EMBARC Case Report Form
Annual Follow-up
Version 2.0 April 2016

BASIC CASE INFORMATION

Case Identifier ____________

Gender: □ Male  □ Female  Date of birth: ____________ (dd/mm/yyyy)

Center: ____________________________

How long has the patient had bronchiectasis?  □ Unknown  □ 11-15 years  □ < 5 years  □ 16-20 years  □ 5-10 years  □ >20 years

Date of Review: ____________ (dd/mm/yyyy)

Is the patient still under clinical follow-up?  □ Yes  □ No

If not, please provide reason ____________________________

Has the patient died since last visit?  □ Yes  □ No

If yes, Date of Death ____________ (dd/mm/yyyy)

Cause of Death ____________________________

******************************************************************************

Red text indicates data fields which must be updated (questions are box highlighted for black and white printing)
Black text areas will autocomplete on the eCRF based on the data provided in the previous year.
Only edit black sections where data has changed from the previous visit.
******************************************************************************
**CO-MORBIDITIES**

**Have any new comorbidities been diagnosed in the past 12 months?**  □ Yes  □ No  
(*If no, please move to next question regarding non-respiratory medications*)

<table>
<thead>
<tr>
<th>Comorbidity</th>
<th>□ Yes</th>
<th>□ No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiovascular diseases</td>
<td></td>
<td></td>
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<tr>
<td><em>If yes:</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Myocardial infarction</td>
<td>□ Yes</td>
<td>□ No</td>
</tr>
<tr>
<td>- Angina</td>
<td>□ Yes</td>
<td>□ No</td>
</tr>
<tr>
<td>- Stroke or Transient Ischaemic Attack</td>
<td>□ Yes</td>
<td>□ No</td>
</tr>
<tr>
<td>- Coronary artery bypass graft</td>
<td>□ Yes</td>
<td>□ No</td>
</tr>
<tr>
<td>- Congestive cardiac failure</td>
<td>□ Yes</td>
<td>□ No</td>
</tr>
<tr>
<td>- Pulmonary hypertension</td>
<td>□ Yes</td>
<td>□ No</td>
</tr>
<tr>
<td>- Atrial fibrillation</td>
<td>□ Yes</td>
<td>□ No</td>
</tr>
<tr>
<td>- Others</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Liver Cirrhosis</td>
<td>□ Yes</td>
<td>□ No</td>
</tr>
<tr>
<td>Osteoporosis</td>
<td>□ Yes</td>
<td>□ No</td>
</tr>
<tr>
<td>Depression</td>
<td>□ Yes</td>
<td>□ No</td>
</tr>
<tr>
<td>Anxiety</td>
<td>□ Yes</td>
<td>□ No</td>
</tr>
<tr>
<td>Chronic renal failure</td>
<td>□ Yes</td>
<td>□ No</td>
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<tr>
<td><em>If yes:</em></td>
<td></td>
<td></td>
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<tr>
<td>- Haemodialysis</td>
<td>□ Yes</td>
<td>□ No</td>
</tr>
<tr>
<td>Neoplastic disease</td>
<td>□ Yes</td>
<td>□ No</td>
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<tr>
<td><em>If yes:</em></td>
<td></td>
<td></td>
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<tr>
<td>- Active</td>
<td>□ Yes</td>
<td>□ No</td>
</tr>
<tr>
<td>- Haematological</td>
<td>□ Yes</td>
<td>□ No</td>
</tr>
<tr>
<td>- Site</td>
<td></td>
<td></td>
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<tr>
<td>Diabetes</td>
<td>□ Yes</td>
<td>□ No</td>
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<td><em>If yes:</em></td>
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<tr>
<td>- Type</td>
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<tr>
<td>- Treatment</td>
<td></td>
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<tr>
<td>□ Lung</td>
<td></td>
<td></td>
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<tr>
<td>□ Breast</td>
<td></td>
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<tr>
<td>□ Prostate</td>
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<tr>
<td>□ Colon</td>
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<tr>
<td>□ Pancreas</td>
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<tr>
<td>□ Bone</td>
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<tr>
<td>□ Skin</td>
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<tr>
<td>□ Brain</td>
<td></td>
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<tr>
<td>□ Other</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Unknown</td>
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</tbody>
</table>

