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Navigating Symptom Reporting Variability by Patients with Chronic Cough

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Dr. Dicpinigaitis:
Hello and welcome to our multidisciplinary expert panel on chronic cough. My name is Peter Dicpinigaitis, I'm a Professor of Medicine at the Albert Einstein College of Medicine in New York and Director of the Montefiore Cough Center. I'm joined by two of my colleagues, Dr. Michael Blaiss. Michael, can you introduce yourself?

Dr. Blaiss:
Sure, Peter. And I am Dr. Michael Blaiss as mentioned. I'm a clinical professor at the Medical College of Georgia at Augusta University in Augusta, Georgia. I'm also the Executive Medical Director of the American College of Allergy, Asthma, and Immunology.

Dr. Dicpinigaitis:
Thanks, Michael. And we're very happy also to have Rachel Taliercio with us.

Dr. Taliercio:
Hi everyone, I'm Rachel Taliercio. I am Vice Chair in the Department of Pulmonary Medicine. I'm also the Institute Experience Officer for the Respiratory Institute and Director of Cough Clinic at Cleveland Clinic.

Dr. Dicpinigaitis:
Well, I'm so happy to have you guys on board to speak about chronic cough because you are both subspecialists. Michael, you're allergist. Rachel, you're a pulmonologist and you are receiving chronic cough referrals from the outside. So, I guess my first question is, Michael, from where are you getting your referrals? Is it primary care or is it subspecialists? Is it self-referrals? What's your experience been?

Dr. Blaiss:
So mostly I get it from primary care. So, family practitioners, a lot of nurse practitioners also refer these patients to me. not so much from other specialists.

Dr. Taliercio:
So, Peter, my experience is somewhat similar to Michael's. I get a lot of referrals from primary care. I also get referrals from specialists, colleagues of mine who are pulmonologists, or pulmonologists outside of our healthcare network. And I have a fair number of patients who find us online and are self-referred.

Dr. Dicpinigaitis:
And I'm finding that too at my cough center. Each year it seems a higher percentage of patients are coming to me because they found us online and not because they were sent over by a physician. The chronic cough patient is a very motivated patient. When we talk

about chronic cough, we're always taught to first, when we meet a chronic cough patient treat the underlying cause not the cough. And we're taught that the big three underlying reasons for chronic cough are postnasal drip syndrome which we now call upper airway cough syndrome, asthma, reflux. Rachel, is there any predominant type of patient you are seeing in terms of underlying ideologies or maybe no underlying ideology?

Dr. Taliercio:
So, it's a bit of a mix. Well, I see a lot of refractory and unexplained chronic cough, I also see patients who have much more common reasons for their cough, including asthma and nonasthmatic eosinophilic bronchitis. The latter of which is important in particular because those patients often have normal breathing tests. And so, you don't necessarily find, you don't see obstruction on the breathing test. I don't see as much reflex in my clinic. I think there's somewhat of a referral bias there because if they have reflex-induced cough, it often gets better, and they don't come to me. So, I see some sinus conditions and some pulmonary as well.

Dr. Dicpinigaitis:
Michael, what kind of profile are you having referred to you?

Dr. Blaiss:
Yeah, so typically I'm referred to by MPs and family dogs to rule out allergy or upper airway cough syndrome as far as the cause of their problem. And I would say that's probably the vast majority. I also get a fair number where they're concerned that in fact, it's asthma that may, in fact, be causing their problem and therefore will work up that. And in some cases, I will see some patients with GERD, but it's usually pretty much, I'm getting that history of GERD and the other things I've been trying to rule out that you've talked about the upper airway cough syndrome, asthma. I've already ruled them out and then I'm going, well, maybe it is the GERD symptoms that the patient is having.

Dr. Dicpinigaitis:
So, I wonder, both of you are seeing a large majority of patients being referred to you by primary care physicians. So, I'm curious whether you're finding that the patients are referred to you too early, too late in the process. I guess in other words, the question is, how much of a workup do you think the primary care physician should do before they refer to a subspecialist like you? What would you say to that, Michael?

