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QoL & Healthcare Costs: Optimizing Patient Experience with Chronic Cough

Announcer:
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Dr. Dicpinigaitis:
Hello and welcome to our round table discussion on chronic cough. I'm Peter Dicpinigaitis, I'm a professor of medicine at the Albert Einstein College of Medicine and the director of the Montefiore Cough Center in New York. And it's my pleasure to have with me my friend and colleague, Dr. Rachel Taliercio, who is the founder and director of the Cough Clinic at the Cleveland Clinic in Ohio. Rachel, great to see you.

Dr. Taliercio:
Oh, thanks for having me.

Dr. Dicpinigaitis:
So, we both deal with patients with chronic cough. We know that they're a very difficult group. Could you share with us what have you seen as the greatest challenge and difficulty that these patients face dealing with their chronic cough on a day-to-day basis?

Dr. Taliercio:
Yeah in all of the patients that I have taken care of chronic cough has a huge impact on their quality of life in all domains. So physical, social, economic. What I hear universally from patients in particular is how isolated they feel, what we describe as social isolation in particular since the Covid pandemic. You know, this feeling that their cough is seen by others as something infectious that can be transmitted to people around them. So, it's the social burden, the feelings of frustration, and even anger at still having a cough that won't go away. And in particular the social isolation.

Dr. Dicpinigaitis:
Not to mention the workplace. And also, you know, there's a spouse and family members involved, not just the patient. So, it really, it's unfortunately a far reaching network of quality of life issues. You know, we know that we as physicians when we meet a patient with chronic cough our job isn't to suppress the cough. Our job is to do a thorough evaluation looking for underlying treatable causes of that chronic cough like postnasal drip, asthma, and reflux. You run a cough clinic what have you found are the barriers to patients getting this work up or maybe getting the appropriate treatment trials for potential causes of cough?

Dr. Taliercio:
Yeah, you're absolutely right, Peter. There is this kind of churn through the healthcare system. Lots of office visits, seeing many different specialists for the cough. And I think in particular one of the challenges is, who's taking ownership of the cough and of the evaluation and management plan. Particularly that there are lots of different specialty groups that are often involved. Some of the gaps in care that I commonly see are knowing what questions to ask, the patient's story of their cough, and then how to interpret the test results as they relate to the chronic cough in patients. And also, empiric treatment trials. So, what dose of a medication do you give, for how long, when

do you assess the treatment response? And then making sure to have frequent check-ins with patients so there's not a delay in their care.

Dr. Dicpinigaitis:
And one thing that's very frustrating is you may get the patient to the right physician who knows how to work up chronic cough, and then maybe the patient doesn't have good insurance coverage for those treatment trials. I know you have an experience there.

Dr. Taliercio:
Yes. In particular, when we look at inhaled therapies. So, if asthma is an underlying cause of cough, those medications are terribly expensive for a majority of patients. So, you might find the cause, have a great treatment plan and the medications not affordable.

Dr. Dicpinigaitis:
And same thing with proton pump inhibitors, for example. We often start with twice a day if we think reflux is causing cough and oftentimes the coverage will cover maybe just once a day or maybe not even a PPI. So very frustrating. But even if we do the proper trials and we come up with no reversible cause, then the chronic cough is appropriately diagnosed as a refractory chronic cough.

Dr. Taliercio:
Yes.

