Complete Summary

GUIDELINE TITLE

Chronic cough due to gastroesophageal reflux disease: ACCP evidence-based clinical practice guidelines.

BIBLIOGRAPHIC SOURCE(S)

Irwin RS. Chronic cough due to gastroesophageal reflux disease: ACCP evidence-based clinical practice guidelines. Chest 2006 Jan;129(1 Suppl):80S-94S. [89 references] PubMed

GUIDELINE STATUS

This is the current release of the guideline.

COMPLETE SUMMARY CONTENT

SCOPE
METHODOLOGY - including Rating Scheme and Cost Analysis
RECOMMENDATIONS
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SCOPE

DISEASE/CONDITION(S)

Chronic cough due to gastroesophageal reflux disease (GERD)

GUIDELINE CATEGORY

Diagnosis
Evaluation
Management
Treatment

CLINICAL SPECIALTY

Family Practice
Gastroenterology
Internal Medicine
Pulmonary Medicine

INTENDED USERS

Physicians

GUIDELINE OBJECTIVE(S)

To critically review and summarize the literature on cough and gastroesophageal reflux disease (GERD), and to make evidence-based recommendations regarding the diagnosis and treatment of chronic cough due to GERD

TARGET POPULATION

Patients with chronic cough due to gastroesophageal reflux disease

INTERVENTIONS AND PRACTICES CONSIDERED

Diagnosis/Evaluation

1. Empiric trial of medical antireflux therapy
2. 24-hour esophageal pH-monitoring
3. Barium esophagography
4. Radionuclide esophageal scintigraphy
5. Esophagoscopy with mucosal biopsy
6. Radionuclide gastric-emptying study with solids

Treatment

1. Antireflux diet and lifestyle modifications
2. Acid suppression therapy
3. Proton pump inhibition
4. Prokinetic therapy
5. Treatment for comorbid diseases such as obstructive sleep apnea or therapy for comorbid conditions
6. Antireflux surgery

Interventions considered but not recommended include assessing for lipid laden macrophages in bronchoalveolar lavage (BAL) fluid and induced sputum, exhaled nitric oxide measurements, Bernstein test, inhaled tussigenic challenges with capsaicin.

MAJOR OUTCOMES CONSIDERED

- Sensitivity and specificity of diagnostic tests
- Rate of cure or improvement of cough

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Hand-searches of Published Literature (Primary Sources)
Hand-searches of Published Literature (Secondary Sources)
Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

The evidence review procedures included section-specific targeted searches as well as a formal systematic review on selected topics.

Formal Systematic Reviews

Formal systematic reviews on selected topics covered in the guideline were performed by the Center for Clinical Health Policy Research at Duke University Medical Center. For the key questions addressed by the formal systematic reviews see the section titled "Methodology and Grading of the Evidence for the Diagnosis and Management of Cough" (see "Availability of Companion Documents" field).

Literature Search Strategy

The Duke University research team conducted a systematic and comprehensive literature review that began with searches of MEDLINE from 1966 through August 2003 with limits of articles published in the English language and with human subjects. Search terms included the medical subject heading term "cough" combined with a published strategy for identifying randomized controlled trials (RCTs). A separate search combined the medical subject heading terms "bronchiectasis," "cystic fibrosis," and "respiratory therapy" with the RCT strategy. However, searches using terms related to the therapeutic use of specific agents, including "antitussive agents," "expectorants," "bronchodilator agents," "ipratropium," "albuterol," "orciprenaline," and "cromolyn sodium" had poor specificity in the absence of the term "cough," and thus were not used. Additional searches were targeted to double-blind RCTs of nonspecific antitussive therapy and protussive drugs (e.g., expectorant, mucolytic, mucus-modifying agents) for all indications other than those listed in question 2 in the section titled "Methodology and Grading of the Evidence for the Diagnosis and Management of Cough" (see "Availability of Companion Documents" field) that reported on cough clearance or cough symptoms and had been published since the previous American College of Chest Physicians cough guidelines were published. The trials identified in this search were provided to the section authors.