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NON RESPIRATORY MEDICATIONS

Have any changes been made to non-respiratory medications in the past 12 months?
☐ Yes  ☐ No

If yes, please complete;

- Statin  ☐ Yes  ☐ No
- Angiotensin-converting-enzyme inhibitor  ☐ Yes  ☐ No
- Angiotensin II receptor blocker  ☐ Yes  ☐ No
- Aspirin  ☐ Yes  ☐ No
- Non-aspirin platelet inhibitors eg, Clopidogrel  ☐ Yes  ☐ No
- Warfarin/Oral anticoagulants  ☐ Yes  ☐ No
- β-Blocker  ☐ Yes  ☐ No
- Proton pump inhibitor  ☐ Yes  ☐ No

Additional medications can be recorded in the respiratory treatments section.


**BRONCHIECTASIS BACKGROUND INFORMATION**

********************************************************************

Spirometry, MRC score and Exacerbation history are deemed Essential Data and will not autopopulate in the eCRF. These must be updated annually. Cases may be rejected from the registry in the absence of Essential Data.

********************************************************************

<table>
<thead>
<tr>
<th>Weight (Kg)</th>
<th>N/A</th>
<th>Height (cm)</th>
<th>N/A</th>
<th>BMI (Kg/m2)</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

(BMI autocalculated by eCRF)

FEV₁ L (recorded) | N/A

FEV₁ L (% predicted) | N/A
(% predicted values as autocalculated by eCRF)

FVC L (recorded) | N/A

FVC L (% predicted) | N/A
(% predicted values as autocalculated by eCRF)

Bronchodilator Status

- Pre-Bronchodilator
- Post-Bronchodilator
- Unknown

(where possible, post-bronchodilator values are preferred)

If spirometry has not been completed in the past 12 months, please give a reason in the box below

Were any additional lung function tests performed?  □ Yes  □ No

If yes:

Total Lung Capacity (L) | N/A

Diffusing capacity (DLCO) (L) | N/A

Residual Volume (L) | N/A

Inspiratory capacity (DLCO) (L) | N/A

Modified MRC dyspnoea score:

- □ 0 (I only get breathless with strenuous exercise)
- □ 1 (I get short of breath when hurrying on level ground or walking up a slight hill)
- □ 2 (On the level ground I walk slower than people of the same age because of breathlessness or I have to stop for breath when walking at my own pace on the level)
- □ 3 (I stop for breath after walking about 100 yards or after a few minutes on the level ground)
- □ 4 (I am too breathless to leave the house or I am breathless when dressing)

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Asthma: □ Yes □ No
COPD: □ Yes □ No
Nasal polyps: □ Yes □ No
Rhinosinusitis: □ Yes □ No

Sputum color when stable: □ Mucoid □ Mucopurulent □ Purulent □ Purulent (severe)
Usual daily sputum volume: ______ (ml/day)

Smoking status: □ Current □ Ex □ Never
Approximate Pack years: □ 0 - 4 □ 5 – 9 □ More than 40 □ 10 - 20

Number of exacerbations not requiring secondary care in the last year:
□ 0 □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10 □ 11 □ 12
Source of this data: □ Patient history □ Antibiotic prescription data □ Hospital records

Number of exacerbations requiring hospital admission in the last year:
□ 0 □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10 □ 11 □ 12
Source of this data: □ Patient history □ Antibiotic prescription data □ Hospital records

Number of respiratory related emergency department visits not resulting in hospitalisation in the last year:
□ 0 □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10 □ 11 □ 12
Source of this data: □ Patient history □ Antibiotic prescription data □ Hospital records

Has the patient ever been hospitalised for bronchiectasis? □ Yes □ No
Has the patient received outpatient intravenous antibiotics in the last year? □ Yes □ No
Has the patient ever had major haemoptysis requiring hospital admission? □ Yes □ No
Has the patient participated in a clinical trial for bronchiectasis (other than the registry)? □ Yes □ No
QOL-B QUESTIONNAIRE

Please provide recent QoL-B data (not more than 12 months old). QOL-B data is deemed Essential Data for those with appropriately verified translations.

