

Bronchiectasis (Obstructive) Cheat Sheet

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Bronchiectasis (Obstructive)

Pathop hysiology

- Permanent, abnormal dilation and destruction of the bronchial walls. Cilia are damaged.
- Onset is usually early in childhood. Infection in a patient with airway obstruction or impaired defense or drainage mechanism precipitates the disease.
- Cause is identified in fewer than half of patients. Less common today due to modern antibiotics.

Causes

• CF is the most common (50% of cases). Infection, alpha1 antitrypsin, post-infectious (TB, aspergillis), rheumatic diseases (RA, Sjogrens), toxins, humoral immunodeficiency (abnormal lung defense), and airway obstruction.

Bronchiectasis (Obstructive) (cont)

Symptoms

- Chronic cough with large amounts of mucopurulent, foul-smelling sputum.
- Rhino sinusitis. Dyspnea, pleurisy, wheezing, crackles, clubbing.
- Hemoptysis due to rupture of blood vessels near bronchial wall surfaces; usually mild and self-limited but sometimes can be brisk and present as an emergency.
- Recurrent or present pneumonia. More likely to have larger volume of sputum, recurrent fever, hemoptysis, and Pseudomonas than chronic bronchitis.

Diagnosis

• CT is the study of choice. Bronchoscopy only in certain cases. CT shows dilated central bronchi that are larger than the adjacent pulmonary artery branches, as well as thickening of the bronchial walls.

Pulmonary
Function
Tests

Obstructive pattern.

CXR

 Abnormal in most cases with nonspecific findings.

Bronchiectasis (Obstructive) (cont)

Treatment

- Antibiotics for acute exacerbations (infections are signaled by change in quality/quantity of sputum, fever, chest pain).
- Bronchial hygiene with hydration, chest PT (postural drainage, chest percussion) to help remove mucus, and inhaled bronchodilators.
- The goal is to prevent complications.
- Corticosteroids and macrolide to reduce airway inflammation.

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