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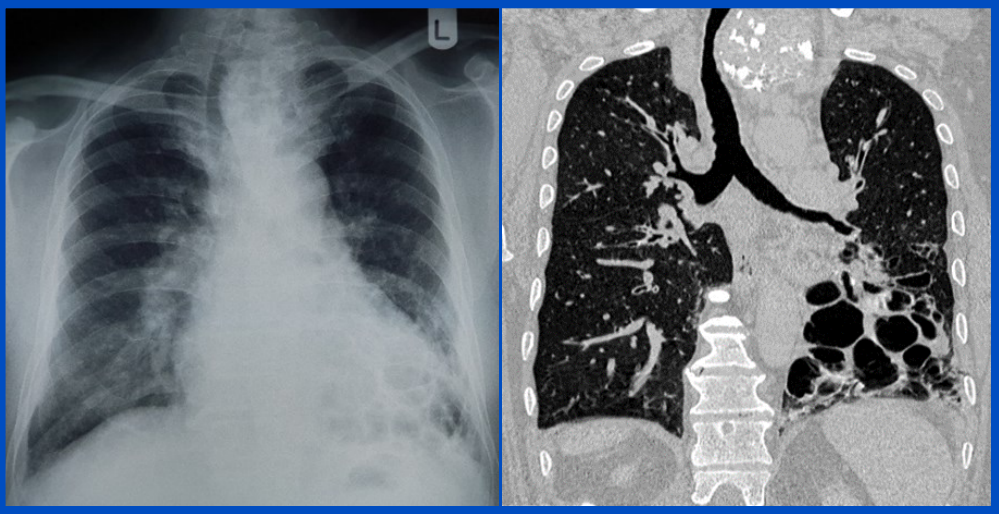

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Aim and Scope of Brunei International Medical Journal

The Brunei International Medical Journal (BIMJ) is a six monthly peer reviewed official publication of the Ministry of Health under the auspices of the Clinical Research Unit, Ministry of Health, Brunei Darussalam.

The BIMJ publishes articles ranging from original research papers, review articles, medical practice papers, special reports, audits, case reports, images of interest, education and technical/innovation papers, editorials, commentaries and letters to the Editor. Topics of interest include all subjects that relate to clinical practice and research in all branches of medicine, basic and clinical including topics related to allied health care fields. The BIMJ welcomes manuscripts from contributors, but usually solicits reviews articles and special reports. Proposals for review papers can be sent to the Managing Editor directly. Please refer to the contact information of the Editorial Office.

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Ethical considerations will be taken into account in the assessment of papers that have experimental investigations of human or animal subjects. Authors should state clearly in the Materials and Methods section of the manuscript that institutional review board has approved the project. Those investigators without such review boards should ensure that the principles outlined in the Declaration of Helsinki have been followed.

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These include controlled trials, interventional studies, studies of screening and diagnostic tests, outcome studies, cost-effectiveness analyses, and large-scale epidemiological studies. Manuscript should include the following; introduction, materials and methods, results and conclusion. The objective should be stated clearly in the introduction. The text should not exceed 2500 words and references not more than 30.

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This section usually consist of invited reports that have significant impact on healthcare practice and usually cover disease outbreaks, management guidelines or policy statement paper.

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Audits of relevant topics generally follow the same format as original article and the text should not exceed 1,500 words and references not more than 20.

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Case reports should highlight interesting rare cases or provide good learning points. The text should not exceed 1000 words; the number of tables, figures, or both should not be more than two, and references should not be more than 15.

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This section includes papers (i.e. how to interpret ECG or chest radiography) with particular aim of broadening knowledge or serve as revision materials. Papers will usually be invited but well written paper on relevant topics may be accepted. The text should not exceed 1500 words and should include not more than 15 figures illustration and references should not be more than 15.

