INTRODUCTION

Chronic cough is cough that has persisted longer than two months. It affects 1 in 10 Australian adults. This common ailment can impede quality of life and become a daily nuisance when standard treatment implemented for diagnoses such as asthma, sinusitis, post nasal drip and gastric reflux do not alleviate the cough. Persistent cough management often involves identification of the multifactorial aetiology of cough and then addressing the causes with a multidisciplinary approach.

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Chronic Cough

Information for GPs

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WHAT IS CHRONIC REFRACTORY COUGH?

Chronic refractory cough (CRC) is defined as a cough lasting more than 8 weeks that persists despite guidelines based treatment.

CRC is typically non-productive and there is often a preceding history of viral respiratory tract infection. Patients frequently describe a dry, irritated cough which may be localised to the laryngeal region.

WHAT ARE THE COMMON CAUSES?

Factors contributing to CRC can be divided into conditions affecting the upper and lower respiratory tracts. Often the aetiology can be multifactorial with more than one pathology present.

A history of dyspnoea, smoking, productive cough or constitutional symptoms may point towards lower respiratory tract pathology including asthma, infection or neoplasm.

Sinonasal symptoms, post nasal drip, throat irritation or associated dysphonia may be present with the common upper respiratory tract causes including rhinosinusitis, allergy and laryngopharyngeal reflux.

Laryngopharyngeal reflux (LPR) is a common cause of CRC and may be present without symptoms of classic gastro-esophageal reflux disease (GORD) including heartburn (silent reflux). There is an increasing awareness of neural hypersensitivity (laryngeal cough hypersensitivity syndrome) as a contributor to chronic cough and its pathophysiology has features in common with neuropathic pain syndromes.

Obstructive sleep apnoea syndrome (OSAS) has also recently been identified as an independent risk factor for chronic cough and a risk factor for LPR / GORD recalcitrant to medical therapy. ACE inhibitors are another common cause of CRC which can occur spontaneously even after many years on this medication without previous problems.

WHAT ARE THE BASIC TREATMENTS?

Treatments should be initially symptom directed. Empiric treatment of lower respiratory causes including asthma should be tried. Simple investigations including pre and post bronchodilator spirometry and chest x-ray can assist with diagnosis.

Potential laryngopharyngeal reflux is best managed with a minimum 6-week trial of medical therapy (PPI + Gaviscon) along with strict anti-reflux dietary and lifestyle modification.

A 6-week trial of topical saline rinses and steroid sprays are recommended for patients with sinonasal symptoms with consideration of imaging of the sinuses if these symptoms persist.

Consider changing ACE inhibitors for a different class and always ask about a history of snoring and tiredness which may warrant further investigation for OSAS.

WHEN SHOULD I REFER TO A SPECIALIST?

Specialist referral is indicated for CRC when the patient has not responded to empiric management. Referral to either Respiratory or ENT specialists is indicated depending upon whether the patient's symptoms point to an upper or lower respiratory aetiology.

If the patient has had no improvement with basic treatments and their cough has persisted for twelve weeks or more, they then can be referred to our multidisciplinary Woolcock Cough Clinic.

HOW DO I REFER TO THE WOOLCOCK MULTIDISCIPLINARY COUGH CLINIC?

Referrals can be emailed to **reception@woolcock.org.au** or faxed to **02 9114 0010**.

A detailed history including previous investigations is preferable. Patients will be sent a screening questionnaire which will allow us to triage to either a respiratory physician, ENT surgeon or our multidisciplinary Woolcock Cough Clinic (ENT, Respiratory and Speech Pathology).

WHAT SHOULD I DO BEFORE REFERRING?

The following checklist may be useful prior to referral:

1. Is the patient on an ACE inhibitor? *If so – consider changing class of medication*
2. Has spirometry been performed?
3. Has the patient had a trial of therapy for asthma?
4. Has the patient had a chest x-ray?
5. Has the patient had a trial of antireflux therapy (dietary/lifestyle modification and/or medical therapy)?
6. Have sinonasal symptoms been adequately treated?

WOOLCOCK COUGH CLINIC

Our team of medical specialists work together to provide an integrated care and management plan for patients with troubling symptomatic cough that has persisted longer than twelve weeks.

Our clinic aims to serve as a convenient 'one stop shop' for patients to attend a multidisciplinary medical assessment.

Contact our clinic on **02 9114 0000** for more information.

The Woolcock Institute of Medical Research is a not-for-profit organisation.

If you are interested in further information about becoming involved in our research studies or donations, please visit our website **www.woolcock.org.au**.

Your contribution will make a difference.
Thank you for your support.