Transcript Details

This is a transcript of a continuing medical education (CME) activity. Additional media formats for the activity and full activity details (including sponsor and supporter, disclosures, and instructions for claiming credit) are available by visiting:
https://reachmd.com/programs/cme/non-cf-bronchiectasis-ncfbe-identifying-at-risk-patients/15619/

Time needed to complete: 1h 13m

ReachMD
www.reachmd.com
info@reachmd.com
(866) 423-7849

Non-CF Bronchiectasis (NCFBE): Identifying At-Risk Patients

Announcer:
Welcome to CME on ReachMD. This episode is part of our MinuteCE curriculum.

Prior to beginning the activity, please be sure to review the faculty and commercial support disclosure statements as well as the learning objectives.

Dr. Swenson:
Hello, my name is Colin Swenson, an Assistant Professor at Emory University in Atlanta, Georgia, where I also run the Non-CF Bronchiectasis and Nontuberculous Mycobacterial Clinic. I'm here to talk to you today about non-CF bronchiectasis, but particularly identifying at-risk patients.

We're going to start with a patient case here. We have a 68-year-old, white female patient who presents with a chronic cough that started approximately 1 year ago. The cough is productive of 5 to 10 mL of off-white sputum per day, and she also complains of breathlessness when walking up more than one flight of stairs. She reports a gradual increase in fatigue also over the last 2 years. In terms of medical history, she has gastroesophageal reflux disease, osteoporosis, and mild asthma. Her social history is significant for being a lifelong nonsmoker. She's married, has 2 grown children, and is a retired teacher. On physical exam, her BMI is low at 18.1 kilograms per meter squared. But her vital signs are unremarkable. And then on spirometry, there's a mild obstructive defect that is not reversible.

We present this case in order to outline when to suspect bronchiectasis. So in this case, we have someone with a chronic daily cough in a patient who is older than 65 years of age. This is extremely common in patients with bronchiectasis, most of whom do complain of a chronic daily cough. Regular chronic sputum production should also raise that possibility, or a diagnosis of COPD in a lifelong nonsmoker. History of recurrent or frequent lower respiratory infections, particularly if they're caused by multidrug resistant pathogens, or nontuberculous mycobacterial species from sputum culture should also be a red flag. If there is a history of hemoptysis, if there is cough associated with fatigue and weight loss, or if there's a history of pediatric lung infections or tuberculosis, these are all risk factors for bronchiectasis and should raise the alarm.

Symptom burden in non-CF bronchiectasis is significant but can also be frustratingly diverse. By far, as you can see from this slide, cough is the number one complaint for those with non-CF bronchiectasis. Usually, it's a chronic cough lasting typically more than 6 months, sometimes for many years. Almost 75% of patients have daily bouts of coughing that can be severe and embarrassing at times. Only half of patients with non-CF bronchiectasis have daily sputum production. These are the what we call the so-called dry bronchiectatics. And around a quarter of patients with non-CF bronchiectasis will have had hemoptysis. Dyspnea with activity, particularly with abnormal or out of the ordinary exertion is very common, as is daily fatigue. And 50% of those patients with non-CF bronchiectasis will have obstruction on pulmonary function testing, and typically it is not reversible.

Of course, chronic cough is not a specific symptom. Part of the workup specific to non-CF bronchiectasis includes, of course, auscultation as one would do during any clinic visit. If there are course breath sounds or rhonchi, especially in the lower lungs zones that may clear with cough or if there are inspiratory squeaks, particularly late inspiratory squeaks, those are findings that could suggest the diagnosis of bronchiectasis. A nasopharyngeal exam may reveal turbinate hypertrophy, erythematous mucosa, polyposis, evidence of

postnasal drip such as cobblestone throat, and also voice changes from chronic cough are also very common. Bacterial culture of sputum or phlegm is warranted if you suspect bronchial stasis and that may be revealing if unusual pathogens are isolated from those cultures. Lastly, chest imaging, particularly high-resolution CT, is the gold standard for diagnosis. Chest x-rays often will miss this diagnosis. And so, you'll want to get that high-resolution CT.

So getting back to our patient case, our patient is female, older than 65 years of age, is of white European ancestry, has a chronic daily cough with mucopurulent sputum, has dyspnea with activity, fatigue, a low BMI at 18.1, and a history of gastroesophageal reflux disease and asthma. So it's also important to note the gastroesophageal reflux disease is very prevalent in patients with non-CF]

bronchiectasis. Almost half of those affected will have a history of GERD. So in many ways, our patient case is highly illustrative of this diagnosis.

I hope that you were able to learn more about when to suspect and identify the diagnosis of non-CF bronchiectasis in this module. Thank you very much for your participation.

Announcer:
You have been listening to CME on ReachMD. This activity is jointly provided by Global Learning Collaborative (GLC) and TotalCME, Inc. and is part of our MinuteCE curriculum.

To receive your free CME credit, or to download this activity, go to ReachMD.com/CME. Thank you for listening.