Chronic Cough

Learning Outcomes

Describe the management of chronic cough in General Practice

Recognise Red Flags that may indicate significant underlying pathology in patients with a chronic cough

Know when specialist referral may be required

Chronic Cough = Irritable Airways Syndrome

Management of Chronic Cough

1. Manage Triggers

2. Early referral to Speech Language Therapy to address the underlying hypersensitivity

Chronic Rhinsosinusitits

Symptoms: nasal obstruction, rhinorrhoea, hay fever, post nasal drip

Cough often worse in the morning

Cough productive of clear mucus

Trial of nasal steroids, sinus rinses, antihistamines- minimum of 6 weeks

Cough variant asthma

Symptoms: usually a dry cough

Present on waking

SOB and Wheeze may be present but minor

Spirometry can show bronchodilator reversibility

Elevated FENO

Prompt resolution with a trial of steroids

GORD

- Reflux cough usually not related to acid but inhaled gaseous mist
- Triggers: eating, speaking, singing, laughing
- Tickly throat, and persistent throat clearing
- Treat with PPI ONLY if indigestion symptoms
- Treatment aims to improve oesophageal motility
- Azithromycin, Domperidone, Metoclopramide
- Oesophageal manometry/ PH testing is considering fundoplication

Other causes of chronic cough

- Bronchiectasis
- Atypical infection: NTM
- Interstitial lung disease
- Chronic bronchitis
- COPD
- Small airways tumour
- Foreign Body
- Cancer

