BTS Bronchiectasis Short Course

Question	Answer
Any thoughts on the simeox device?	https://clinicaltrials.gov/study/NCT06487273?cond=bronchiectasis&term=physio%20assist&rank=2
what about patients with Bx that are not productive daily	is there need for the PT to wear a mask when patient is carrying out technique
What's your experience with chest clearance in patients with dementia? Have you found a technique that seems to work better in this group of patients?	i have found using a PEP device like Arobika is little easier for them to understand - its often reminding them to do it and convincing them to do it that i find is the difficulty
What's your experience with chest clearance in patients with dementia? Have you found a technique that seems to work better in this group of patients?	I think adjuncts can definitly be helpful as this can provide a prompt to optimise techniques. Also maybe this is when activity is important too, punctuated with FET/Cough
Autogenic Drainage is a more specilised technique to learn. Can you recommend a place to get this training?	There are some great videos on the austrailian tool box which were on the presentation. The ACPRC often have short courses which teach this, more recently these have been online, however there are practical f2f sessions planned.
The BTS recommends that patients with bronchiectasis are offered a review by specialist respiratory physiotherapist or a qualified healthcare professional, what are you thoughts on the MDT approach to ACT and nurses providing this as work such as by Emma rickards have shown effective outcomes from nurse led opep.	Thank you for this interesting question. I think as a routine review this works really well and certainly issues of adherence and action plans can be effectively managed by the whole MDT. My caution would be that physiotherapists have a clear important role in optimising the technqiues through the training they go through and so new patients, exacerbating patients and those with specific symptoms of difficulty like UA or breathing pattern will need to be seen by a physio
Currently the waits for physiotherapy review where I work is a year to be seen as a outpatient unfortunatly,	This type of data is really important to share. Looking at your service information against what is recommended in the guidelines might be a helpful start?

Is there any risk with PEP with patients who have recently treated for PE ?	I am not aware of any. Obviously the patient mayve more breathless which requires adaptations. If they are on treatment for PE then this is also optimal. If they have VQ mismatch it is also really important for them to optimise ventilation during this time
You have spoken about pneumothracies and positive presure such as PEP, would you use it with Bullae or try to avoid	should all patient with bronchiectasis do airway clearance or those who struggle with secretion alone. I have patient say they are ok not coughing and no phlegm.. what do you advice
You have spoken about pneumothracies and positive presure such as PEP, would you use it with Bullae or try to avoid	PEP: Def have caution with Bullae and remember there are many device independent technqiues you can use if worried. Non productive: I would always challenge this as there are some patients that say they dont clear but then you review and hear the secretions in the FET. Sometimes they have secretions but they are swallowing them thinking that they are 'unproductive'. If they dont have many secretions then I would make sure they are really active and no exactly what to do this ACT during exacerbations
How important is it to optimise clearance prior to colomycin for pseudomonas? Find if hard often to time this well alongside when nursing staff will give patients colomycin.	incredibly important. All patients with deteriorating conditions including new PSA suggest that all aspects of care should be optimised. PSA often leads to increased freq of exacerbations - and optimising ACT is therefore key. Also clearing chest before taking Colomycin is optimal if possible
if a patient has lower lung zone mucus plugging, would you try posutral drainage or would it be ineffective if not using head down tilt	Positioning does not need to be head down to be effective. but good 3/4 side lying would be useful with techniques to enhance ventilation in this region
What is your opinion on hypertonic saline trials during an exacerbation as an in patient on the ward? The drs at our site are very reluctant to consider it on the ward?	sorry hit the wrong button! Your doctors will be reluctant to risk bronchospasm which HtS can provoke - but if the patient is improving down the line, you could try a test dose then. I wouldn't do it while the patient is actively unwell though.

What is your opinion on hypertonic saline trials during an exacerbation as an in patient on the ward? The drs at our site are very reluctant to consider it on the ward?

Thank you, it’s a conversation that I as an acute in pt resp physio have been having with our resp out pt physio and I agree with you advice. That’s really helpful.

question to judy for the last presentation. Can you give examples for action plans for when pt misses treatment and coping mechanism when an exacerbation happens despite adherence

Hi there, I think this is a really difficult one as I oftne think Airway Clearance is one of those management strategies that you can sometimes not automatically feel better after doing it. Like you say, patients can still get unwell despite good compliance. I think it the patient needs to think that ACT is like cleaning your teeth- you don't do it because of infection/tooth decay- you do to prevent it as well as immediate changes like bad breath. This is when the whole team needs to review to see what aspects might be contributing to this deterioration. The Action plan will need to flex for 'standard treatment' as well as 'during exacerbations'. I hope that helps. The next few sessions may also help with answer to this

What order of treatment do you suggest if using an inhaler which is a combined bronchodilator and steroid? i.e using airway clearane before or after use.

Patients need to ensure they pre dose with a bronchodilator prior to ACT. If they are using their combined inhaler for this then this should be used first. Otherwise the combined inhaler can be used after airways are optimally cleared.

does milk or diary product encourages secretion build up

Some patients report this. In my experience it is upper airway sscretions and not chest secretions. However if reducing these products is not deleterous to health and improves respiratory symptoms then this might be sensible to trial.

Is it possible to share your diary cards?

They are the Bronko-test cards - we order them in. Other diary cards are available too.

Hello, amongst younger patients who would have had this, how effective is new born CF screening testing at identifying the majority of CF cases?

https://adc.bmj.com/content/109/4/292

test sensitivity 97.1%

Odd question but do bronciectasis patients need to have a fit to fly test ?	Hi Kathryn, if the bronchiectasis is associated with an element of respiratory failure, fit to fly consideration applies - the BTS Clinical Statement on Air Travel is very helpful
is there high risk of immunosuppresion withthe biologics ? Is there any risk of ABPA patients on Biologics doing PR in group settings ?	no additional cross infection risk - as previously mentioned, the evidence base is lacking and would avoid attending PR if acutely unwell
Do the anti-inflammatory and anti-infective treatments mentioned have an impact on haemoptysis? (assuming there is no specific target for bronchial artery hypertrophy)	it is sometimes difficult to control, so I was wondering if there is a specific strategy that could help more. thanks