



# Tackling the heart sink symptom

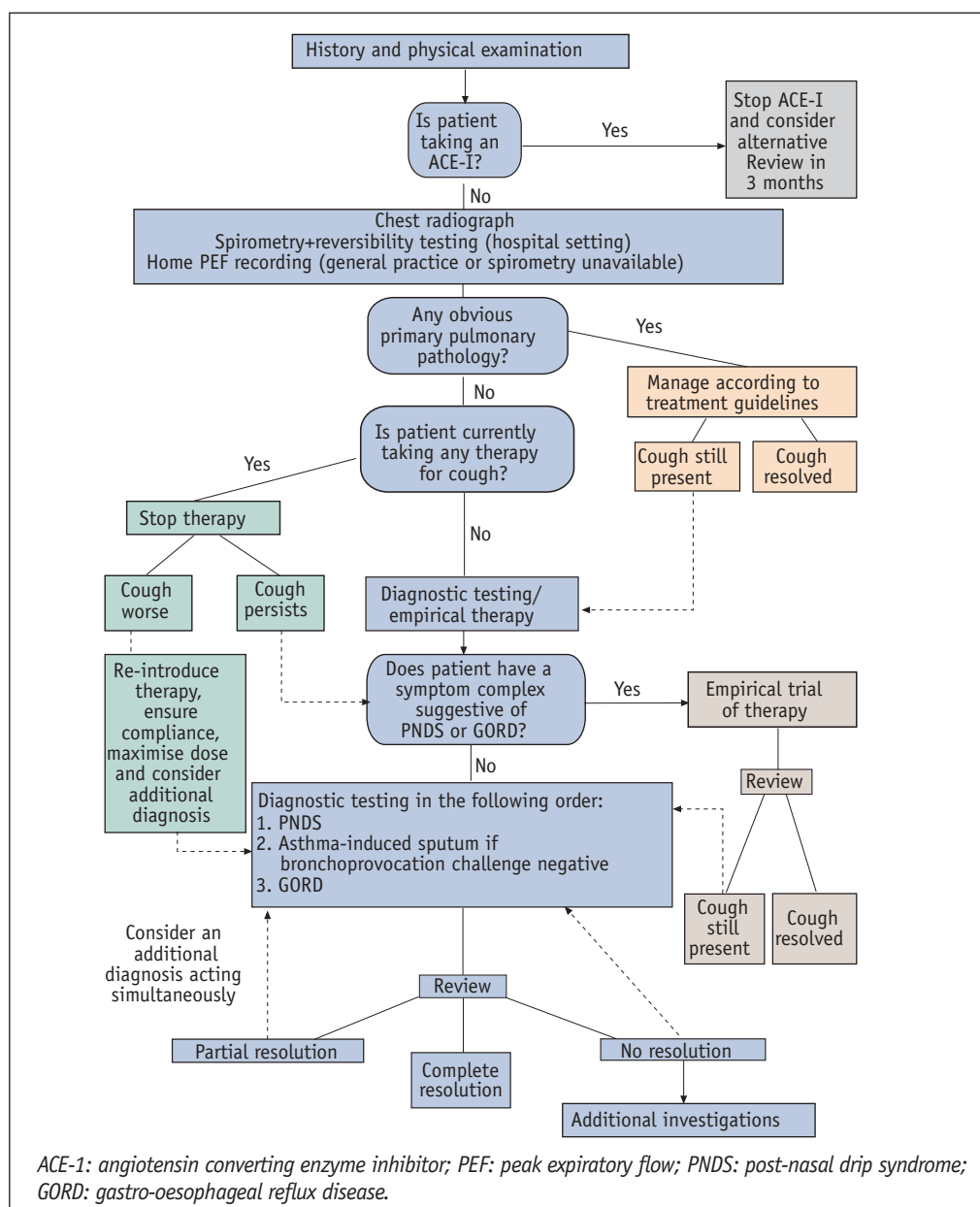
## ERS guidelines on chronic cough

Cough is probably the most common symptom of medical importance. Chronic cough, as defined as a cough lasting >8 weeks, afflicts large numbers of people within the European Union

(EU). The European Community Respiratory Health Survey reports that in excess of 10% of the young adult population complain of chronic cough. We all know that chronic cough is one of

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**Figure 1**  
Overview of the evaluation of chronic cough in an adult.

the most frequent presenting symptoms seen in respiratory clinics, yet the perception among most chest physicians is that chronic cough is an intractable problem that responds poorly to therapy. In contrast to this view, the experience



guidelines to the practicing physician. A simple diagnostic algorithm (see figure 1) has been provided as the first port of call for a clinical problem and, since children and adults are different in the spectrum of disease-causing cough, a separate algorithm is provided for this important subgroup of patients.

The majority of the Task Force members run specialist cough clinics and we, therefore, tend to see a different spectrum of patients than those presenting to the general respiratory physician. We took the view, however, that the guidelines were unlikely to be referred to for what is clearly an asthmatic with a cough; this after all is the bread and butter of respiratory medicine. The guidelines, therefore, concentrate on the patient with isolated chronic cough. Since asthma is the only diagnosis that is usually considered in such patients, we have concentrated on the more exotic forms of asthma, such as eosinophilic bronchitis and, particularly, on the often forgotten and ill understood phenomenon of reflux cough. Gastro-oesophageal reflux is probably the commonest diagnosis seen in tertiary referral, and is often missed because of a failure of the referring physician to understand that the sort of reflux leading to cough is distinct and different from the type of reflux which causes heartburn. In heartburn, prolonged exposure to relatively high concentrations of acid are required, whereas in reflux cough even a brief episode of non-acidic reflux hitting the larynx can make the patient cough. Thus, the guidelines recommend that higher concentrations of proton pump inhibitors (*bd* in my opinion) should be given for a minimum of 2 months. The objective here is to try and totally neutralise stomach acid, since even slightly acidic conditions in the upper aero-digestive tract can precipitate coughing. This is one example of the differences in the management of patients with chronic cough.

We all think we know how to treat the most common causes of chronic cough, reflux and asthma, but when these two conditions produce cough as an isolated symptom, management can be markedly different from the conventional wisdom. Hopefully, these accessible guidelines will contribute to the wider appreciation of this frequently misunderstood subject.

from cough clinics around the world demonstrates that, provided there is an understanding of the aetiology of chronic cough, coupled with an appreciation of the differences in treatment of cough compared with other respiratory illnesses, successful management is possible in the majority of patients.

Recognising the need for further education and guidance in this common problematic area, the European Respiratory Society commissioned a Task Force on Chronic cough. The guidelines that have been produced from this Task Force were published in the September 2004 edition of the *European Respiratory Journal*. The guidelines are brief, covering <10 pages. This was a deliberate attempt to increase the accessibility of the

*The original guidelines can be found in the European Respiratory Journal at [erj.ersjournals.com](http://erj.ersjournals.com) Eur Respir J 2004; 24: 481–492.*

*All ERS guidelines can be found at [www.ersnet.org](http://www.ersnet.org) in the e-Learning Centre.*