



Complete Summary

GUIDELINE TITLE

Chronic cough due to chronic bronchitis: ACCP evidence-based clinical practice guidelines.

BIBLIOGRAPHIC SOURCE(S)

Braman SS. Chronic cough due to chronic bronchitis: ACCP evidence-based clinical practice guidelines. Chest 2006 Jan;129(1 Suppl):104S-15S. [79 references]
[PubMed](#)

GUIDELINE STATUS

This is the current release of the guideline.

**** REGULATORY ALERT ****

FDA WARNING/REGULATORY ALERT

Note from the National Guideline Clearinghouse: This guideline references a drug(s) for which important revised regulatory and/or warning information has been released.

On November 18, 2005, the U.S. Food and Drug Administration (FDA) notified manufacturers of Advair Diskus, Foradil Aerolizer, and Serevent Diskus to update their existing product labels with new warnings and a Medication Guide for patients to alert health care professionals and patients that these medicines may increase the chance of severe asthma episodes, and death when those episodes occur. All of these products contain long-acting beta2-adrenergic agonists (LABA). Even though LABAs decrease the frequency of asthma episodes, these medicines may make asthma episodes more severe when they occur. A Medication Guide with information about these risks will be given to patients when a prescription for a LABA is filled or refilled. See the [FDA Web site](#) for more information.

COMPLETE SUMMARY CONTENT

**** REGULATORY ALERT ****

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INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT

SCOPE

DISEASE/CONDITION(S)

Chronic cough due to chronic bronchitis (chronic obstructive pulmonary disease [COPD])

GUIDELINE CATEGORY

Diagnosis
Management
Treatment

CLINICAL SPECIALTY

Family Practice
Internal Medicine
Pulmonary Medicine

INTENDED USERS

Physicians

GUIDELINE OBJECTIVE(S)

To present the evidence for the diagnosis and treatment of cough due to chronic bronchitis, and to make recommendations that will be useful for clinical practice

TARGET POPULATION

Patients with cough due to chronic bronchitis

INTERVENTIONS AND PRACTICES CONSIDERED

Diagnosis

1. Medical history (including a complete history regarding exposures to respiratory irritants including cigarette, cigar, and pipe smoke; passive smoke exposures; and hazardous environments in the home and workplace)
2. Physical examination

Treatment

1. Avoidance of exposure to respiratory irritants
2. Antibiotics
3. Beta-agonist bronchodilators (short- and long-acting)

4. Ipratropium bromide
5. Theophylline
6. Anticholinergic bronchodilators
7. Inhaled corticosteroids
8. Systemic corticosteroids
9. Cough suppressants
 - Codeine
 - Dextromethorphan

Interventions considered but not recommended include postural drainage and chest percussion, expectorants, and the long-term maintenance therapy of oral corticosteroids such as prednisone.

MAJOR OUTCOMES CONSIDERED

- Reduction of symptoms (including cough and sputum production)
- Frequency of exacerbations of chronic obstructive pulmonary disease (COPD)
- Lung function (forced expiratory volume in 1 second, [FEV₁])

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

Recommendations for this section of the review were obtained from a National Library of Medicine (PubMed) search dating back to 1950, performed in August 2004, of the literature published in the English language. The search was limited to human studies, using the search terms "cough," "chronic bronchitis," and "COPD."

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

Quality of Evidence	Net Benefit					
	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.

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

1. Adults who have a history of chronic cough and sputum expectoration occurring on most days for at least 3 months and for at least 2 consecutive years should be given a diagnosis of chronic bronchitis when other respiratory or cardiac causes of chronic productive cough are ruled out. **Level of evidence, low; net benefit, substantial; grade of recommendation, B**
2. The evaluation of patients with chronic cough should include a complete history regarding exposures to respiratory irritants including cigarette, cigar, and pipe smoke; passive smoke exposures; and hazardous environments in the home and workplace. All are predisposing factors of chronic bronchitis. **Level of evidence, low; net benefit, substantial; grade of recommendation, B**
3. Smoke-free workplace and public place laws should be enacted in all communities. **Level of evidence, expert opinion; net benefit, substantial; grade of recommendation, E/A**
4. Stable patients with chronic bronchitis who have a sudden deterioration of symptoms with increased cough, sputum production, sputum purulence, and/or shortness of breath, which are often preceded by symptoms of an upper respiratory tract infection, should be considered to have an acute exacerbation of chronic bronchitis, as long as conditions other than acute tracheobronchitis are ruled out or are considered unlikely. **Level of evidence, expert opinion; net benefit, substantial; grade of recommendation, E/A**
5. In patients with chronic cough who have chronic exposure to respiratory irritants, such as personal tobacco use, passive smoke exposure, and workplace hazards, avoidance should always be recommended. It is the most effective means to improve or eliminate the cough of chronic bronchitis. Ninety percent of patients will have resolution of their cough after smoking cessation. **Level of evidence, good; net benefit, substantial; grade of recommendation, A**