☐ English-UK  ☐ Danish-Denmark  ☐ Dutch-Belgium  ☐ Dutch-Netherlands  ☐ Finnish
☐ French-Belgium  ☐ French-France  ☐ German  ☐ Hungarian  ☐ Italian  ☐ Lithuanian
☐ Norwegian  ☐ Polish  ☐ Portuguese  ☐ Romanian  ☐ Russian-Israel  ☐ Russian-Russia
☐ Serbian  ☐ Spanish-Latin  ☐ Spanish-Spain

Date of completion: _______________ (dd/mm/yyyy)

Q1 ______  Q2 ______  Q3 ______  Q4 ______  Q5 ______
Q6 ______  Q7 ______  Q8 ______  Q9 ______  Q10 ______
Q11_______  Q12_______  Q13_______  Q14_______  Q15_______
Q16_______  Q17_______  Q18_______  Q19_______  Q20_______
Q21_______  Q22_______  Q23_______  Q24_______  Q25_______
Q26_______  Q27_______  Q28_______  Q29_______  Q30_______
Q31_______  Q32_______  Q33_______  Q34_______  Q35_______
Q36_______  Q37_______
### AETIOLOGY AND LABORATORY TESTING

**Has the patient had any new aetiology tests in the past 12 months?**  
(If not, please move to next question)  
☐ Yes  ☐ No

<table>
<thead>
<tr>
<th>Test Description</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ABPA</strong></td>
<td></td>
<td></td>
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<tr>
<td>- Serum eosinophil count</td>
<td></td>
<td></td>
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<tr>
<td>- Total IgE</td>
<td></td>
<td></td>
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<tr>
<td>- Specific IgE to aspergillus</td>
<td></td>
<td></td>
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<tr>
<td>- Aspergillus IgG</td>
<td></td>
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<tr>
<td>- Aspergillus Skin prick test</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Test Description</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cystic Fibrosis</strong></td>
<td></td>
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<tr>
<td>- Sweat test</td>
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<tr>
<td>- Genetics</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Test Description</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Serum Immunoglobulins</strong></td>
<td></td>
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<tr>
<td>- Serum level IgM</td>
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<tr>
<td>- Serum level IgG</td>
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<tr>
<td>- Serum level IgA</td>
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<tr>
<td>- Serum level IgG1</td>
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<td>- Serum level IgG2</td>
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<td>- Serum level IgG3</td>
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<tr>
<td>- Serum level IgG4</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Test Description</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>α-1 antitrypsin deficiency</strong></td>
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<tr>
<td>- Level</td>
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<tr>
<td>- Genetics</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Test Description</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Functional antibodies to</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Pneumococcal/H influenza vaccine</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Test Description</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Serum electrophoresis</strong></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Test Description</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

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### Tests of ciliary function

*If yes:*

- Nasal eNO
  - Yes
    - Positive
    - Intermediate
    - Negative
    - Not performed
- Saccharin test
  - Yes
    - Positive
    - Intermediate
    - Negative
    - Not performed
- Scintigraphic mucociliary clearance
  - Yes
    - Positive
    - Intermediate
    - Negative
    - Not performed
- Biopsy for electron microscopy
  - Yes
    - Positive
    - Intermediate
    - Negative
    - Not performed
- Biopsy for analysis of ciliary beat pattern/frequency
  - Yes
    - Positive
    - Intermediate
    - Negative
    - Not performed
- Genetics
  - Yes
    - Positive
    - Intermediate
    - Negative
    - Not performed

### Bronchoscopy

- Yes
  - No

### Autoantibody testing

*If yes:*

- CCP screen results
  - Yes
    - Positive
    - Intermediate
    - Negative
    - Not performed
- ANA screen results
  - Yes
    - Positive
    - Intermediate
    - Negative
    - Not performed
- ENA screen results
  - Yes
    - Positive
    - Intermediate
    - Negative
    - Not performed
- ANCA
  - Yes
    - Positive
    - Intermediate
    - Negative
    - Not performed
- Additional tests performed
  - Yes
    - No
**Has the patient been diagnosed with any of the following in the past 12 months?**
*(If not, please move to microbiology section)*

