



Complete Summary

GUIDELINE TITLE

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

BIBLIOGRAPHIC SOURCE(S)

Rosen MJ. Chronic cough due to bronchiectasis: ACCP evidence-based clinical practice guidelines. Chest 2006 Jan;129(1 Suppl):122S-31S. [66 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 **

SCOPE

METHODOLOGY - including Rating Scheme and Cost Analysis

RECOMMENDATIONS

EVIDENCE SUPPORTING THE RECOMMENDATIONS

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

QUALIFYING STATEMENTS

IMPLEMENTATION OF THE GUIDELINE

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT

SCOPE

DISEASE/CONDITION(S)

Chronic cough due to bronchiectasis, including bronchiectasis caused by:

- Cystic fibrosis (CF)
- Congenital and acquired hypogammaglobulinemia
- Human immunodeficiency virus (HIV) infection
- Primary ciliary dyskinesia
- Allergic bronchopulmonary aspergillosis (ABPA)
- *Mycobacterium Avium* Complex

For a complete list of disorders that predispose patients to the development of bronchiectasis, see table in the "Major Recommendations" field.

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 bronchiectasis, and to make recommendations that will be useful for clinical practice

TARGET POPULATION

Patients with cough due to bronchiectasis

INTERVENTIONS AND PRACTICES CONSIDERED

Diagnosis

1. Physical examination
2. Chest radiography
3. High resolution computed tomography chest scan (HRCT)

Treatment

1. Bronchodilators (including short-acting and long-acting beta-agonists, anticholinergics, leukotriene antagonists, and theophylline)
2. Mucolytic drugs
 - Recombinant human DNase (rhDNase) (in patients with cystic fibrosis [CF])
3. Inhaled corticosteroids
4. Antibiotics
 - Antibiotic treatment of exacerbations
 - Aerosolized antipseudomonal antibiotics (in patients with CF)
5. Chest physiotherapy
6. Surgery

Interventions considered but not recommended include systemic corticosteroids and ibuprofen.

MAJOR OUTCOMES CONSIDERED

- Accuracy, sensitivity, and specificity of diagnostic tests
- Symptom improvement or resolution (cough, sputum production, and dyspnea)
- Progression of airway damage

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

The articles produced by the Duke systematic literature search were reviewed, along with others found in searches of Ovid MEDLINE 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) from 1966 through 2003.

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.

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

Disorders That Predispose the Patient to the Development of Bronchiectasis

Disorders	Description
<i>Focal distribution</i>	
Bronchial obstruction	Foreign body Tumor Broncholithiasis Compression by peribronchial lymph nodes
Previous pneumonia	
<i>Diffuse distribution</i>	
Cystic fibrosis (CF)	
Reduced host immunity	Congenital and acquired hypogammaglobulinemia (especially Immunoglobulin G (IgG) and/or IgG subclasses)
	Human immunodeficiency virus (HIV) infection
Primary ciliary dyskinesia	
Allergic bronchopulmonary mycoses	
Chronic <i>Mycobacterium avium</i> complex (MAC) infection	
Aspiration or toxic inhalation	
Rheumatoid arthritis	
Inflammatory bowel disease	
Other congenital disorders	Alpha-1-antitrypsin deficiency

Disorders

Description

Tracheobronchomegaly (Mounier-Kuhn syndrome)
Cartilage deficiency (Williams-Campbell syndrome)
Young syndrome
Pulmonary sequestration
Marfan syndrome

Yellow nail syndrome

1. In patients with suspected bronchiectasis without a characteristic chest radiograph finding, a high resolution computed tomography (HRCT) scan should be ordered because it is the diagnostic procedure of choice to confirm the diagnosis. **Level of evidence, low; benefit, substantial; grade of recommendation, B**
2. In patients for whom there is no obvious cause, a diagnostic evaluation for an underlying disorder causing bronchiectasis should be performed, because the results may lead to treatment that may slow or halt the progression of disease. **Level of evidence, low; benefit, substantial; grade of recommendation, B**
3. In patients with bronchiectasis with airflow obstruction and/or bronchial hyperreactivity, therapy with bronchodilators may be of benefit. **Level of evidence, expert opinion; benefit, small; grade of recommendation, E/C**
4. In patients with bronchiectasis caused by cystic fibrosis (CF), recombinant human DNase (rhDNase) should be used to improve spirometry. **Level of evidence, low; benefit, small; grade of recommendation, C**
5. In patients with CF, prolonged treatment with systemic corticosteroids should not be offered to most patients because of significant side effects. **Level of evidence, low; benefit, conflicting; grade of recommendation, I**
6. In patients with CF, prolonged courses of ibuprofen should not be used. **Level of evidence, low; benefit, conflicting; grade of recommendation, I**
7. In patients with idiopathic bronchiectasis, the prolonged systemic administration of antibiotics may produce small benefits in reducing sputum volume and purulence, but may also be associated with intolerable side effects. **Level of evidence, low; benefit, conflicting, grade of recommendation, I**
8. In patients with CF, therapy with aerosolized antipseudomonal antibiotics are recommended. **Level of evidence, low; benefit, intermediate; grade of recommendation, C**
9. In patients with idiopathic bronchiectasis, aerosolized antibiotics should not be used. **Level of evidence, low; benefit, negative; recommendation, D**
10. In patients with conditions associated with the hypersecretion of mucus and the inability to expectorate effectively, chest physiotherapy should be used and patients should be monitored for symptom improvement. **Level of evidence, expert opinion; benefit, small/weak; grade of recommendation, E/C**
11. In selected patients with localized bronchiectasis that causes intolerable symptoms despite maximal medical therapy, surgery should be offered. **Level of evidence, low; benefit, substantial; grade of recommendation, B**
12. In patients with exacerbations of bronchiectasis, antibiotics should be used, with the selection of agents depending on the likely pathogens. **Level of evidence, low; benefit, substantial; grade of recommendation, B**

Definitions:

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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 bronchiectasis

POTENTIAL HARMS

Side effects of treatment

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)

Rosen MJ. Chronic cough due to bronchiectasis: ACCP evidence-based clinical practice guidelines. Chest 2006 Jan;129(1 Suppl):122S-31S. [66 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

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

Primary Author: Mark J. Rosen, MD, FCCP

Panel Members: Richard S. Irwin, MD, FCCP (Chair); Michael H. Baumann, MD, FCCP (HSP Liaison); Donald C. Bolser, PhD; Louis-Philippe Boulet, MD, FCCP (CTS Representative); Sidney S. Braman, MD, FCCP; Christopher E. Brightling, MBBS, FCCP; Kevin K. Brown, MD, FCCP; Brendan J. Canning, PhD; Anne B. Chang, MBBS, PhD; Peter V. Dicpinigaitis, MD, FCCP; Ron Eccles, DSc; W. Brendle Glomb, MD, FCCP; Larry B. Goldstein, MD; LeRoy M. Graham, MD, FCCP; Frederick E. Hargreave, MD; Paul A. Kvale, MD, FCCP; Sandra Zelman Lewis, PhD; F. Dennis McCool, MD, FCCP; Douglas C. McCrory, MD, MHSc; Udaya B.S. Prakash, MD, FCCP; Melvin R. Pratter, MD, FCCP; Mark J. Rosen, MD, FCCP; Edward Schulman, MD, FCCP (ATS Representative); John Jay Shannon, MD, FCCP (ACP Representative); Carol Smith Hammond, PhD and Susan M. Tarlo, MBBS, FCCP

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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