Dr. Blaiss:
So, I think most of the time I'm not seeing a major workup by the primary care doctors, which I think they can and in fact do, especially when we're talking about some of the basic types of things whether just even a chest x-ray and spirometry. So, I do think that there are definitely, this is a condition that in fact a lot of the things that we look at can be easily done by a primary care physician.

Dr. Dicpinigaitis:
Rachel, what are you seeing in Ohio?

Dr. Taliercio:
Yeah, I continue to be surprised by what you could describe as the lateness of the referral or the cycle of multiple specialists that these patients have gone through. It is not uncommon in my clinic, even if they're referred by primary care that they've already seen allergy and GI and a different pulmonologist. And so, they're kind of going through all these different clinics. And to Michael's point, I think sometimes the basic workup is missed and we're looking for the zebra when it's a field of horses, so to speak. So, you really have to go back to the basics and do a very good history, the testing that's necessary and determine the cause.

Dr. Dicpinigaitis:
Yeah, I'd have to agree. I mean, I run a subspecialty cough center as do you and I am surprised and disappointed sometimes at that the fact that even the most basic first steps of the workup aren't done until they come to a subspecialty clinic. So, I guess the question is, is there a model type of multidisciplinary approach to the chronic cough patients? It's certainly not one size fits all with this group but Michael, what's the best combination? It's really primary care then sending over to a subspecialist, I guess given some sort of clinical suspicion.

Dr. Blaiss:
Yeah, I agree with you, Peter. I think that you need that, that person there that in fact can get that initial history, look for all the major causes, and in fact as we talk about in the chest guidelines, the red flags. And then do the appropriate testing whether we talk about upper airway cough syndrome, or asthma, or GERD. And then I think then if there's still a question and I think, well, maybe this is upper airway cough syndrome I'm not sure then to refer to an allergist, or asthma, an allergist or a pulmonologist. But I really think the primary care physician should be the conductor here of that orchestra and then determine it, in fact, where that patient goes to after they do their initial workup.

Dr. Dicpinigaitis:
Yeah, ideally. Now Rachel, you actually fairly recently set up yourself the cough center at the Cleveland Clinic. Does that mean that you have within the same building or within close proximity all of the necessary subspecialists? In other words, do you have an ENT, a GI, an allergist who are specifically interested in cough to whom you can promptly refer?

Dr. Taliercio:
We do, and we try under the best-case scenario to do a brief interview with the patient before they make the trip because they're often coming from out of town to see if it makes sense for them to see an additional specialty department in addition to coming to pulmonary. So, we try to determine that ahead of time. And if they're here and based on the evaluation they need to see GI, or ENT or. Fortunately, we do have those clinics even just within the same building and have a fair good access for that. So, we use a multidisciplinary approach. And to Michael's point, it's really important to identify who owns it, who's the captain of the ship? And what I worry about and what I see in the care of chronic cough is the kitchen sink approach. So, I'm going to do a quick interview and then treat for the big three, upper airway, lower inflammatory, airway condition, and reflux, and then just hope that the cough goes away. So, the key here in that multidisciplinary approach is a detailed history, looking at the appropriate testing. and then determining which empiric treatment trial makes sense

Dr. Dicpinigaitis:
And move the algorithm along promptly because oftentimes patients maybe have one step done, then months go by before the next step, and then next thing you know the cough's gone on for two or three years. We talk a lot about treating with drug trials, but there's also non-pharmacological approaches that can help. For example, I always give my patients a long talk about non-pharmacological anti-reflux strategies. Michael, in that same vein, what about the speech-language pathologists' role in the cough treatment team?

Dr. Blaiss:
I think we know that they can be extremely valuable to help these patients where we've diagnosed refractory or unexplained chronic cough. I do think it's important that you have a speech pathologist that in fact does understand about chronic cough and understands what these patients are going through and how best that they can in fact help these patients. So, I do think they're an important partner in these patients that we see with refractory or unexplained chronic cough.

Dr. Dicpinigaitis:
Absolutely. I find them invaluable. Well, thank you so much Rachel and Michael for this very stimulating talk about a very challenging topic, and that is the treatment of the patient with chronic cough. So, thank you very much.

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