- **Pneumonia**
  - Yes ☐  No ☐

- **Whooping cough/pertussis**
  - Yes ☐  No ☐

- **Other childhood/respiratory infection**
  - Yes ☐  No ☐

- **Tuberculosis**
  - Yes ☐  No ☐
  - Infection
    - Current ☐  Previous ☐
  - Treatment received
    - Yes ☐  No ☐  Unknown ☐

- **Atypical mycobacterial infection**
  - Yes ☐  No ☐
  - Infection
    - Current ☐  Previous ☐
  - Treatment received
    - Yes ☐  No ☐  Unknown ☐

- **Rheumatoid arthritis**
  - Yes ☐  No ☐

- **Other connective tissue disease**
  - Yes ☐  No ☐
  - Systemic lupus erythematosus ☐
  - Systemic sclerosis/scleroderma ☐
  - Ehlers_danlos syndrome ☐
  - Mixed connective tissue disease ☐
  - Stills disease ☐
  - Sjogrens syndrome ☐
  - Poly/dermatomyositis ☐
  - Juvenile idiopathic arthritis ☐
  - Relapsing polychondritis ☐
  - Other ☐

- **Inflammatory bowel disease**
  - Yes ☐  No ☐
  - Ulcerative colitis
    - Yes ☐  No ☐
  - Crohns disease
    - Yes ☐  No ☐

- **HIV**
  - Yes ☐  No ☐
<table>
<thead>
<tr>
<th>Immunodeficiency</th>
<th>□ Yes</th>
<th>□ No</th>
</tr>
</thead>
<tbody>
<tr>
<td>If yes:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- B-cell deficiencies:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ Common variable immunodeficiency</td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ X-linked agammaglobulinaemia</td>
<td></td>
<td></td>
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<tr>
<td>☐ Thymoma with antibody deficiency</td>
<td></td>
<td></td>
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<tr>
<td>☐ Hyper IgM syndrome</td>
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<td></td>
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<tr>
<td>☐ Activate PI3K-delta syndrome</td>
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<td></td>
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<tr>
<td>☐ Selective IgA deficiency</td>
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<td></td>
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<tr>
<td>☐ IgG subclass deficiency</td>
<td></td>
<td></td>
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<tr>
<td>☐ Specific antibody deficiency</td>
<td></td>
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<tr>
<td>☐ Other</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- T-cell and combined deficiencies</td>
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<td></td>
</tr>
<tr>
<td>☐ Severe combined immunodeficiency</td>
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<td></td>
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<tr>
<td>☐ DiGeorge syndrome</td>
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<tr>
<td>☐ X-linked lymphoproliferative syndrome</td>
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<tr>
<td>☐ Hyper IgM syndrome (CD40 ligand)</td>
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<tr>
<td>☐ MHC class II deficiency</td>
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<td></td>
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<tr>
<td>☐ Ataxia-telangiectasis</td>
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<td></td>
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<tr>
<td>☐ Wiskott-Aldrich syndrome</td>
<td></td>
<td></td>
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<tr>
<td>☐ Chronic mucocutaneous candidiasis</td>
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<tr>
<td>☐ TAP deficiency</td>
<td></td>
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<tr>
<td>☐ IPEX (immune dysfunction, polyendocrinopathy, enteropathy, X-linked)</td>
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<tr>
<td>☐ ALPS (autoimmune lymphoproliferative syndrome)</td>
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<tr>
<td>☐ WHIM syndrome</td>
<td></td>
<td></td>
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<tr>
<td>☐ Other</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Secondary immunodeficiencies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ Chronic Lymphocytic leukemia</td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ Multiple Myeloma</td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ Immunodeficiency associated with haematological malignancy</td>
<td></td>
<td></td>
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<tr>
<td>☐ Immunodeficiency secondary to systemic chemotherapy</td>
<td></td>
<td></td>
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<tr>
<td>☐ Immunodeficiency secondary to immunosuppressive drugs</td>
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<td></td>
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<tr>
<td>☐ Stem cell transplantation</td>
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<td></td>
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<tr>
<td>☐ Solid organ transplantation</td>
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<tr>
<td>☐ Other</td>
<td></td>
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</tr>
</tbody>
</table>
- Phagocyte deficiencies
  - Chronic granulomatous disease
  - Familial Haemophagocytic lymphohistiocytosis
  - Congenital agranulocytosis
  - Cyclic neutropenia
  - Leucocyte adhesion deficiency
  - Chediak-Higashi syndrome
  - Griscelli’s syndrome
  - Hyper IgE syndrome
  - Interferon gamma/IL-12 rec
  - Other cytokine deficiencies

