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Management of Chronic Cough: Pharmacological and Nonpharmacological Modalities to Enhance the Patient Experience

Announcer:
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Dr. Dicpinigaitis:
Hello, my name is Dr. Peter Dicpinigaitis. I'm a Professor of Medicine at the Albert Einstein College of Medicine, and I'm the director of the Cough Center at Montefiore Medical Center in New York. Our topic today is the management of refractory chronic cough. What are our current options? It's important to start with definitions. The definition of chronic cough is simply a cough that has been present for more than eight weeks. However, a refractory chronic cough is defined as a chronic cough that persists despite appropriate therapeutic trials aimed at the known underlying causes of chronic cough.

There are three main underlying ideologies of chronic cough and those are, number one, what we now call Upper Airway Cough Syndrome, but more commonly known as Post-Nasal Drip Syndrome, or rhinitis. The second group of ideologies are the airway eosinophilic syndromes, such as asthma, and the entity known as non-asthmatic eosinophilic bronchitis. And lastly, GERD, acid, and non-asset reflux. It's very important to thoroughly evaluate and treat for these underlying potential causes of chronic cough in our patients presenting with chronic cough.

The reason it's so important to do a thorough evaluation for underlying causes is that if our patient with chronic cough does not respond to appropriate therapeutic trials, then it's appropriate to enter the diagnosis of refractory chronic cough. And unfortunately, for refractory chronic cough, we have no particularly good, safe, effective interventions, and all of the drugs we do use are in fact off label. The first of those would be narcotics. And of course, narcotics are not a particularly satisfactory option for a problem that may require chronic therapy. In the United States, we tend to use hydrocodone or codeine in our cough preparations, and in the UK, morphine is more commonly used.

There is in fact one randomized controlled trial looking at low-dose morphine in chronic cough patients published back in 2007, and that study showed that a low dose of morphine was actually effective and well tolerated by patients. In the United States, we more commonly use two so-called neuromodulator agents for cough, amitriptyline, and gabapentin. Amitriptyline many of you will recognize as an old tricyclic anti-depressant drug, but it also has efficacy in chronic cough. And those studies were first done in the 1990s and early 200s showing that amitriptyline can in fact be effective for cough, especially a cough that followed a viral infection. And in those days, that type of cough was given titles such as sensory neuropathic cough or post-viral vagal neuropathy, and we now call this entity of hypersensitized cough reflex the Cough Hypersensitivity Syndrome.

So, in my practice, if I'm going to use amitriptyline against chronic cough, what I do is I start with a course of 10 milligrams nightly for one month and then I reassess. If the dose is tolerated and there's either no effect or a partial effect, then I'll try a 25-milligram nightly dose for another month to assess if there's any effect against cough.

The next neuromodulator drug that is used is gabapentin. And in fact, for gabapentin, there is one randomized control trial showing its efficacy in chronic cough, and that was published back in 2012 in the "Lancet." In this study, the authors used a particularly large dose of gabapentin aiming to achieve 600 milligrams three times daily. But in my experience, gabapentin, even at much lower doses, causes a great degree of sedation. So, my goal is to achieve a 300 milligram three times daily dose, which I start gradually with just a nightly dose, and then up to a twice-daily dose and then a three times daily dose gradually if tolerated. Unfortunately, my experience with gabapentin has been poor in that patients have to both get a cough suppressant effect from the gabapentin, but also tolerate the dose of the drug that achieves that antitussive effect.

We've learned over the last decade that the speech-language therapist or the speech-language pathologist can be a very important member of the chronic cough management team. And in fact, there are now multiple good studies, including a randomized control trial, showing that speech-language pathology in addition to pharmacological therapy can be a useful adjunct for refractory chronic cough. The problem is that unfortunately, there are few speech-language pathologists who are interested and an expert in the treatment of chronic cough, and hopefully, there'll be more of those healthcare professionals entering the field to help us out with this particularly difficult patient group. So, unfortunately, most patients will not respond to these interventions. Some patients will respond to some of these interventions. So, therefore, since we don't have good options for refractory chronic cough, again, it becomes very important for us to make sure that we rule out reversible causes of chronic cough before we render the diagnosis of refractory chronic cough. Thank you for your attention.

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