

ing chronic sarcoidosis, 60 patients were identified, 51.7% female and with a mean age of 51.7 ± 15.1 years. In this subgroup, the definitive diagnosis involved the use of biopsy in 40% of the cases. In the last evaluation, Scadding stage 0 was observed in 48.3%, stage I in 15%, stage II in 16.7%, stage III in 5% and stage IV in 15%. The mean ACE at diagnosis and at the last assessment was 83.03 ± 48.31 and 58.23 ± 26.55 , respectively. The mean soluble IL2 receptor assay was $1,569 \text{ pg/ml}$ ($N 458-1,997 \text{ pg/ml}$). The mean lymphocytosis in BAL was $37.40 \pm 22.18\%$, with a CD4/CD8 ratio of 5.3 ± 5.79 . The respiratory functional study revealed a mean FVC at diagnosis of $93.8\% \pm 22.6$ and $92.5\% \pm 13.3\%$ at the last evaluation, while the mean DLCO at diagnosis was $74.9\% \pm 17.3\%$ and $75.8\% \pm 19.1\%$ in the last assessment. Regarding the current treatment, 32% are under surveillance only, 31.7% are under prednisolone, 11.7% with hydroxychloroquine, 16.7% with methotrexate, 1.7% with leflunomide, 1.7% with azathioprine, 1.7% with infliximab and 3.3% with nintedanib. Of the global cohort of stage IV chronic sarcoidosis, 22.2% demonstrated criteria of progressive fibrotic disease in the previous 24 months.

Conclusions: The data presented illustrate the heterogeneity in the biological behavior trend and severity of sarcoidosis.

Keywords: Sarcoidosis. Granulomatous disease. Progressive fibrotic disease.

PC 021. FUNCTIONAL IMPAIRMENT IN PEOPLE WITH INTERSTITIAL LUNG DISEASES: IS ONE MEASURE ENOUGH?

C. Dias, A. Machado, C. Paixão, M.A. Mendes, P.G. Ferreira, A. Marques

Lab3R-Respiratory Research and Rehabilitation Laboratory, School of Health Sciences, University of Aveiro (ESSUA). iBiMED-Institute of Biomedicine, Department of Medical Sciences, University of Aveiro.

Introduction: Interstitial lung diseases (ILD) comprehend a large group of lung diseases that include disease settings associated with sustained progression and leading to respiratory failure, decreased functional status and premature death. Functional status can be defined as an individual's ability to perform normal daily activities required to meet basic needs, fulfill usual roles and maintain health and well-being. It includes functional capacity, i.e., an individual's maximum capacity to perform daily life activities in a standardized environment; and functional performance, i.e., the activities people actually do during the course of their daily life. Decreased functional status is the most frequent reported impact by people with ILD and is associated with increased dependence on others, exacerbations and hospital admissions. Yet, little is known how functional status is impaired in people with ILD.

Objectives: To explore functional impairments in people with ILD.

Methods: A cross-sectional study was conducted with people with ILD. Age, sex, body mass index (BMI) and lung function were collected. Functional capacity was assessed with the 1-minute sit-to-stand test (1-minSTS), the 6-minute walk test (6MWT) and quadriceps maximum voluntary contraction (QMVC). Functional performance was assessed with the London Chest Activities of Daily Living (LCADL). Participants' functional capacity was classified as impaired if the 1-minSTS, 6MWT and/or QMVC values were below 70% of predicted. Participants' functional performance was considered impaired if above the cut-off point of 28% of the LCADL. Descriptive statistics were performed.

Results: In total, 156 people with ILD (65 ± 13 years; 51.9% female; BMI $28.7 \pm 6.1 \text{ kg/m}^2$; FVC $79.2 \pm 20.1\%$ predicted; DLCO $55.4 \pm 21.2\%$ predicted) participated. ILD diagnosis included fibrosis hypersensitivity pneumonitis (43%), idiopathic pulmonary fibrosis (24%), connective tissue disease-associated ILD (14%), dust-related (1%)

and others (17%). Functional capacity was impaired in 55.3%, 23.8% and 41.8% of the sample assessed with the 1-minSTS, 6MWT and QMVC, respectively. Functional performance was impaired in 48.5% of people with ILD.