CXR and Spirometry will pick up the majority of these, but not all…

46yrs Dry cough for 6 months

Dry cough for 6 months

Persistent throat clearing

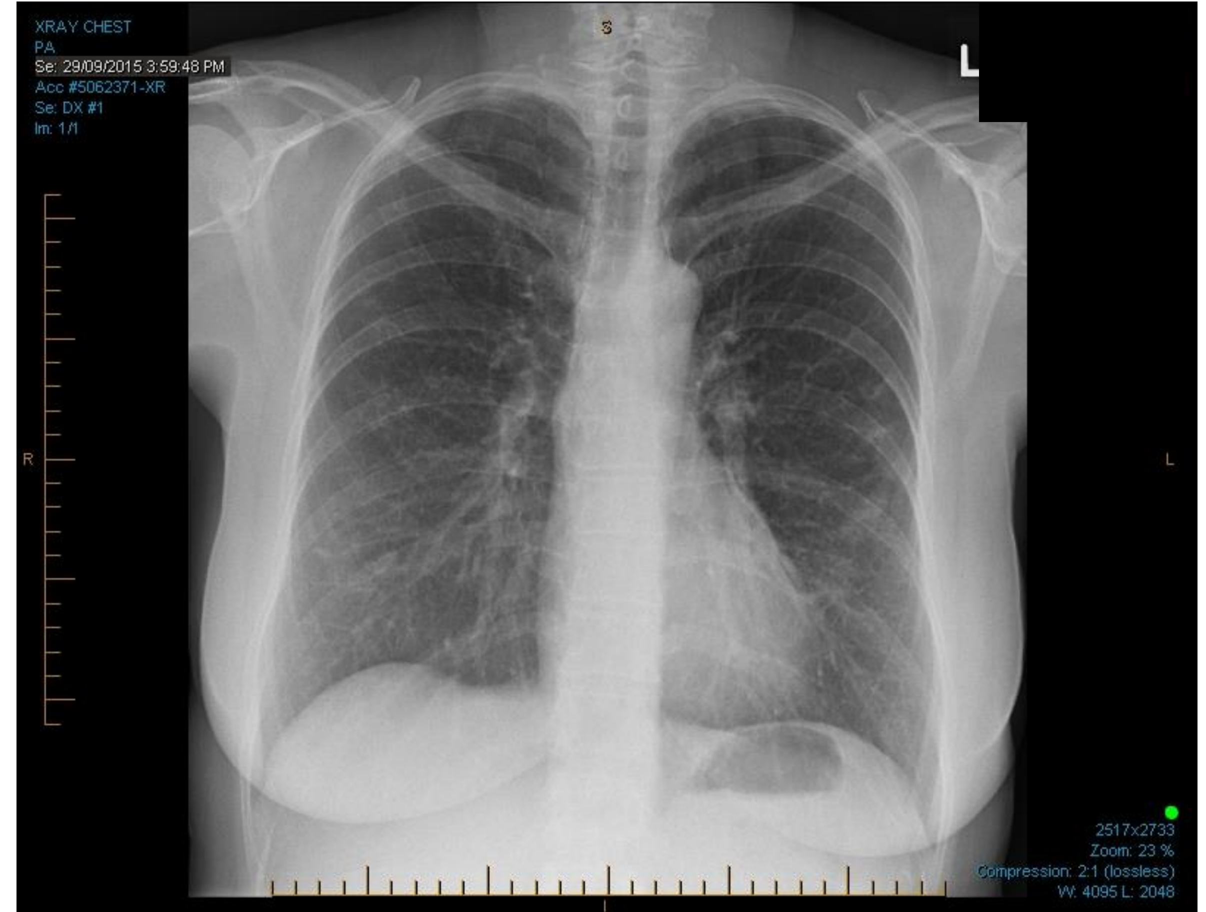
Episodic shortness of breath

Significant anxiety

Daily symptoms of acid reflux

CXR and Spirometry reportedly normal

No response to Flixonase, Omeprazole or Seretide



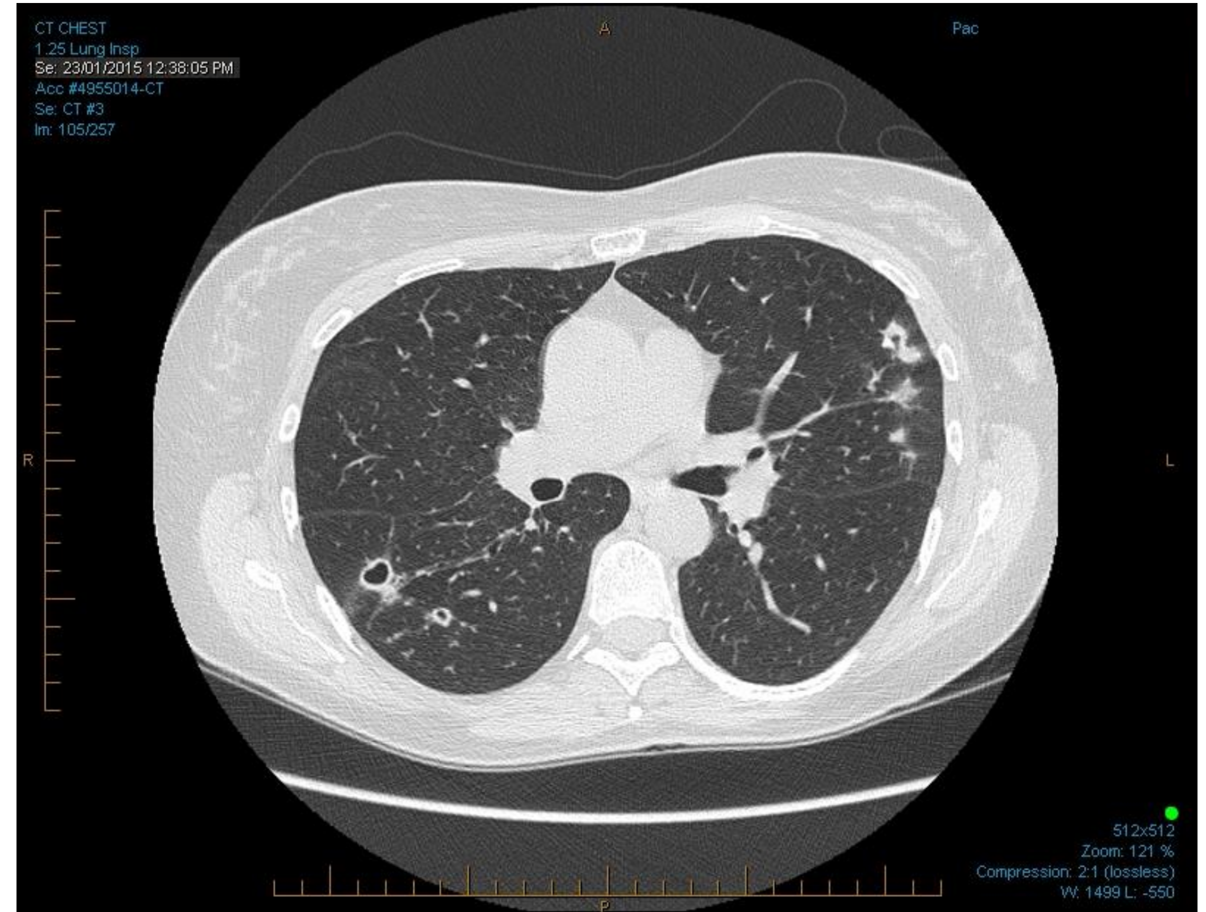
46yrs Dry cough

CT shows widespread cavitating nodules, and tree in bud pattern.