In addition to MEDLINE, the Duke University research team searched the National Guideline Clearinghouse and the Cochrane Library (including the Cochrane Database of Systematic reviews, the Cochrane Controlled trial register, and the Database of Abstracts of Reviews of Effectiveness). Additional studies were identified from the reference lists of review articles and by querying experts in the field.

Inclusion and Exclusion Criteria

The criteria for the inclusion and exclusion of articles were developed for each research question and are shown in Table 1 in the section titled "Methodology and Grading of the Evidence for the Diagnosis and Management of Cough" (see the "Availability of Companion Documents" field). The abstracts of all articles were reviewed by two physicians (one with methodological expertise and one with content area expertise), and those meeting the inclusion criteria were selected for review in full text.

Section-Specific Review

Ovid MEDLINE literature review (through March 2004) for all studies published in the English language and selected articles published in other languages such as French since 1963 using the medical subject heading terms "cough," "gastroesophageal reflux," and "gastroesophageal reflux disease."

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Expert Consensus
Weighting According to a Rating Scheme (Scheme Given)

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Quality of the Evidence

Good = evidence based on good randomized controlled trials (RCTs) or meta-analyses

Fair = evidence based on other controlled trials or RCTs with minor flaws

Low = evidence based on nonrandomized, case-control, or other observational studies

Expert opinion = evidence based on the consensus of the carefully selected panel of experts in the topic field. There are no studies that meet the criteria for inclusion in the literature review.

METHODS USED TO ANALYZE THE EVIDENCE

Systematic Review with Evidence Tables

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Note from the National Guideline Clearinghouse (NGC): The evidence review procedures included section-specific targeted searches as well as a formal systematic review on selected topics. Formal systematic reviews on selected

topics covered in the guideline were performed by the Center for Clinical Health Policy Research at Duke University Medical Center. For more information see the section titled "Methodology and Grading of the Evidence for the Diagnosis and Management of Cough" (see "Availability of Companion Documents" field).

Formal Systematic Reviews

Synthesis

Details from "included" articles (see the "Description of Methods Used to Collect/Select the Evidence" field) were extracted and recorded into evidence tables. No quantitative synthesis, such as meta-analysis, was performed, but aggregated data were described and analyzed qualitatively.

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus
Expert Consensus (Consensus Development Conference)
Informal Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

The recommendations were formulated by an international panel of 26 experts representing seven clinical specialties. Many were members of the American College of Chest Physicians (ACCP), but representatives from other medical associations, including the American College of Physicians, Canadian Thoracic Society, and American Thoracic Society, also participated on the panel. These experts convened on several occasions, including a panel conference in Boston, MA, in November 2004, in which they deliberated the final content and recommendations, the rating of the quality of the evidence, the estimation of benefits to the patient population, and the grading of the strength of the recommendations. Authors were selected, or in some cases writing committees were formed, for each topic to review evidence, write an article, and draft guidelines. These assignments were made by the steering committee based on the authors' known expertise in that specific area of the diagnosis and treatment of cough, and their research and writing skills.

The recommendations were graded, by consensus of the panel, using the ACCP Health and Science Policy Grading System, which is based on the following two components: quality of the evidence; and the net benefit of the diagnostic or therapeutic procedure. The quality of evidence is rated according to the study design and strength of the other methodologies used in the included studies. The net benefit of the recommendation is based on the estimated benefit to the specific patient population described in each recommendation and not for an individual patient. The authors of each recommendation proposed their best estimate of the net benefit, and the entire panel considered these choices for each recommendation. At the conference, the panel revised the assessments of net benefit for many recommendations to be consistent across all recommendations.

When there was insufficient evidence, the panel used informal group consensus techniques to refine or develop recommendations based on the expert opinion of the panel. Eighty percent of the panel was in attendance at the final conference to collaborate on the final wording and grading of the recommendations. Even those recommendations that were based on expert opinion were considered to be worthy of inclusion, as they were the recommendations of an international and multidisciplinary team with considerable expertise in the diagnosis and treatment of patients with cough.

