therapies remain a distant prospect. Digital approaches to care, and self-management, show considerable promise but integrating such approaches into a traditional healthcare system has proven challenging.

The prognosis of heart failure has improved dramatically for many patients over the past 30 years –but the residual risk of mortality and urgent hospitalisation means that there is much work to be done.

REFERENCES

1. Conrad N, Judge A, Tran J, *et al*. Temporal trends and patterns in heart failure incidence: a population-based study of 4 million individuals. *Lancet* 2018;**391**:572–580.
2. Chronic heart failure in adults: diagnosis and management (NG106). National Institute for Health and Care Excellence, September 2018. Available at: https://www.nice.org.uk/guidance/ng106
3. Failure to Function: a review of the care received by patients who died in hospital following an admission with acute heart failure. National Confidential Enquiry into Perioperative Deaths, November 2019. Available at: https://www.ncepod.org.uk/2018report2/AHF%20full%20report.pdf

4 ADVANCES IN PALLIATIVE CARE

Ros Taylor. *Former Clinical Director at Hospice UK*

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Palliative care is at a pivotal point in its trajectory. For the last 50 years there has been a focus on service development for the new specialty, the safer use of opioids and obtaining the evidence that palliative care makes a difference, the earlier the better.

However the next 50 years will be a massive challenge, but also an opportunity. There will be a shortage of all physicians, not just palliative physicians and this is a perfect storm with our increased longevity, frailty and comorbidities.

The lecture will focus on potential solutions, drawing on global innovation and imagination. Having braver conversations about the future is all very well but we also need practical options to improve the care of dying people in all settings not just five-star hospices, and we need to be less risk-averse about supporting patient and family goals of care in a culture dominated by compliance rather than comfort and care!

5 NEW GUIDELINES FOR MANAGING TUBERCULOSIS

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In 2018, tuberculosis (TB) was still among the top 10 leading causes of death, and the leading infectious agent, above HIV/AIDS. An estimated 10 million cases occurred in 2018, with 1.2 million deaths in people uninfected with HIV, and another 250,000 cases of HIV-associated TB. Among all TB cases, 8–6% were HIV infected; 57% were men, 32% women and 11% children (<15 years). About 500,000 cases of rifampicin resistant RR-TB also occurred. Between 2000 and 2018 TB incidence fell on average about 1.6% annually, and 2% between 2017 and 2018. The new global control targets will be presented and recent changes to guidelines positioned in this new scenario.

Guidelines for TB management from the UK, US and WHO were reviewed for recent changes. NICE's 2016 guidance not to screen contacts of non-pulmonary TB met with widespread criticism, but has recently been supported by a cost-effectiveness analysis. A 2019 meta-analysis of the seminal 2014 studies, OFLOTUB, ReMOX and RIFAQUIN trials showed that while none of those trials showed non-inferiority of a four month fluoroquinolone-containing regimen in all patients, those with low smear grade or no cavitation may be treated with 4-month rifampicin containing regimens. ATS/CDC/IDSA guidelines reflect this, but had not been accepted in the UK by October 2019. WHO has recently recommended the use of new agents in the treatment of rifampicin and multi-drug resistant TB. The rapidly-evolving picture of treatment recommendations for MDR-TB will be explained.

6 TRANSLATING GENOMICS FOR CLINICAL BENEFIT

[1,2]Mark Caulfield. [1]*Chief Executive and Chief Scientific Officer, Genomics UK*; [2]*Co-Director and Professor of Clinical Pharmacology, William Harvey Research Institute, Barts and the London*

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The UK 100,000 Genomes Project has focussed on transforming genomic medicine in the National Health Service using whole genome sequencing in rare disease, cancer and infection. Genomics England partnering with the NHS established 13 Genomic Medicine Centres, the NHS whole genome sequencing centre and the Genomics England Clinical Interpretation Partnership (3337 researchers from 24 countries). We sequenced the 100,000th genome on the 5th December 2019 and completed an initial analysis for participants in July 2019. Alongside these genomes we have assembled a longitudinal life course dataset for research and diagnosis including 2.6 billion clinical data points for the 3000 plus researchers to work on to drive up the value of the genomes for direct healthcare. In parallel we have partnered the NHS to establish one of the world's most advanced Genomic Medicine Service where we re-evaluated 300,000 genomic tests and upgraded 25% of tests to newer technologies with an annual review. The Department of Health have announced the ambition to undertake 5 million genome analyses over the next 5 years focused on new areas tractable to health gain.

Poster presenter abstracts

7 ASSESSING MELANOMA BRAF STATUS THROUGH DDPCR OF CFDNA

Lauren Passy, Shobha Silva, Ian Brock, Greg Wells, Angela Cox, Sarah Danson. *University of Sheffield*

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Introduction Treatment of recurrent and metastatic melanoma has been revolutionised by targeted therapy. Inhibitors of mutant BRAF are a systemic treatment offered for patients with stage III/IV melanoma who are known to carry a mutation in BRAF. Currently patients' BRAF mutation status is assessed through molecular analysis of tissue specimens.

Cell-free DNA (cfDNA) released from tumours can be used to non-invasively detect active disease and predict survival in