Sputum samples grow Mycobacterium avium

Diagnosed with NTM-pulmonary disease

Started treatment with Rifampacin, Azithromycin and Ethambutol with resolution of the cough.



84 yrs Cough for 6 months

Daily cough

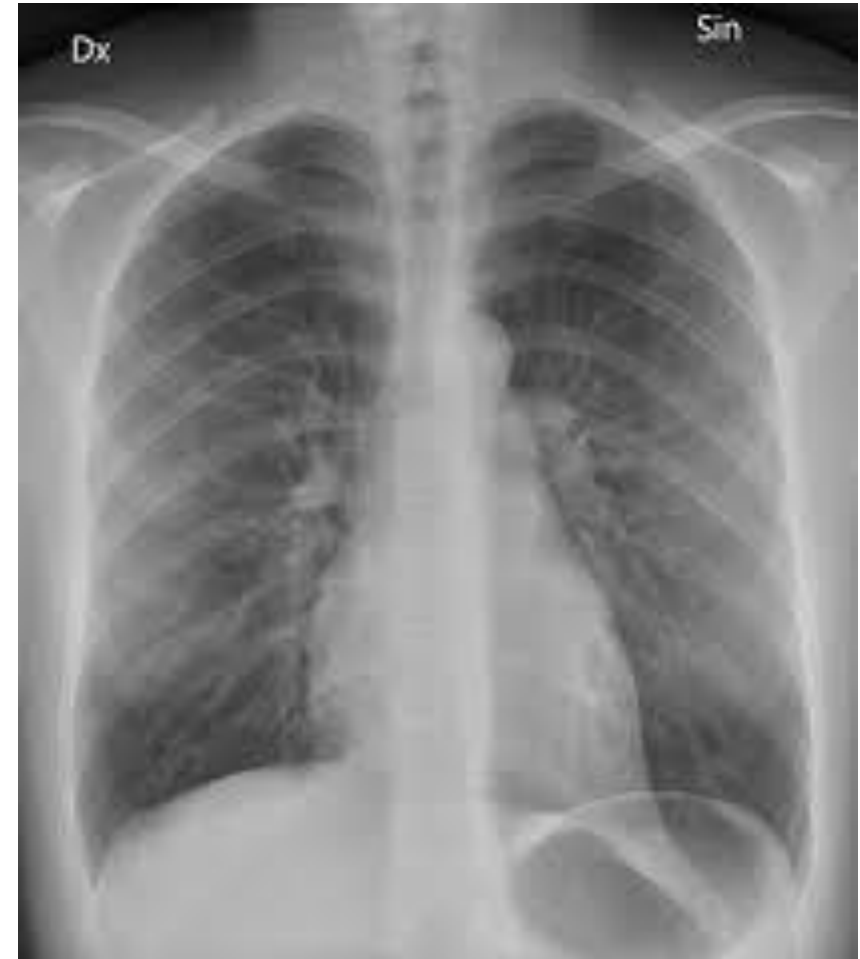
Coughing up 3-4 times/hour

Disturbing sleep

Some clear mucus

Normal CXR

No response to nasal steroids, antihistamines, antibiotics, Prednisone, omeprazole