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Strength of Recommendations

A = strong recommendation

B = moderate recommendation

C = weak recommendation

D = negative recommendation

I = no recommendation possible (inconclusive)

E/A = strong recommendation based on expert opinion only

E/B = moderate recommendation based on expert opinion only

E/C = weak recommendation based on expert opinion only

E/D = negative recommendation based on expert opinion only

Net Benefit

Substantial = There is evidence of benefit that clearly exceeds the minimum clinically significant benefit and evidence of little harm

Intermediate = Clear evidence of benefit but with some evidence of harms, with a net benefit between that defined for "substantial" and "small/weak"

Small/weak = There is evidence of a benefit that may not clearly exceed the minimum clinically significant benefit, or there is evidence of harms that substantially reduce (but do not eliminate) the benefit such that it may not clearly exceed the minimum clinically significant benefit

None = Evidence shows that either there is no benefit or the benefits equal the harms

Conflicting = Evidence is inconsistent with regard to benefits and/or harms such that the net benefit is uncertain

Negative = Expected harms exceed the expected benefits to the population

Table: Relationship of Strength of the Recommendations Scale to Quality of Evidence and Net Benefits

	Net Benefit					
Quality of Evidence	Substantial	Intermediate	Small/Weak	None	Conflicting	Negative
Good	A	A	B	D	I	D
Fair	A	B	C	D	I	D
Low	B	B	C	I	I	D
Expert Opinion	E/A	E/B	E/C	I	I	E/D

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

External Peer Review
Internal Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

The executive committee of the panel extensively reviewed each section of the guideline manuscript during the writing process. The November 2004 conference provided an opportunity for the entire panel to review the latest drafts. Following final revisions and one final review by the executive committee, each section of the guidelines was reviewed and approved by the Clinical Pulmonary Medicine, Respiratory Care, Pediatric Chest Medicine, Environmental and Occupational and Airways Disorders NetWorks of the American College of Chest Physicians (ACCP), as well as the ACCP Health and Science Policy Committee, and subsequently by the ACCP Board of Regents.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

Note from the National Guideline Clearinghouse (NGC): For full context of the major recommendations stated below, please see the National Guideline Clearinghouse (NGC) summary of the American College of Chest Physician's guideline An Empiric Integrative Approach to the Management of Cough: ACCP Evidence-based Clinical Practice Guidelines, which utilizes a comprehensive approach, including algorithms for the clinician to follow in evaluating and treating the patient with acute, subacute, and chronic cough.

Definitions for the level of evidence, strength of recommendation, and net benefit follow the "Major Recommendations."

1. In patients with chronic cough due to gastroesophageal reflux disease (GERD), the term acid reflux disease, unless it can be definitively shown to apply, should be replaced by the more general term reflux disease so as not to mislead the clinicians into thinking that all patients with cough due to GERD should improve with acid-suppression therapy. Level of evidence, expert opinion; benefit, substantial; grade of recommendation, E/A
2. In patients with chronic cough who also complain of typical and frequent gastrointestinal (GI) complaints such as daily heartburn and regurgitation, especially when the findings of chest-imaging studies and/or clinical syndrome are consistent with an aspiration syndrome, the diagnostic evaluation should always include GERD as a possible cause. Level of evidence, low; benefit, substantial; grade of recommendation, B
3. Patients with chronic cough who have GI symptoms that are consistent with GERD or who fit the clinical profile described in the table below, titled "Clinical Profile That Predicts That Chronic Cough Is Likely Due to GERD", should be considered to have a high likelihood of having GERD and should be prescribed antireflux treatment even when they have no GI symptoms. Level of evidence, low; benefit, substantial; grade of recommendation, B

Clinical Profile That Predicts That Chronic Cough Is Likely Due to GERD

Chronic cough Not exposed to environmental irritants nor a present smoker Not taking an angiotensin-converting enzyme inhibitor Chest radiograph is normal or shows nothing more than stable, inconsequential scarring Symptomatic asthma has been ruled out: • Cough has not improved with asthma therapy, or • Methacholine inhalation challenge is negative Upper airway cough syndrome due to rhinosinus diseases has been ruled out: • First-generation H_1-antagonist has been used and cough failed to improve, and • "Silent" sinusitis has been ruled out Nonasthmatic eosinophilic bronchitis has been ruled out: • Properly performed sputum studies are negative, or • Cough has not improved with inhaled/systemic corticosteroids

