Lothian Paediatric Chronic Cough Guideline (Dry cough)

- See Part 1 for chronic cough assessment guidance before entering the dry cough flowchart
- Over diagnosis of asthma may be a problem in children with isolated dry cough (no wheezing)
- See relevant guidance if treating acute cough or asthma

Paediatric chronic dry cough >4 weeks

Detailed history & examination as per page 1

If there are no specific cough pointers and no red flags it is reasonable to watch and wait for up to 8 weeks when the trajectory suggests improvement. Most coughing in children is related to transient infections.

Check for irritants (eg. Exposure to tobacco smoke, pet dander) and for signs of atopy

Consider precedent infection: observe,

cough receptor hypersensitivity can occur after upper respiratory tract infection

Dry coughing suggests airway irritation and or inflammation

Dry cough lasting > 8 weeks from onset

- What is the trajectory?
- Have any pointers or red flags emerged?

Investigate/treat/refer accordingly

- Has the child, in fact, had well periods within the 8 weeks? If yes, reassure, consider observation (4 -8/52)

Pointers/atopy/irritants:

Investigate/treat accordingly. eg antihistamines

Remove aero-irritant exposures. Eg tabacco smoke

Consider specialist paediatric referral.

Consider continuing pathway.

Towards spontaneous regression?

- Reassure
- Follow up until complete spontaneous resolution

Persistent isolated cough, child otherwise well

A subset of children benefit from treatment with ICS

1. 8 week trial of paediatric moderate dose* inhaled corticosteroid
   e.g. 200mcg Beclomethasone twice a day (2-16 years)
   100mcg Beclomethasone twice a day (<2 years)
2. Book a review appointment for 8 weeks

Cough resolved at8 week review?

1. **STOP** inhaled corticosteroid
2. Review in 4 weeks for recurrence

Dry cough persistent?

[check adherence]

1. **STOP** inhaled corticosteroid and refer

Resolution sustained?

Advise to return if there is recurrence of chronic cough

Dry cough returned?

1. Age permitting (>5), test for asthma; airway obstruction/airway variability
2. Restart ICS at a **paediatric low dose** as first-line maintenance therapy and check for second response*
   Seek advice if <2 years
3. Cautious and provisional diagnosis of suspected asthma and follow asthma guidelines
4. Consider antihistamines & intranasal steroids for children with an allergic cough in the pollen season
5. Revisit asthma diagnosis regularly; unlikely in the absence of wheeze

Refer:

- Requires specialist respiratory discussion/ referral (routine except)
- Consider chest X-ray
- Consider trial of allergic rhinitis treatment or GORD treatment parallel to referral

See also Paediatric Asthma RefHelp

Advice can be given if unsure:
Email RHCYP Asthma Nurses

* NICE guidance precribing inhaled corticosteroids