6. In stable patients with chronic bronchitis, there is no role for long-term prophylactic therapy with antibiotics. **Level of evidence, low; benefit, none; grade of recommendation, I**
7. In patients with acute exacerbations of chronic bronchitis, the use of antibiotics is recommended; patients with severe exacerbations and those with more severe airflow obstruction at baseline are the most likely to benefit. **Level of evidence, fair; net benefit, substantial; grade of recommendation, A**
8. In stable patients with chronic bronchitis, the clinical benefits of postural drainage and chest percussion have not been proven, and they are not recommended. **Level of evidence, fair; net benefit, conflicting; grade of recommendation, I**
9. In patients with an acute exacerbation of chronic bronchitis, the clinical benefits of postural drainage and chest percussion have not been proven, and they are not recommended. **Level of evidence, fair; net benefit, conflicting; grade of recommendation, I**
- 10a. In stable patients with chronic bronchitis, therapy with short-acting beta-agonists should be used to control bronchospasm and relieve dyspnea; in some patients, it may also reduce chronic cough. **Level of evidence, good; net benefit, substantial; grade of recommendation, A**
- 10b. In stable patients with chronic bronchitis, therapy with ipratropium bromide should be offered to improve cough. **Level of evidence, fair; net benefit, substantial; grade of recommendation, A**
- 10c. In stable patients with chronic bronchitis, treatment with theophylline should be considered to control chronic cough; careful monitoring for complications is necessary. **Level of evidence, fair; net benefit, substantial; grade of recommendation, A**
11. For patients with an acute exacerbation of chronic bronchitis, therapy with short-acting beta-agonists or anticholinergic bronchodilators should be administered during the acute exacerbation. If the patient does not show a prompt response, the other agent should be added after the first is administered at the maximal dose. **Level of evidence, good; net benefit, substantial; grade of recommendation, A**
12. For patients with an acute exacerbation of chronic bronchitis, theophylline should not be used for treatment. **Level of evidence, good; net benefit, none; grade of recommendation, D**
13. For stable patients with chronic bronchitis, there is no evidence that the currently available expectorants are effective and therefore they should not be used. **Level of evidence, low; net benefit, none; grade of recommendation, I**
14. In stable patients with chronic bronchitis, treatment with a long-acting beta-agonist when coupled with an inhaled corticosteroid should be offered to control

chronic cough. **Level of evidence, good; net benefit, substantial; grade of recommendation, A**

15. For stable patients with chronic bronchitis and an FEV₁ (forced expiratory volume in 1 second) of <50% predicted or for those patients with frequent exacerbations of chronic bronchitis, inhaled corticosteroid therapy should be offered. **Level of evidence, good; net benefit, substantial; grade of recommendation, A**

16. For stable patients with chronic bronchitis, long-term maintenance therapy with oral corticosteroids such as prednisone should not be used; there is no evidence that it improves cough and sputum production, and the risks of serious side effects are high. **Level of evidence, expert opinion; net benefit, negative; grade of recommendation, E/D**

17. For patients with an acute exacerbation of chronic bronchitis, there is no evidence that the currently available expectorants are effective, and therefore they should not be used. **Level of evidence, low; net benefit, none; grade of recommendation, I**

18. For patients with an acute exacerbation of chronic bronchitis, a short course (10 to 15 days) of systemic corticosteroid therapy should be given; intravenous (IV) therapy in hospitalized patients and oral therapy for ambulatory patients have both proven to be effective. **Level of evidence, good; net benefit, substantial; grade of recommendation, A**

19. In patients with chronic bronchitis, central cough suppressants such as codeine and dextromethorphan are recommended for short-term symptomatic relief of coughing. **Level of evidence, fair; benefit, intermediate; grade of evidence, B**

Definitions:

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Low	B	B	C	I	I	D
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 chronic bronchitis

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)

Braman SS. Chronic cough due to chronic bronchitis: ACCP evidence-based clinical practice guidelines. Chest 2006 Jan;129(1 Suppl):104S-15S. [79 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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