Dr. Dicpinigaitis:
And unfortunately, one of the great challenges we face is that there are no and have never been any drugs actually approved for refractory chronic cough. So, we are limited to using really off-label therapy and for refractory chronic cough, the list we have available to us is pretty brief, right? We have opiates, which certainly isn't a satisfactory option for what may be chronic therapy. So, we then are using the so-called neuromodulators like amitriptyline and gabapentin that can be useful in chronic cough but in my experience, have not been very good in terms of efficacy. But also, oftentimes the dose of the drug needed to suppress the cough isn't tolerated from the standpoint usually of sedation. So, unfortunately, we have no good options right now but at least I can give some positive news in that the last five years or so have been very active in the cough world and they have now are undergoing multiple clinical trials of new antitussives are going on. In fact, we just had the completion of the first-ever phase three study of a chronic cough drug and we have several other so-called P2X3 antagonists in the pipeline, as well as several other drugs in the clinical pipeline in phase one and phase two and several getting ready for phase three. So hopefully if we meet again in a year or two or three for a session like this, we'll be able to talk about some of the new drugs available. So, luckily that's exciting and that's good news. But in the meanwhile, we really have to keep in mind that we need to do a thorough workup looking for underlying causes before we get to the diagnosis of refractory chronic cough and therefore have to use these off-label drugs. So, it's a tough group, Rachel to deal with, a very challenging group. What resources have you found most effective in helping you and therefore your patients in going through the chronic cough algorithm and getting to a diagnosis?

Dr. Taliercio:
Yeah, so you mentioned Peter, the feelings of frustration are not just unique to patients, right? So, we as providers are incredibly frustrated at not having the tools that we need to give patients the best care possible. And as you said, we're excited to share with patients that there's a lot of drug development in this area. I think what's been particularly helpful are some of the national guidelines that have been created in terms of the algorithmic approach. You know, we talk about the importance of have a plan, stick to the algorithm, treat every patient the same in terms of what you are expecting in workup. The empiric treatment trials, discussions on expectations has also been very helpful. So, when you have a patient with an unexplained or refractory chronic cough for decades as is often in our practice, what can we, what's our best-case scenario with treatment? We may not get to zero, we may not eliminate the cough a hundred percent, but if we could get 80% better, we agree that that would be a win. And all of my patients have never said no to that. So, I think using the guidelines that are available for the care of these patients, validating that the cough is a condition and sometimes a disease and not just a symptom because these patients often feel dismissed and managing expectations during the visit.

Dr. Dicpinigaitis:
You touched upon some very important points. I'll just echo them that, I explain to patients the plan is not to go to zero on the cough. No one doesn't cough nor would you not to want ever cough, right? So, the plan is to make the cough maybe go from the forefront of a person's every waking minute to maybe a cough in the background that isn't so distressing in terms of affecting day-to-day life. So, you mentioned the guidelines. There are the chest guidelines, the European Respiratory Society guidelines, those are useful. I know there have been a lot of programs also at national meetings, the pulmonary meetings, the allergy meetings. Hopefully soon the internal medicine and family practice meetings, will have symposia on cough. I've noticed that whenever there's a cough-related symposium going on, the room is always standing room only. So, you know, our colleagues want education, they want help on how to deal with this very difficult patient group. So hopefully that will continue ongoing especially as we mentioned, we're going onto this very exciting period

where we may finally get drugs for refractory chronic coughs, safe effective nonnarcotic drugs which is what we've been waiting for. And yeah, I think like you said, persistence, patience, patients, and patients social network, follow the algorithms, and manage expectations, absolutely. Any final thoughts on what to do with that next chronic cough patient that comes in the door for our listeners?

Dr. Taliercio:
I think just to echo what you said, cough is common as a symptom and chronic cough is a common condition, right? 10% of the patients that we see. So, we're all going to be taking care of patients with chronic cough, managing these patients. And it's not just about the patient experience, it's about the provider experience and having a plan, having guidelines, having an evaluation and treatment approach that you can follow so that both you and the patient leave the appointment feeling satisfied, feeling like that you've done your best is a win for everybody.

Dr. Dicpinigaitis:
That's a good point. Maybe from the point of the primary care physician, maybe identify colleagues in pulmonary allergy, ENT, and GI who you feel comfortable referring chronic cough patients to, maybe folks that have expertise or an interest in chronic cough. So, another good point. Yeah. Rachel Taliercio from Cleveland Clinic. Thank you so much for joining me today for this discussion on these tough patients with chronic cough. Thanks so much.

Dr. Taliercio:
Thanks for having me. Take care.

Announcer:
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