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Guideline Implementation and Referral Management of Patients with Chronic Cough

Announcer:

Welcome to CME on ReachMD. This episode is part of our MinuteCME curriculum.

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Dr. Taliercio:

Hi, my name is Rachel Taliercio. I'm a pulmonologist at the Cleveland Clinic and will be discussing the guideline implementation and referral management of patients with chronic cough.

I'd like to start by reviewing the patient experience. Chronic cough is common with a global prevalence of 10-12%. In most studies, it is defined as a cough duration of at least eight weeks and a majority of patients have been coughing for years. Patients that I see in my clinic have often been coughing for decades. Patients will often tell me, and this is well reported in the literature, that they feel dismissed by the healthcare providers and by the healthcare system as a whole. The cough is considered a symptom and not a condition that requires treatment, something that they should just live with. They feel stuck in the healthcare system. Most patients see numerable specialists and still haven't felt relief from their coughing. Social isolation in patients is almost universal, especially with the COVID pandemic. Patients fear that the public and friends and family will think that they have an infectious condition that's contagious. Also, there's a huge economic impact with the healthcare utilization and missed days from work. Chronic cough has a significant impact on quality of life.

Additionally, these patients, often there's a lag between the onset of the cough and the time to resolution. Primary care providers are often the front line and handle the cough as a primary complaint. And patients often see, again, a lot of specialists to try to get resolution of their cough. We'll talk about the balance of testing and not over-testing. So, there are some tests that most patients will have in the evaluation, and you want to take a detailed history and figure out what tests make the most sense. It's not uncommon for patients with chronic cough to have a multitude of test at a high cost, again, a high healthcare burden, and often they get the same test more than once without resolution of the cough. So here are the chronic cough guidelines that were published in CHEST and updated in 2018. It's got a nice algorithm to follow when evaluating patients, starting with assessing for red flags and these are patients who have been coughing for eight weeks or more. This is a dry cough in never smokers who aren't on any medications that can cause coughing. So, in that patient population, the four most common causes of cough are upper airway cough syndrome. So, this is akin to postnasal drip from irritant, vasomotor, allergic, non-allergic rhinitis, also follows the spectrum of sinus disease, asthma including cough-variant asthma, the condition of non-asthmatic eosinophilic bronchitis which can cause confusion for clinicians and patients. Non-asthmatic eosinophilic bronchitis is airway inflammation without bronchospasm. So, these patients have a normal spirometry. They don't have a bronchodilator response to albuterol, and they often have a very high exhaled nitric oxide level. The fourth most common cause is gastroesophageal reflux disease. So, you're going to take a dedicated detailed history, assess for red flags, and think about the four most common causes. Based on the most likely condition, you can initiate empiric therapy. So, for upper airway cough syndrome, most likely that's going to be an intranasal medication. The patient should see a response within a matter of weeks. For asthma, it's usually going to be some form of inhaled steroids, of course. Sometimes patients require systemic steroids. Systemic steroids, the cough should be better

within days. Inhaled steroids, within a couple of weeks. Non-asthmatic eosinophilic bronchitis is treated with inhaled steroid therapy, should get better in a couple of weeks at most. And then if you think that the patient has active reflux-causing cough, you initiate therapy with acid suppressants or a PPI. So, it's important to collaborate on a treatment plan with the patient. Set expectations and have a plan for follow-up. You're going to pick a common cause based on what's most likely, initiate empiric therapy, reassess in about four to six weeks, and the CHEST will have guidelines on further investigations to consider. Patients with chronic cough should have had a minimum of a chest x-ray within the prior year. It is very reasonable to have all of these patients undergo spirometry with bronchodilator, an exhaled NO, and then start with that testing based on those results and what you think is most likely. Additional testing may be required. And, of course, you can involve specialty care in the management.

So here are the guidelines from the European Respiratory Journal updated in 2020. What I appreciate about these guidelines is the recommendation for using a scale system. I find this helpful in clinic. So, you ask patients on a scale of 0-10, with 0 being no cough and 10 being the cough at its worst, where has the cough been in the weeks prior to the evaluation? You will often be surprised by the response, and you can use this to help gauge the burden and the severity of the cough and then also follow response to treatment. So, at every visit, we ask the patient to use this scaling or scoring system, and it's a more objective way of assessing treatment response. In these guidelines, they have the consideration of neuromodulator therapy. This would be particularly when the cough is refractory and you've assessed for common causes, maybe you've done impaired treatment trials and the cough is not responding, there's some recommendations for additional evaluations when needed. I caution you in using low-dose opiates in this patient population because of the risk of dependency.

Lastly, just another way of looking at the steps in chronic cough management. Again, your initial clinical evaluation. Assess for the most frequent causes. Treat for those most frequent causes, what you think is most likely. Consider other conditions that could be causing the cough or contributing to it and then consider refractory chronic cough. This is where we often use neuromodulators, behavioral cough suppression therapy, and there's a lot of exciting drug development in this area. I hope that you have seen that there's a systematic way to assess patients with chronic cough, initiate empiric treatment, and then follow up. Thank you.

Announcer:

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