In the future assessments of different airway clearance techniques to optimise clearance without the use of FET is essential which should include positive expiratory pressure devices (PEP) and their potential role in airway splitting alongside airway clearance.

‘It’s not easy being green’ – Suppurative lung diseases

**P107** REAL-WORLD IMPACT OF ELX/TEZ/IVA ON QUALITY OF LIFE OF CHILDREN WITH CF Aged 6–11 YEARS AND PRIMARY CAREGIVERS IN THE UK: MAGNIFY, A PROSPECTIVE, OBSERVATIONAL, NON INTERVENTIONAL STUDY

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**Objective** To describe the impact of ELX/TEZ/IVA on quality of life (QOL) in children and caregivers.

**Methods** QOL of children with CF aged 6–11 years was evaluated via caregiver proxy using the Cystic Fibrosis Questionnaire-Revised (CFQ-R). Caregivers’ QOL was self-reported using the Care-Related QOL (CarerQoL). Data were collected at 13 sites in the UK before (baseline) and every 3 (±1) months after ELX/TEZ/IVA initiation. Change from baseline was calculated as the average of all postbaseline measurements minus baseline (mean [SD]). Additionally, children and caregivers completed a single-item measure assessing overall change in CF symptoms and caregiver’s status, respectively, on a 5-level scale from ‘much better’ to ‘much worse.’

**Results** 27 children and 25 caregivers provided data before and after ELX/TEZ/IVA initiation. 63.0% of children were male and 66.7% were homozygous for F508del-CFTR and after ELX/TEZ/IVA initiation. 63.0% of children were 27 children and 25 caregivers provided data before ELX/TEZ/IVA initiation. Mean ppFEV\textsubscript{1} was 94.3 (15.5) prior to initiation. Most caregivers were female (84.0%) with a mean age of 37.6 (4.2) years at ELX/TEZ/IVA initiation. Most children (18/27; 67%) and caregivers (17/25; 68%) reported improvement in symptoms/status on the single-item measure.

**Conclusions** Data suggest that both children with CF aged 6–11 years and caregivers experienced improvement in QOL and well-being following initiation of ELX/TEZ/IVA. Further study is warranted to understand the experiences of those who did not report improvement.

Please refer to page A289 for declarations of interest related to this abstract.
cystic fibrosis (CF), it is recommended that patients are segregated to prevent cross-infection. To date there are no evidence-based eradication treatment regimens and there is no universally agreed consensus on the number of negative sputum samples required or the time interval since last isolation of BCC for eradication to be deemed successful. Our objectives were to determine the duration after which it is likely that BCC has been eradicated or cleared, and where BCC was eradicated any significant differences in treatment duration or modality.

Methods All cases of new BCC isolation at a large adult CF centre were followed up between May 2002 and May 2022. The number of subsequent positive and negative sputum samples for BCC were recorded, as well as details of eradication treatment received. Cases of BCC isolation were deemed to have been successfully eradicated if there were ≥3 negative sputum samples and no further positive sputum samples for the same species and strain over ≥12 months until the end of follow-up.

Results Of 50 new BCC isolations, 28 were successfully eradicated and 22 resulted in chronic colonisation. 6 (18.2%) of 50 new BCC isolations, 28 were successfully followed up. The same species and strain over sputum samples and no further positive sputum samples for eradication.

Conclusions A cautious approach to segregation should be maintained after new isolation of BCC in CF, as some individuals with ≥3 negative sputum samples 12–24 months after initial isolation subsequently re-isolated BCC. There were no significant differences in eradication treatment duration, number of antibiotics or administration route between cases of BCC which successfully eradicated versus those which resulted in colonisation.

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