4. In patients with chronic cough, it should not be assumed that GERD has been definitively ruled out as a cause of cough simply because there is a history of antireflux surgery. Level of evidence, low; benefit, substantial; grade of recommendation, B

5. In patients with chronic cough, while tests that link GERD with cough suggest a potential cause-effect relationship, a definitive diagnosis of cough due to GERD requires that cough nearly or completely disappear with antireflux treatment. Level of evidence, low; benefit, substantial; grade of recommendation, B
6. In patients with chronic cough being evaluated for GERD, the 24-hour esophageal pH-monitoring test is the most sensitive and specific test; however, it is recommended that the test results be interpreted as normal only when conventional indexes for acid reflux are within the normal range and no reflux-induced coughs appear during the monitoring study. Level of evidence, low; benefit, substantial; grade of recommendation, B
7. In patients with cough who are undergoing 24-hour monitoring, a low percentage of coughs associated with (or induced by) reflux does not exclude a diagnosis of cough due to GERD. Level of evidence, low; benefit, substantial; grade of recommendation, B
8. In patients with cough due to GERD, the degree of abnormality noted in the esophageal pH-monitoring variables, such as the frequency and duration of reflux events, does not directly correlate with the severity of the patients' cough. Level of evidence, low; benefit, substantial; grade of recommendation, B
9. In diagnosing nonacid GERD as the cause of cough, barium esophagography may be the only available test to reveal gastroesophageal reflux of potential pathologic significance in this setting (see the discussion regarding esophageal impedance monitoring in the "Laboratory Testing" section of the original guideline document). When this is the case, barium esophagography is the test of choice to reveal gastroesophageal reflux of potential pathologic significance. Level of evidence, low; benefit, substantial; grade of recommendation, B
10. In patients with cough due to GERD, normal esophagoscopy findings do not rule out GERD as the cause of cough. Level of evidence, low; benefit, substantial; grade of recommendation, B
11. For patients fitting the clinical profile for cough due to GERD, it is recommended that treatment be initially started in lieu of testing. Level of evidence, low; benefit, substantial; grade of recommendation, B
12. For patients fitting the clinical profile for cough due to GERD, the performance of 24-hour esophageal pH monitoring is recommended on therapy when cough does not improve or resolve to assist in determining whether the therapy needs to be intensified or if medical therapy has failed. Level of evidence, low; benefit, substantial; grade of recommendation, B
13. For patients with chronic cough, the following tests are not routinely recommended to link cough with GERD: (a) assessing for lipid-laden macrophages in bronchoalveolar lavage (BAL) fluid and induced sputum, because this test has not been studied in patients with chronic cough and because a positive test result is not specific for aspiration; (b) exhaled nitric oxide measurements, because they do not appear to be helpful in diagnosing cough due to GERD; (c) a Bernstein test, because a negative Bernstein test result cannot be used to exclude the diagnosis of cough due to GERD; and (d) inhaled tussigenic challenges with capsaicin, because they are not specific for coughs due to GERD and because the test result can be positive in patients with GERD without cough. Level of evidence, low; benefit, conflicting; grade of recommendation, I
14. In patients who meet the clinical profile predicting that silent GERD is the likely cause of chronic cough or in patients with chronic cough who also have

prominent upper GI symptoms consistent with GERD, an empiric trial of medical antireflux therapy is recommended. Level of evidence, low; benefit, substantial; grade of recommendation, B

