Conclusion A specialist in-patient CF physiotherapy service is equipped to deliver high quality care to non-CF bronchiectasis patients in line with national guidelines. Further evaluation is required to review the impact this has on the physiotherapy outpatient bronchiectasis service.

Background International guidance recommends airway microbiology testing in paediatric outpatients with bronchiectasis (NCFB) every 6–12 months,1 and every 3 months in Primary Ciliary Dyskinesia (PCD)2 to identify new pathogens early, and guide antibiotic therapy. Previous audits of our caseload showed sporadic microbiology testing for these patient groups.

To enable guideline-driven care, a model for surveillance self-sampling (SS-Sa) was created to meet these targets without increasing appointment burden or health miles.

Objectives

- Evaluate participation by patients and their families/carers in SS-Sa
- Evaluate the impact of increased microbiology data on decision making

Methods Participation was offered to all children and young people (CYP) with NCFB and PCD <15 years old on the 2022 caseload. Sputum samples were preferred and throat swabs when unable to expectorate; an additional nasal swab or nasal rinse sample was collected in PCD. Samples were taken at surveillance timepoints, during clinic reviews if clinically indicated, and at home during an exacerbation through the acute service. If families could be independent, they were encouraged to self-sample using labelled posted-out kits.

Data on sample results, changes to clinical management, and patterns of collection were collected prospectively from March 2020.

Results 18/20 identified patients participated from March 2022–June 2023:

- Total number of samples n=130. 15/130 were unsupervised SS-Sa from 11 CYP. 67/130 were positive cultures, and antibiotics were prescribed for 32/74. Those with PCD had a greater variety of pathogens identified, with two CYP isolating Pseudomonas Aeruginosa asymptomatically. Recurrent pathogens were identified through surveillance and guided antibiotic prophylaxis.

Conclusions

- Surveillance sampling identified PsA early and guided empirical and prophylactic prescribing.

Abstract P118 Table 1

<table>
<thead>
<tr>
<th>Participants</th>
<th>PCD n=7</th>
<th>NCFB n=11</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sum of samples</td>
<td>N=86</td>
<td>N=44</td>
</tr>
<tr>
<td>Number positive results</td>
<td>51/86 samples (59%)</td>
<td>16/44 samples (36%)</td>
</tr>
<tr>
<td>Treatment started as result</td>
<td>24/57(47%)</td>
<td>8/16 (50%)</td>
</tr>
<tr>
<td>Recurrent Staphylococcus aureus</td>
<td>3/7</td>
<td>4/11</td>
</tr>
<tr>
<td>Recurrent Haemophilus influenzae</td>
<td>2/7</td>
<td>0</td>
</tr>
<tr>
<td>Patients with no bacterial isolates</td>
<td>0</td>
<td>2 (11%)</td>
</tr>
</tbody>
</table>

REFERENCES


‘The way you make me feel’ – Beyond the basics in asthma

P119 MORTALITY IN PATIENTS WITH SEVERE ASTHMA AND SEVERE UNCONTROLLED ASTHMA IN THE UK: A RETROSPECTIVE COHORT STUDY

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Introduction and Objectives In the UK, the latest data on mortality in patients with severe asthma was estimated in 2013 (14.8 deaths/1000 person-years). With an increasing trend in asthma-related deaths, a more recent estimate is warranted. In addition, the mortality rate in patients with severe uncontrolled asthma is yet to be explored. To address this, we assessed all-cause and asthma-related mortality rates in patients with severe asthma and severe uncontrolled asthma, and identified characteristics associated with all-cause mortality in severe asthma.

Methods Primary care records from UK’s Clinical Practice Research Datatlink (CPRD) dataset linked to Hospital Episode Statistics were used to identify patients with severe asthma aged ≥12 years between January 1, 2012 and December 31, 2017. Data on mortality was obtained from the Office for National Statistics linked to CPRD. Index date was the diagnosis of severe asthma (as per ERS/ATS criteria). Patients were followed up until March 29, 2021, death or transferred out. Within this cohort, patients were defined as severe uncontrolled asthma if they had 2 or more exacerbations. The primary outcome was all-cause and asthma-related mortality. Mortality rates were calculated by dividing the number of deaths by the respective number of person-years of follow-up. Patient characteristics associated with mortality were assessed by means of age- and sex-adjusted, as well as multivariable Cox regression analysis.

Results The cohort consisted of 34,301 severe asthma patients, of whom 1679 patients (4.9%) had severe uncontrolled asthma. Median follow-up was 5 years. All-cause mortality rate was 15.77 deaths/1000 person-years (PY) and 22.87/1000 PY in severe asthma and severe uncontrolled asthma, respectively (table 1). Asthma-related mortality rate was 2.01 deaths/1000 PY and 5.31/1000 PY in severe asthma and severe uncontrolled asthma, respectively. Increasing age, deprivation, comorbidity, smoking status, baseline exacerbations and maintenance oral corticosteroid (mOCS) were associated with increased risk of all-cause mortality in patients with severe asthma.

Poster sessions

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