→ Cough is common, often causes unnecessary anxiety → Cough interferes with sleep, work, school, social life! →Any vagal afferent can carry signals to the brainstem to trigger coughing.

Normal CXR

→ Do spirometry

Chronic Cough (>8 weeks)

→ Do CXR if cough >3 weeks →if self-limiting, no investigation needed.



Chronic

infection

 \rightarrow TB



COPD Asthma (controlled) (controlled) → Hx of chronic → Hx of allergy + smoking bronchial hyper-→ Progressive sensitivity Dyspnea →Episodic dyspnea →Usually + wheeze →Usually dry cough productive cough

→ Rhinitis → Post-nasal drip → Sinusitis (Tx w/ nasal corticosteroid or

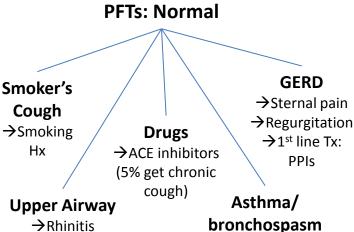
saline rinse)

Red Flags: Fever, night sweats, chills (infection) Weight loss, fatigue (↓ sleep, or serious underlying

- Dyspnea (underlying lung disease or CHF)
- Hemoptysis (blood in cough)

dx, i.e. cancer)

- Abnormal physical findings (i.e. lymadenopathy, clubbing, chest exam, etc)
- Abnormal CXR: refer + order CT, bronchoscopy to complete invesetigation
- History of cancer, lung disease



triggers present

→(on remission)

→ Positive methacholine

challenge

→ Eosinophils on

induced sputum test

→ Common asthma

Lung Cancer →Unilateral masses in lung → May have hemoptysis

COPD (bad)

→hyperinflation: flat diaphragm, reduced vessel markings

→ Fungal **CHF** → Mild: Upper-zone batwing distribution: vascular

Intersitial Lung

disease

→ Moderate: Kerley B lines (inter-lobular edema, between lobes in pleural space)

redistribution

- → Severe: Pulmonary edema, atalectasis of alveoli *→ peri-bronchial* cuffing (donut sign) & airbronchograms → Cardiomegaly
- → Pleural effusion (costo-
- phrenic angles blurred)

Complications of chronic cough:

- Headaches
- Muscle strain, rib fractures
- ↑ intrathoracic pressure → Vomiting, Syncope (↓ venous return, hypotension)
- ↑ intrathoracic pressure → hernias, stress incontinence

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