15. For treating the majority of patients with chronic cough due to GERD, the following medical therapies are recommended: (a) dietary and lifestyle modifications; (b) acid suppression therapy; and (c) the addition of prokinetic therapy either initially or if there is no response to the first two therapies. The response to these therapies should be assessed within 1 to 3 months. Level of evidence, expert opinion; benefit, substantial; grade of recommendation, E/A
16. In patients in which this empiric treatment fails, it cannot be assumed that GERD has been ruled out as a cause of chronic cough; rather, the objective investigation for GERD is then recommended because the empiric therapy may not have been intensive enough or medical therapy may have failed. Level of evidence, expert opinion; benefit, substantial; grade of recommendation, E/A
17. In some patients, cough due to GERD will favorably respond to acid suppression therapy alone; proton pump inhibition may be effective when H_2-antagonism has been ineffective; prokinetic therapy and diet, when added to proton pump inhibition, may be effective when proton pump inhibition alone has been ineffective. Level of evidence, low; benefit, substantial; grade of recommendation, B
18. Patients requiring an intensive medical treatment regimen should be treated with the following: (a) antireflux diet that includes no >45 g of fat in 24 hours and no coffee, tea, soda, chocolate, mints, citrus products, including tomatoes, or alcohol, no smoking, and limiting vigorous exercise that will increase intraabdominal pressure; (b) acid suppression with a proton pump inhibitor (PPI); (c) prokinetic therapy; and (d) efforts to mitigate the influences of comorbid diseases such as obstructive sleep apnea or therapy for comorbid conditions (e.g., nitrates, progesterone, and calcium channel blockers) whenever possible. Level of evidence, expert opinion; benefit, substantial; grade of recommendation, E/A
19. In patients with chronic cough due to GERD that has failed to improve with the most maximal medical therapy, which includes an intensive antireflux diet and lifestyle modification, maximum acid suppression, and prokinetic therapy, and the rest of the spectrum of treatment options in the table below, titled "Spectrum of Options for Treating Chronic Cough Due to GERD, " cough may only improve or be eliminated with antireflux surgery. Level of evidence, low; benefit, substantial; grade of recommendation, B
20. In patients who meet the following criteria, antireflux surgery is the recommended treatment: (a) findings of a 24-hour esophageal pH-monitoring study before treatment is positive, as defined above; (b) patients fit the clinical profile suggesting that GERD is the likely cause of their cough (see table above, titled "Clinical Profile That Predicts That Chronic Cough Is Likely Due to GERD"); (c) cough has not improved after a minimum of 3 months of intensive therapy (see table below, titled "Spectrum of Options for Treating Chronic Cough Due to GERD "), and serial esophageal pH-monitoring studies or other objective studies (e.g., barium esophagography, esophagoscopy, and gastric-emptying study with solids) performed while the patient receives therapy show that intensive medical therapy has failed to control the reflux disease and that GERD is still the likely cause of cough; and (d) patients express the opinion that their persisting cough does not allow them a

satisfactory quality of life. Level of evidence, expert opinion; benefit, substantial; grade of recommendation, E/A

Spectrum of Options for Treating Chronic Cough Due to GERD

Treatment	Options

Antireflux medical therapy	Diet
	
	Lifestyle changes
	
	• Smoking
	• Exercising
	• Consuming alcohol
	
	Medications
	
	• Acid suppression
	• Prokinetic
	
	Address risk factors
	
	• Treat other causes of cough
	• Treat comorbid conditions
	  • Obesity
	  • Obstructive sleep apnea
	
	Consider changing medications for comorbid conditions

Antireflux surgery	

Definitions:

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Strength of Recommendations

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Expert Opinion	E/A	E/B	E/C	I	I	E/D

CLINICAL ALGORITHM(S)

The following clinical algorithms are provided in the section titled "Diagnosis and Management of Cough Executive Summary" (see "Availability of Companion Documents" field)"

- Acute cough algorithm for the management of patients ≥15 years of age with cough lasting <3 weeks
- Subacute cough algorithm for the management of patients ≥15 years of age with cough lasting 3 to 8 weeks
- Chronic cough algorithm for the management of patients ≥15 years of age with cough lasting >8 weeks
- Approach to a child <15 years of age with chronic cough
- Approach to a child ≤14 years of age with chronic specific cough

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of supporting evidence is identified and graded for each recommendation (see "Major Recommendations").

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

Appropriate diagnosis and effective management of cough due to gastroesophageal reflux disease resulting in increased quality of life

POTENTIAL HARMS

Not stated

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

- The information provided in the guideline should be used in conjunction with clinical judgment. Although the guideline provides recommendations that are based on evidence from studies involving various populations, the recommendations may not apply to every individual patient. It is important for the physician to take into consideration the role of patient preferences and the availability of local resources.
- The American College of Chest Physicians (ACCP) is sensitive to concerns that nationally and/or internationally developed guidelines are not always applicable in local settings. Further, guideline recommendations are just that, recommendations not dictates. In treating patients, individual circumstances, preferences, and resources do play a role in the course of treatment at every decision level. Although the science behind evidence-based medicine is rigorous, there are always exceptions. The recommendations are intended to guide healthcare decisions. These recommendations can be adapted to be applicable at various levels.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

An implementation strategy was not provided.

