Reviewer 2 v.1

Comments to the Author

This study mainly represents an interrogation of a database of people diagnosed with bronchiectasis. There are no clinical datails about the patients other than their co-morbidities. We don't know if they had severe bronchiectasis before they contracted COVID. This would be based on their exacerbation frequency, FEV1, HRCT thorax and P aeruginosa in their sputum. Also bronchiectasis aetilogy is the end result of a number of different processes- 40% idiopathic, post-infectious, immunodeficiency, reflux, dysphagia, congenital causes and chronic airway diseases. Which of these would be most vulnerable to COVID? A major limitation of this study is that 57% have COPD and this makes it more a COPD study. We already know that these patients get more severe COVID. 50% of COPD patients attending hospital clinics have secondary bronchiectasis. Also 62.1% of patents have asthma - this is considerably higher than any previous aetiological /co-morbidity study of bronchiectasis before. Also the prevalence of asthma is not higher in COVID-19 patients. In fact asthmatics may be protected from COVID -19 (Curr Opin Pulm Med 2021 Jan;27(1):45-53.) Also linear regression analysis would have to be done on this population to make certain is not the co-morbidities that is causing the increased prevalence and severity of COVID. Final point -how can patients need more oxygen, ECMO, have a higher mortality but not need an elevated ICU admission rate. Was there an age cut-off for COVID-19 patients to ICU?