- Complement deficiencies
  - Mannose binding lectin (MBL) deficiency
  - Properdin deficiency
  - Complement C3 deficiency
  - Terminal complement component deficiency
  - Other

Primary ciliary dyskinesia
  - Yes
  - No

Aspiration
  - Yes
  - No

Gastro-oesophageal reflux disease
  - Yes
  - No

Congenital airway abnormality
  - Yes
  - No
If yes, please specify: ____________________________

Foreign body inhalation or obstruction
  - Yes
  - No
MICROBIOLOGY

********************************************************************

Microbiology is deemed Essential Data. This must be updated annually. Cases may be rejected from the registry in the absence of Essential Data.

********************************************************************

Have any new microbiology samples been obtained in the past 12 months? □ Yes □ No

If no;
Microbiology samples should be collected from the bronchiectasis patients at least once per year, if no sample has been collected please provide a reason: __________________________________________________________

If yes, complete the following:
Samples are divided into those performed when clinically stable and those performed during exacerbation. If it is uncertain whether patients were stable or not at the time of sampling please record under “clinically stable”.

While clinically stable

Please provide details of all sputum results while stable over the last 12 months including negative cultures (use additional sheets where necessary)

Date of sample: _____________ (mm/yyyy) Source: □ Sputum □ BAL □ Induced sputum □ Throat swab

□ No organism isolated
□ Organism: ____________________________ Antibiotic: Sensitive:_________________
                   Sensitive:_________________
                   Sensitive:_________________
                   Sensitive:_________________
                   Resistant:_________________
                   Resistant:_________________
                   Resistant:_________________
                   Resistant:_________________

□ Organism: ____________________________ Antibiotic: Sensitive:_________________
                   Sensitive:_________________
                   Sensitive:_________________
                   Sensitive:_________________
                   Resistant:_________________
                   Resistant:_________________
                   Resistant:_________________
During Exacerbations

Please provide details of all sputum results during exacerbations over the last 12 months (use additional sheets where necessary)

Date of sample: _____________ (mm/yyy)       Source:  
☐ Sputum
☐ BAL
☐ Induced sputum
☐ Throat swab

☐ No organism isolated
☐ Organism: _____________________________  Antibiotic: Sensitive:_____________________________
                        Sensitive:_____________________________
                        Sensitive:_____________________________
                        Sensitive:_____________________________
                        Sensitive:_____________________________
                        Resistant:_____________________________
                        Resistant:_____________________________
                        Resistant:_____________________________
                        Resistant:_____________________________

☐ Organism: _____________________________  Antibiotic: Sensitive:_____________________________
                        Sensitive:_____________________________
                        Sensitive:_____________________________
                        Sensitive:_____________________________
                        Sensitive:_____________________________
                        Resistant:_____________________________
                        Resistant:_____________________________
                        Resistant:_____________________________
                        Resistant:_____________________________

Mycobacterial samples

Please provide details of all sputum results for acid fast bacilli/mycobacterial culture over the last 12 months (use additional sheets where necessary).