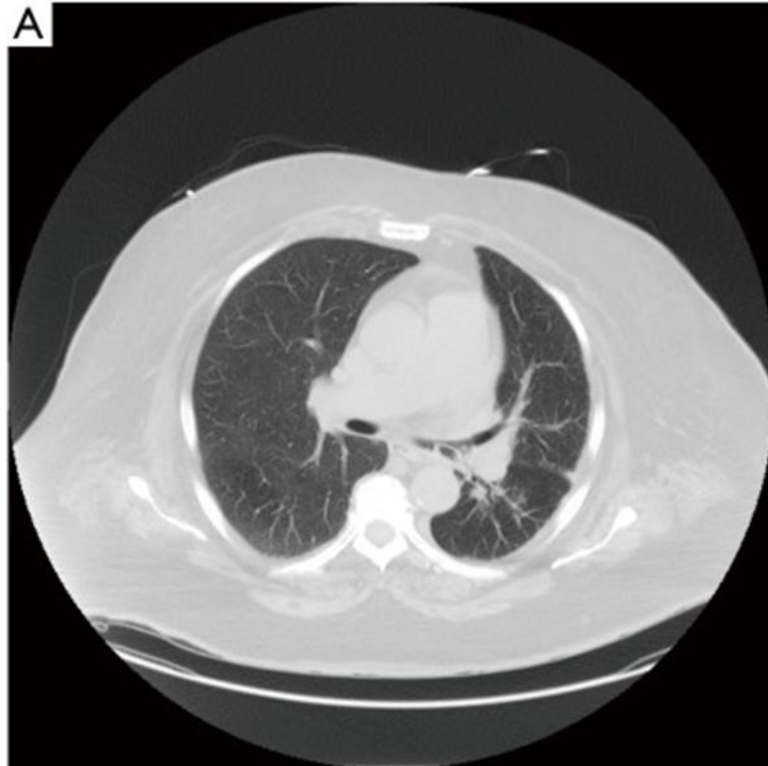


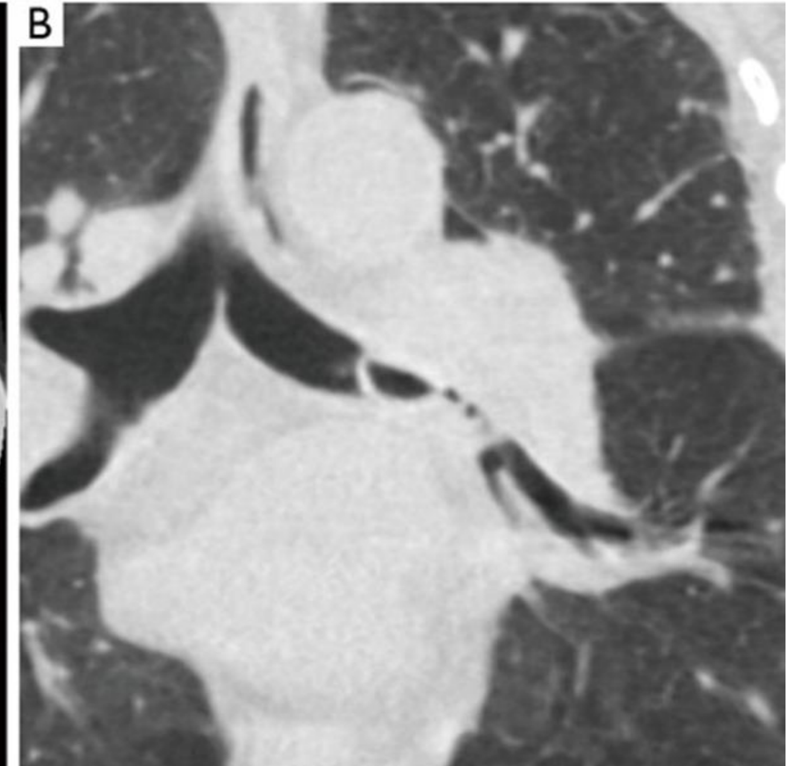
84 yrs Cough for 6 months

Ct Scan- foreign body in Right Main Bronchus

Pistachio nut shell

No recollection of aspiration event





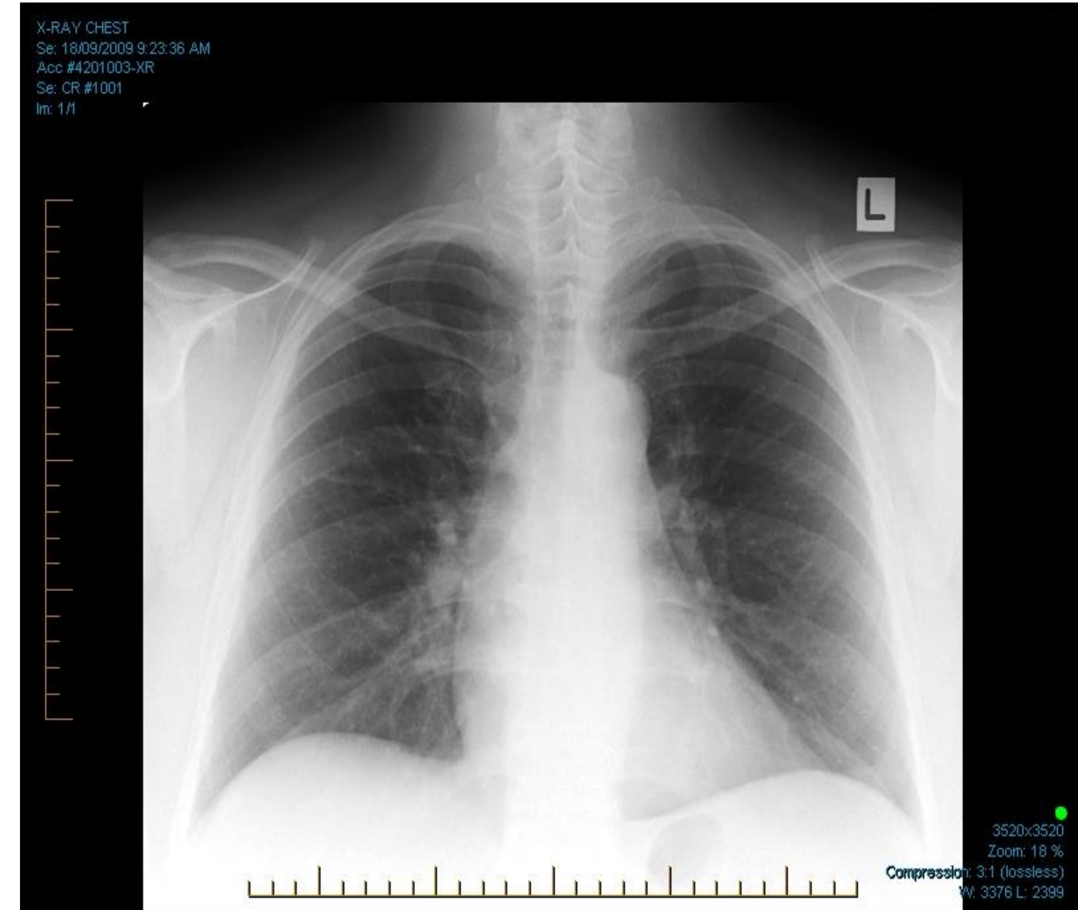
50 yrs old Post viral cough

8 month history of dry cough following a viral URTI
Short of breath on exertion for last 3 months
Wheeze at times but no response to Symbicort
No post nasal drip or GORD
Obese
Disrupted sleep and loud snoring
Past history of breast cancer 10 years prior

Normal CXR
Normal full lung function tests
Sleep study- moderate OSA. ?cause of cough
Cardiopulmonary exercise test- normal

No improvement in cough and shortness of breath with CPAP treatment. Reported weight loss.

