CICADA: Cough in Children and Adults: Diagnosis and Assessment. Australian Cough Guidelines summary statement

Raymond J Mullins, Constance Katelaris and Janet Rimmer

TO THE EDITOR: We read the article by Gibson and colleagues on the assessment and management of cough1 with some concern, specifically regarding the authors’ classification of levels of evidence for current therapies for allergic rhinitis. We would agree that a trial of antihistamines, intranasal corticosteroids and allergen immunotherapy is unlikely to help non-specific cough in the absence of allergic rhinitis. This consensus should be distinguished from the beneficial impact of other modalities on symptoms of allergic rhinitis, as recently reviewed2,4-6 — evidence consistent with “weak” evidence of benefit from these is “weak”. Although evidence of benefit from allergen avoidance to help manage allergic respiratory disease is controversial,3 a large number of double-blind placebo-controlled trials of all other modalities show Level I evidence of benefit and category A strength of recommendation specifically for treatment of allergic rhinitis, as recently reviewed2,4-6 — evidence consistent with “strong” recommendations using the GRADE (Grading of Recommendations, Assessment, Development and Evaluation) criteria.7 We do our patients and colleagues a disservice to suggest otherwise.

Competing interests: Janet Rimmer has been on drug advisory boards for Novartis and GlaxoSmithKline and has received reimbursement for travel/accommodation expenses from Schering Plough. She has also received institutional support from Novatech, Novartis, GlaxoSmithKline and Schering Plough for clinical trials work. Constance Katelaris has been on drug advisory boards for GlaxoSmithKline and Nycomed and received reimbursement for travel/accommodation expenses.

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TO THE EDITOR: We read with interest the Australian Cough Guidelines summary statement by the CICADA multidisciplinary group.1 However, we feel that the role of direct examination of the upper aerodigestive tract in assessing cough was underemphasised.

Flexible nasal endoscopy (FNE) is a quick, relatively straightforward examination performed under topical anaesthesia as part of an ear, nose and throat (ENT) consultation.

It allows direct visualisation of the nasal cavities, postnasal space, oropharynx and larynx, and can be performed on adults and older children and also some younger children.2 Nasal causes of cough, and hence the potential role of FNE, appear to have received more emphasis in previous chronic cough management strategies, including those proposed by the American College of Chest Physicians in 20063 and the European Respiratory Society task force in 2004.4

The diagnosis of chronic rhinosinusitis or upper airway cough syndrome (postnasal drip syndrome) is enhanced by direct examination.

The presence of mucopus in the middle meatus of the nasal cavity is associated with a positive diagnosis of chronic rhinosinusitis.1 FNE can also provide direct evidence of the presence of gastro-oesophageal reflux affecting the larynx (laryngopharyngeal reflux), and plays a significant role in the clinical diagnosis of laryngopharyngeal reflux.5 FNE should be used in patients with alarm symptoms for serious underlying disease (as suggested by the CICADA group1), particularly those potentially related to laryngeal causes (hoarseness, haemoptysis, feeding difficulties, stridor or smoking).

As part of a complete examination, FNE can help in targeting therapy for two of the three most common causes of cough in adults (gastro-oesophageal reflux and rhinosinusitis), and in excluding some of the significant causes of cough in both adults and children.

LETTERS
It is particularly recommended in patients with a suspected nasal or laryngeal cause, in those with alarm symptoms, and in those for whom initial therapy fails.

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IN REPLY: The recently published CICADA cough guidelines1 draw attention to the important role of systematic assessment of chronic cough in children and adults, and provide an appraisal of the evidence that treating specific conditions will improve cough. Mullins and colleagues raise a key point that requires emphasis, and is relevant beyond the instance of allergic rhinitis that they cite. Chronic cough is associated with several common conditions, such as allergic rhinitis, asthma, gastro-oesophageal reflux disease and sleep apnoea. For each of these conditions, there are well established treatment guidelines that describe the effectiveness of treating that primary condition.

However, in developing the CICADA guidelines we were considering the effect of the treatments on the symptom of cough, not on the primary condition. It was stated at the bottom of Box 1 (page 266)2 that “The final GRADE recommendations were based on [the votes of committee members] and considered cough in the context of the respective conditions”. We agree that the evidence for treating symptoms of allergic rhinitis per se is strong, as published.2 But in the case of a patient presenting with cough and associated rhinitis, the CICADA group determined that the evidence that treating allergic rhinitis would resolve the cough was weak. It is often not possible to determine from successful trials of immunotherapy for rhinitis the outcome for cough. For example, trials of injectable or sublingual immunotherapy both mention cough only once, and it is not possible to determine the effect of the treatment on this symptom.3,4

We welcome the comments by Potter and Pudel giving more specific details of the role of FNE in assessing the upper airway in people with chronic cough. We agree that this is a quick and useful examination. We believe we have placed greater emphasis on upper airway disorders compared with other cough guidelines. Specifically, we have identified vocal cord dysfunction and sleep apnoea as relevant upper airway disorders that are associated with chronic cough. These conditions are not featured in previous guidelines, yet they respond well to specific therapy. We also devote comparatively more space to upper airway disorders than to lower airway disorders.

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