratory diseases, which involves exercise training, education and behavioral changing. The ideal domiciliary PR (DPR) protocol is still unknown, as well as its efficacy, compared with the hospital PR (HPR), which remains

the gold standard. Due to the scarce studies, DPR is only a reality in 5% of centers, worldwide.

Methods: Literature revision to define a protocol for DPR.

Results: Objectives: to be accessible, low-cost, include essential components of PR, easy to implement and develop equivalent benefits of HPR. Benefits: it may have functional/quality-of-life benefits comparable to HPR. Safety: DPR is safe. Studies excluded patients with contraindications to a HPR, long-term oxygen therapy, COPD acute exacerbations. An informed consent for each patient is required. Monitoring: ideally, 2 weekly sessions should be supervised. Means of monitoring: Telephone contacts (1-2/week), domiciliary visits, videocalls, clinical registries; Tablets, Smartphones or smartwatches; Patients should monitor and register vital signs and symptoms; Pedometers or accelerometers. Training progression may be based on Borg scale. Duration: usual duration is 8-12 weeks, with at least 3 weekly sessions. PR components: training protocol should be individualized, respecting each patient preferences and capacities. Include recommendations from the book *Living Well With COPD*. Education: promote health literacy to improve self-management capacities; Doubts should be addressed; Suggestions should be considered; Stipulate goals; Resources: books, informative pamphlets; telephone or presentational contacts; tablets with videos. Ventilatory control: airway secretions clearance (if required). Warm-up, flexibility, cool-down: 5-10 min, light-moderate intensity. Balance training (if required). Endurance training: Type: Walking, bicycle. Duration: 3 sessions/week, 30 min/session. Intensity: Borg 3-4 or 4-6 (adapt); 80% 6-min walking test velocity. Resistance training: Type: stairs, sit-to-stand, weights. Duration: 3 sessions/week, up to 20 min/session. Intensity: body weight, resistance bands, water bottles, gym equipment. 60-70% maximal capacity. 10-12 reps, 1-3 sets. Evaluation: functional capacity: 6MWT, ISWT, 1-min sit-to-stand; PFTs. Symptoms: mMRC; CAT; CRQ; Global Rating of Change Questionnaire; PRAISE; HADS; LCADL. Adherence: Participation in ≥ 50-70% of calls/sessions/appointments. Training ≥ 30 min, 3 sessions/week. Feedback: Consider patients' opinions/critics.

Conclusions: The ideal DPR protocol is unknown. Most studies recommends 8-12 weeks, with at least 3 sessions/week (ideally 2 supervised), including essential components of PR. Studies demonstrate safety and comparable benefits to HPR.

Keywords: *Pulmonary rehabilitation. Domiciliary. Protocol.*

PC 010. MUSCULAR STRENGTH ASSESSMENT FOR THE DEVELOPMENT OF A PULMONARY REHABILITATION PROGRAM

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Introduction: Pulmonary rehabilitation (PR) consists in an individualized intervention to the chronic respiratory patients, which includes exercise training, education and behavior changing. The main goal is to promote long-term adhesion of a healthy life-style. Exercise training is a key-component of PR. In these patients, muscular weakness is common and may significantly impact the prognosis. Thus, it is crucial to define training intensity to obtain the best results and assure safety. It is more important to define the strength of a compound movement (with multiple accessory muscles) than of a single muscle group.

Methods: Literature revision on muscle strength assessment for the definition of a PR program.

Results: The results are described on the table. The protocol is evidenced on the figure.

Conclusions: To elaborate a PR plan, it is more useful to assess the load a patient can lift for 8-12 repetitions, which corresponds to 60-80% 1MR. After the definition of the ideal load, the patient should perform 2-4 sets per exercise, 2-3 times/week, assuring at