Date of sample: _____________ (mm/yyy)       Source:  
☐ Sputum
☐ BAL
☐ Induced sputum
☐ Throat swab

☐ No organism isolated
☐ Organism: _____________________________
RADIOLOGY

Has the patient had an updated CT scan in the past 12 months?  □ Yes  □ No

*If yes:*

Date of CT scan: ___________ (dd/mm/yyyy)

Type of imaging:  □ High resolution CT scan (HRCT)  □ CT Thorax

Is there CT evidence of Bronchiectasis in;

**Right upper lobe:**  □ No Bronchiectasis  □ Cylindrical  □ Varicose  □ Cystic  □ Unknown Severity  □ No Bronchiectasis  □ Cylindrical  □ Varicose  □ Cystic  □ Unknown Severity

**Left upper lobe:**  □ No Bronchiectasis  □ Cylindrical  □ Varicose  □ Cystic  □ Unknown Severity

**Right middle lobe:**  □ No Bronchiectasis  □ Cylindrical  □ Varicose  □ Cystic  □ Unknown Severity  □ No Bronchiectasis  □ Cylindrical  □ Varicose  □ Cystic  □ Unknown Severity

**Lingula:**  □ No Bronchiectasis  □ Cylindrical  □ Varicose  □ Cystic  □ Unknown Severity

**Right lower lobe:**  □ No Bronchiectasis  □ Cylindrical  □ Varicose  □ Cystic  □ Unknown Severity  □ No Bronchiectasis  □ Cylindrical  □ Varicose  □ Cystic  □ Unknown Severity

**Left lower lobe:**  □ No Bronchiectasis  □ Cylindrical  □ Varicose  □ Cystic  □ Unknown Severity
**RESPIRATORY TREATMENTS**

**Have there been any changes to respiratory medication in the past 12 months?**

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Long term oxygen therapy:</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Non invasive ventilation:</td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>

**The patient has regular respiratory treatments?**

*If yes, complete below;*

**Respiratory Medications**

- □ Inhaled steroid
- □ Inhaled steroid/Long acting beta agonist
- □ Intravenous Immunoglobulin
- □ Itraconazole
- □ Leukotriene receptor antagonist
- □ Long acting anti-muscarinic
- □ Long acting beta agonist/Long acting anti-muscarinic
- □ Long acting beta agonist
- □ Long term (>28 days) Oral corticosteroids
- □ Monoclonal antibody
- □ Mucolytic
- □ Nebulised bronchodilators
- □ Oral theophylline

**Drug:** __________________________

**Antibiotic Medications**

- □ Inhaled/Nebulised antibiotics
- □ Long term (>28 days) Oral antibiotics
- □ Cyclical antibiotic therapy

**Drug:** __________________________

**Physiotherapy Adjuncts**

- □ DNAaese
- □ Inhaled mannitol
- □ Nebulised Hypertonic saline

**Drug:** __________________________

**Vaccination**

- □ Pneumococcal polysaccharide vaccine (e.g.: PSV23): □ Yes □ No
- □ Pneumococcal conjugate vaccine (e.g.: PCV13): □ Yes □ No
- □ Influenza vaccine: □ Yes □ No
PHYSIOTHERAPY AND ACTIVITY

Within the last 12 months has the patient
- Seen a specialist physiotherapist  □ Yes  □ No
- Had a self management plan written   □ Yes  □ No
- Practiced regular chest physiotherapy □ Yes  □ No

Manual airway clearance:
- □ Active cycle of breathing technique
- □ Autogenic drainage
- □ Postural drainage
- □ Assisted cough
- □ Manual vibration
- □ Percussion
- □ ELTGOL
- □ None
- □ Regular physical exercise

Devices:
- □ Positive expiratory pressure (PEP) device
- □ Flutter device
- □ Cornet
- □ Acapella
- □ Mechanical vibration
- □ Percussionaire
- □ High frequency chest wall oscillation
- □ Other
- □ None

Has the patient attended pulmonary rehabilitation? □ Yes
- □ Not referred
- □ Not fit due to co-morbidities
- □ Patient refused
- □ Patient failed to attend

ADDITIONAL INFORMATION

Provide any additional required information in the free text provided:
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
Disclaimer
In using this paper case report form to record identifiable patient data, the user accepts all responsibility for the secure storage of this data and disposal of this data in accordance with local ethical approvals and policies.

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