CT and bronchoscopy requested

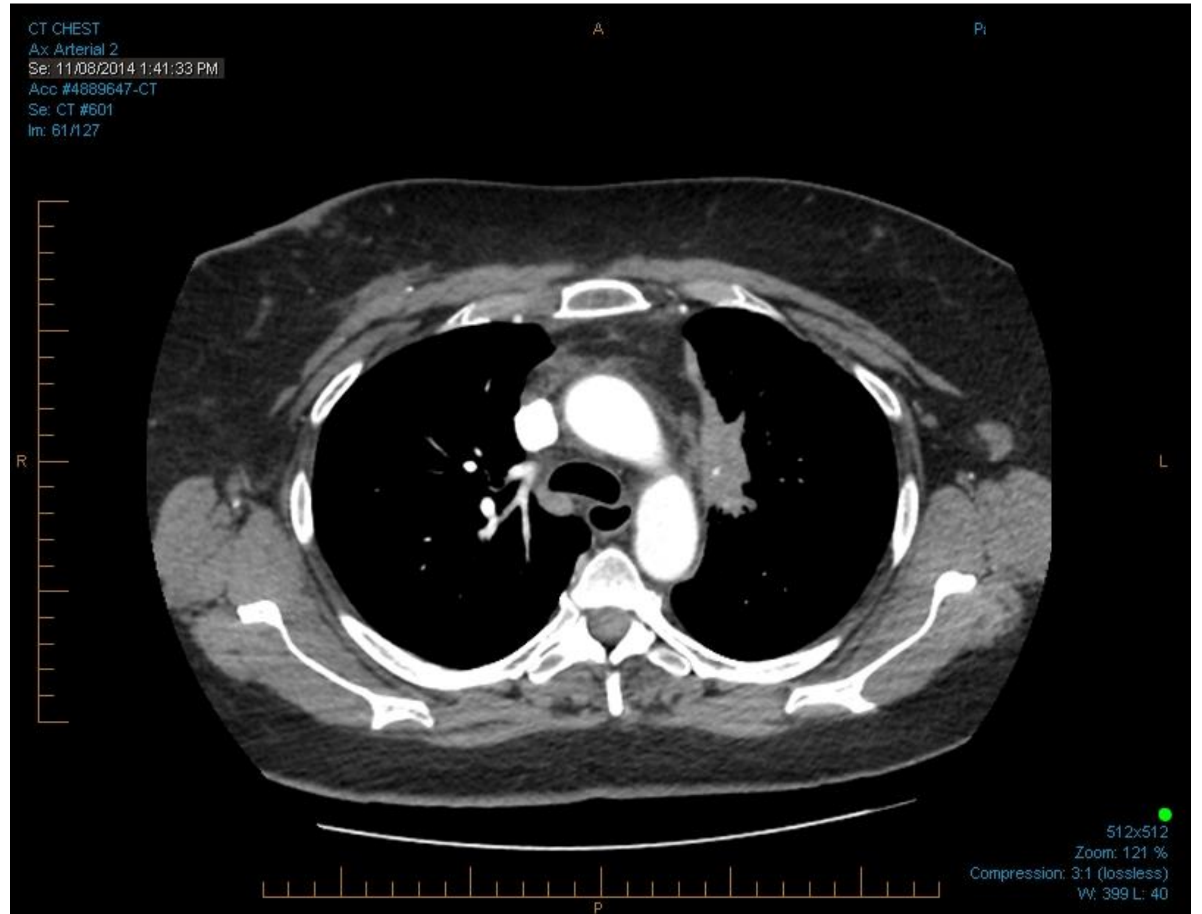


50 yrs old Post viral cough

Ct shows a spiculated mass adjacent to the mediastinal pleura surrounding the left upper lobe bronchus. Large pericardial effusion.

CXR remains normal

Bronchoscopy- Narrowing of the left upper lobe. Biopsies- metastatic adenocarcinoma



Red Flags

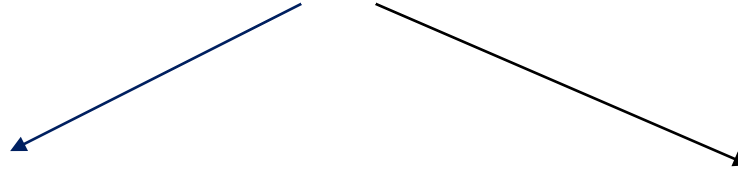
- Recurrent chest infections
- Chronic sputum production
- Weight loss
- Haemoptysis
- Smoker
- NTM phenotype
- Past history of cancer
- Abnormal examination
- Failure to respond to standard treatment despite normal investigations

When to refer to a specialist

- No response to management of rhinitis, atopy, asthma, reflux.
- Need to exclude any pulmonary pathology prior to SLT referral
- Any red flags present- needs CT Chest +/- bronchoscopy
- High levels of patient anxiety

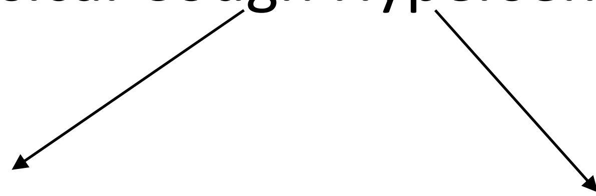
Speech Language Therapy for Chronic Cough

Review history, Examination, CXR, Spirometry



Classical Cough Hypersensitivity

Atypical Cough/ Red Flags



Manage Triggers

SLT

CT Chest +/- Bronchoscopy

Manage Underlying Pathology