IMPLEMENTATION TOOLS

Clinical Algorithm

For information about availability, see the "Availability of Companion Documents" and "Patient Resources" fields below.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Getting Better
Living with Illness

IOM DOMAIN

Effectiveness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

Irwin RS. Chronic cough due to gastroesophageal reflux disease: ACCP evidence-based clinical practice guidelines. Chest 2006 Jan;129(1 Suppl):80S-94S. [89 references] PubMed

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

2006 Jan

GUIDELINE DEVELOPER(S)

American College of Chest Physicians - Medical Specialty Society

SOURCE(S) OF FUNDING

American College of Chest Physicians

GUIDELINE COMMITTEE

American College of Chest Physicians (ACCP) Expert Panel on the Diagnosis and Management of Cough

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FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

The American College of Chest Physicians (ACCP) has a very stringent approach to the issue of potential or perceived conflicts of interest. This policy is published on the ACCP Web site at www.chestnet.org. All conflicts of interest within the preceding 5 years were required to be disclosed by all panelists, including those who did not have writing responsibilities, at face-to-face meetings, the final conference, and prior to submission for publication.

The most recent of these are documented in the published guideline supplement. Furthermore, the panel was instructed in this matter, verbally and in writing, prior to the deliberations of the final conference.

ENDORSER(S)

American Thoracic Society - Medical Specialty Society
Canadian Thoracic Society - Medical Specialty Society

GUIDELINE STATUS

This is the current release of the guideline.

GUIDELINE AVAILABILITY

Electronic copies: Available to subscribers of Chest - The Cardiopulmonary and Critical Care Journal.

Print copies: Available from the American College of Chest Physicians, Products and Registration Division, 3300 Dundee Road, Northbrook IL 60062-2348.

AVAILABILITY OF COMPANION DOCUMENTS

The following are available:

- Diagnosis and management of cough executive summary: ACCP evidence-based clinical practice guidelines. Northbrook, IL: ACCP, 2006 Jan.

Background and Methodology Information

- Introduction to the diagnosis and management of cough: ACCP evidence-based clinical practice guidelines. Northbrook, IL: ACCP, 2006 Jan.
- Methodology and grading of the evidence for the diagnosis and management of cough: ACCP evidence-based clinical practice guidelines. Northbrook, IL: ACCP, 2006 Jan.

Additional Background Information

- Anatomy and neurophysiology of the cough reflex: ACCP evidence-based clinical practice guidelines. Northbrook, IL: ACCP, 2006 Jan.
- Global physiology and pathophysiology of cough: ACCP evidence-based clinical practice guidelines. Northbrook, IL: ACCP, 2006 Jan.
- Complications of cough: ACCP evidence-based clinical practice guidelines. Northbrook, IL: ACCP, 2006 Jan.
- Overview of common causes of chronic cough: ACCP evidence-based clinical practice guidelines. Northbrook, IL: ACCP, 2006 Jan.
- Assessing cough severity and efficacy of therapy in clinical research: ACCP evidence-based clinical practice guidelines. Northbrook, IL: ACCP, 2006 Jan.
- Potential future therapies for the management of cough: ACCP evidence-based clinical practice guidelines. Northbrook, IL: ACCP, 2006 Jan.
- Future directions in the clinical management of cough: ACCP evidence-based clinical practice guidelines. Northbrook, IL: ACCP, 2006 Jan.

Electronic copies: Available to subscribers of Chest - The Cardiopulmonary and Critical Care Journal.

Print copies: Available from the American College of Chest Physicians, Products and Registration Division, 3300 Dundee Road, Northbrook IL 60062-2348.

PATIENT RESOURCES

None available

NGC STATUS

This NGC summary was completed by ECRI on May 4, 2006. The information was verified by the guideline developer on June 5, 2006.

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