Bronchiectasis (Obstructive)	
Pathophysiology	• **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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