ANTIBIOTIC GUARDIAN

Pledge to become an Antibiotic Guardian at www.antibioticguardian.com

NHS Vale of York Clinical Commissioning Group

Referral Support Service

ENT

ENT 19
Chronic cough and suspected Laryngopharyngeal Reflux (LPR)

Definition

LPR is the retrograde movement of stomach acid and enzymes (Pepsin) into the lower throat and larynx region. The patient is typically not aware of it consciously, in terms of symptomatic “heart burn” (only present in possibly 30% of cases). Typical symptoms include excessive throat-clearing, especially in the morning or after a meal, persistent dry cough, sore throats not associated with a cold, hoarseness, or some globus sensation.

Exclude Red Flag Symptoms

- Higher risk patients (> 50 years, smokers), with new onset of symptoms will need further investigations, including a CXR and possibly upper GI endoscopy.
    - Unexplained weight loss, haemoptysis, therapy-resistant chronic cough for more than eight weeks.
    - Any apparent risk for possible foreign body aspiration, pneumothorax, or tuberculosis.
    - True dysphagia to solids and liquids (not only difficulty in dry swallowing, which would suggest globus type problems).
- If there are acute symptoms such as chest pain, breathing problems, stridor, unexplained tachycardia, or a very sudden onset of symptoms, admit the patient immediately (think cardiac problem or pulmonary embolism).

Management

Establish the time line and some details of the onset and possible maintaining factors. Was there a recent harmless URTI, which may cause a continued hypersensitivity of the upper airway for several weeks?

Are there signs for any upper airway cough syndrome (previously "post-nasal drip syndrome") due to chronic rhinitis or chronic sinusitis – if so, consider a trial of antibiotics (as per latest antimicrobial guidance).

Life-style factors can play an important part in chronic cough and LPR.

Explore the intake of caffeine, alcohol, chocolates, and peppermints, which can all weaken the lower oesophageal sphincter. Furthermore, acidic foods, such as citrus fruits, kiwi, pineapples or tomatoes, spicy meats and hot spices (mustard, curry, hot peppers) can directly irritate the throat lining, and any kind of fizzy drinks (even if caffeine free) increase the chance of stomach content refluxing.

Responsible GP: Dr Tillmann Jacobi
Responsible Consultant: Mr Alastair Mace
Responsible Pharmacist: Laura Angus

Clinical Effectiveness Advisory Group approved: Apr 2019
Date published: Jul 2019
Next Review: Sep 2024

Review current medication (ACE inhibitors; possible overuse of inhalers for asthma or COPD).

Check any weight changes – weight gain can increase the risk for (silent) reflux. Aim for achieving a BMI < 30, if at all possible.

Consider other factors, which can increase the pressure on the stomach, such as exercising, strenuous singing, or even just lying down flat within two hours after a meal.

Physical examination includes a check of cervical glands, apparent throat abnormalities, chest auscultation, temperature, pulse and oxygen saturation (when available).

- Consider spirometry, if risk factors present.

For treatment, and in the absence of any apparent red flags, consider a trial of alginates (e.g. **Gaviscon Advance®** etc.) in the first place, on prescription or over the counter. These should be taken regularly after main meals with **no food or fluid intake for the subsequent two hours** (otherwise the sealant effect is ruined). The patient should try this for at least three to six weeks before judging their efficiency.

If this shows only limited or only temporary benefit consider a sufficiently high dose PPI (e.g. **omeprazole 20mg bd, lansoprazole 30mg od**) for short courses circa 3-6 months, with or without some alginate treatment (**Gaviscon Advance®**) as described above.

- PPI longterm adverse effects- CKS summary

It is important to encourage the patient to schedule a clear follow-up after that time to assess the situation and effectiveness.

Referral Information

Indications for referral

- Additional clinical concerns, unsuccessful trial of treatment.

Information to include in referral letter

- Timeline and any progression
- Diurnal fluctuation or continuum of symptoms
- Relevant past medical/surgical history
- Current regular medication
- BMI (any unintended weight loss) / Smoking status / Alcohol status / Occupation
- Investigations done so far (e.g. CXR, spirometry)

Responsible GP: Dr Tillmann Jacobi
Responsible Consultant: Mr Alastair Mace
Responsible Pharmacist: Laura Angus

Clinical Effectiveness Advisory Group approved: Apr 2019
Date published: Jul 2019
Next Review: Sep 2024

- Adequate trial of alginates (as described above; for 3-6 weeks), or a PPI +/- antacid done with partial or no success
- Advice given on “lifestyle” / possible food triggers

Investigations prior to referral

- CXR (particularly if the patient is >50 years and/or a smoker)
- Consider spirometry, if available and clinically indicated
- Consider baseline bloods to exclude infection / inflammation

Patient information leaflets/ PDAs

- https://patient.info/health/cough-leaflet
- https://patient.info/health/diet-sheet-for-oesophageal-reflux

Reference

- https://cks.nice.org.uk/cough#!scenario:2
- Chung, K.F. and Pavord, I.D. (2008) Prevalence, pathogenesis, and causes of chronic cough.*Lancet***371**(9621), 1364-1374.
  Abstract: http://www.ncbi.nlm.nih.gov/pubmed/18424325)