Conclusions: A large proportion of people with ILD show impairments in functional status, i.e., in capacity, in performance or in both. Lack of impairment in one measure does not rule out functional status impairment. Patient-centered and comprehensive assessment of functional status seems vital to guide individually tailored interventions and improve this meaningful domain for the daily life of ILD patients.

Keywords: ILD. Functional status. Functional capacity. Functional performance.

PC 022. ABILITY TO IDENTIFY RISK OF FALLS OF THE BRIEF-BESTEST IN PATIENTS WITH INTERSTITIAL LUNG DISEASE

C. Paixão, A.S. Grave, P.G. Ferreira, M.A. Mendes, F. Teixeira Lopes, J. Coutinho Costa, D. Brooks, A. Marques

Lab3R-Respiratory Research and Rehabilitation Laboratory, School of Health Sciences (ESSUA) and Department of Medical Sciences of University of Aveiro.

Falls are one of the major causes of morbidity, healthcare utilisation and mortality, worldwide. Deficits in balance have been associated with an increased risk of falls in people with chronic obstructive pulmonary disease, who fall 3-5 times more than their healthy age-matched peers. Much less is yet known about the balance of individuals with interstitial lung disease (ILD) which are a highly disabling group of chronic respiratory diseases. The Brief-Balance Evaluation Systems Test (Brief-BESTest) is a comprehensive balance measure, which provides important information for tailoring balance training, however, its ability to identify risk of falls in people with ILD is still unknown. Thus, the aim of this study was to determine the discriminative ability of the Brief-BESTest in identifying people with ILD with high/low predicted risk of falls. A retrospective cross-sectional study was conducted with people with ILD. At inclusion, people with ILD had to be clinically stable (i.e., no history of acute cardiac condition, acute ILD exacerbation or other respiratory complications) in the previous month. A definition of falls (an unexpected event when you find yourself unintentionally on the ground, floor or lower level) was provided to participants. History of falls was investigated by asking participants two standardised questions: (1) "Have you had any falls in the last 12 months?" and, if yes, (2) "How many times did you fall down in the last 12 months?". Balance was assessed with the Brief-BESTest. Differences between people who suffered a fall and those who did not, in the previous year, were explored with independent t-tests. A receiver operating characteristics (ROC) curve analysis was used to assess the ability of the Brief-BESTest to differentiate between people with ILD with (≥ 1) and without (0) history of falls. The area under the curve (AUC), sensitivity, specificity and accuracy were also calculated. The optimal cut-off point was identified by the highest Youden index. Sixty-seven people with ILD (66 ± 12 years old; 38 [56.7%] female; FVC $80.8 \pm 18.8\%$ predicted; DLCO $56.8 \pm 22.2\%$ predicted) were included in the analysis. From these, 20 (29.9%) had, at least, 1 fall in the previous year. People who suffered falls were older (63 ± 10 vs. 72 ± 13 years, $p = 0.015$), had a worst DLCO (60.8 ± 21.3 vs. $46.8 \pm 21.9\%$ predicted, $p = 0.032$) and balance (Brief-BESTest 17.8 ± 5.2 vs. 13.5 ± 6.4 points, $p = 0.012$) at baseline than those who had not fallen in the previous year. A cut-off point in the Brief-BESTest of 15.5 points for risk of falls (AUC = 0.71; 95%CI 0.56-0.85; 65% sensitivity; 75% specificity; accuracy = 0.71) was found in people with ILD. The Brief-BESTest is a simple and comprehensive balance test able to discriminate patients with ILD with risk of falls. A cut-off of 15.5