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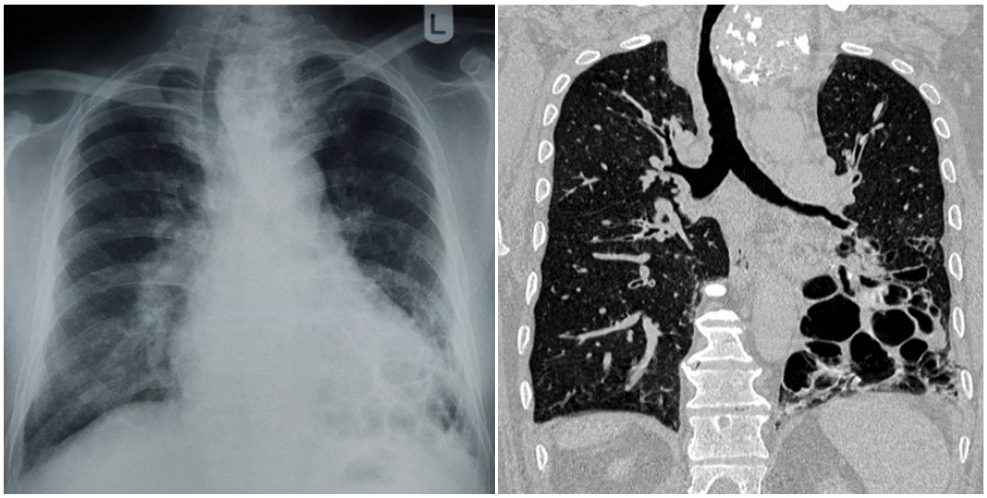

A 68-year-old man, ex-smoker of 15 years presented with worsening of dyspnoea, hoarseness and cough productive of greenish sputum that was worst in the past one week. His medical history included hypertension, diabetes mellitus, bronchial asthma and a neck swelling diagnosed two years previously for which he declined any surgical intervention. Examination revealed mild respiratory distress, neck swelling and coarse inspiratory crackles both lower zones, left more than right. Imaging (chest radiography and computed tomography scan) are shown as above (Figures). Previous chest radiography at diagnosis of the neck swelling did not show any chronic pulmonary changes.

What are the diagnoses?

Answer**: refer to page **23

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DISCLOSURE: There is no conflict of interest and consent has been obtained from parents for use of these images.

(Refer to page 22)

ANSWER: CYSTIC BRONCHIECTASIS AND RETROSTERNAL GOITRE

This patient has cystic bronchiectasis of the left lower lobe and a goitre with retrosternal extension causing tracheal compression and deviation. He was treated with a course of intravenous antibiotic and frequent pulmonary suctioning to clear the secretions.

Bronchiectasis refers to the permanent destruction and dilatation of the airways in focal/diffuse manner.[1, 2] It is classified into fusiform, saccular and cystic form. Causes include pulmonary infections that can be acute but more commonly chronic such as pulmonary tuberculosis and recurrent aspiration causing localised bronchiectasis, and immune deficiency state and less common genetic (cystic fibrosis), autoimmune or rheumatologic aetiologies causing diffuse bronchiectasis. The underlying pathogenesis include inadequate clearance of mucus secretion and infection resulting in chronic inflammatory damage and this often results in a vicious cycle of excessive bronchial inflammation, bacterial colonisation and infection.[1, 2] In our case, it is possible the retrosternal goitre contributed to the pathogenesis. Tracheal compression may affect swallowing resulting in aspiration and biliary clearance, resulting in recurrent infections.

Patients with bronchiectasis are clinically characterised by a chronic, productive cough and infectious exacerbations. Bacterial colonisation is common and include *Pseudomonas aeruginosa*.[1-3] Recurrent infections lead to further damages and destruction of the pulmonary parenchyma, resulting in eventual respiratory failure and associated complications (pulmonary hypertension, cor pulmonale and progressive deterioration).

Patients should be compliant with postural pulmonary drainage, treatment, follow up and avoid any pulmonary risk factors such as smoking. Annual vaccinations (influenza and pneumococcal) are recommended. Infective exacerbations need to be treated promptly and adequately, and for some patients, long-term antimicrobial such macrolides may be considered.[1-3]

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