Cough, please...

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Apart from the new look *Australian Family Physician* is sporting this year, we are also undertaking a new approach to selecting the theme for each issue. Our intent is to make *AFP* even more relevant to the busy general practitioner.

It has taken us a while to figure out what has rung so untrue about much of the educational material that lands on a GP's desk: it's based on diseases, not symptoms.

General practitioners usually don't see diseases – we see people who have symptoms. And then we match those symptoms with the patient's signs to arrive at a diagnosis. If all those pieces fall into place, then we can work with the patient to manage their problem. Even if it does not, we can glean enough from the patient's description of their symptoms to manage the undifferentiated illness while we explore further.

Future 2004 'symptom themed' issues of *AFP* include June (back pain), July (itch), and December (abdominal pain). Each one will take a broad look at the variety of conditions that can cause these presenting complaints.

This month's issue of *AFP* is based squarely on the commonest single symptom with which patients come to see us: cough. According to the most recent report from the BEACH study,[1] 23.0 out of every 100 'reasons for encounter' will be respiratory in nature; 6.7 per 100 will be due to cough. Only repeat prescriptions are a more frequent reason for encounter (7.2 per 100), and they are often not the primary reason for the patient presenting.

So if cough is common in general practice, why is it so difficult to diagnose and treat? Maybe the range of articles in this month's *AFP* gives a clue: a cough could be the first presentation of influenza, bronchitis, asthma, pertussis, or cancer. Or legionnaire disease, SARS, tuberculosis, or AIDS. Or it could just be a nervous mannerism.

By being such a protean presenter, cough challenges all our skills as GPs. Even the most recent Cochrane review on the topic leads us to a therapeutic balancing act.[2] As this month's authors demonstrate, we have to be alert to the variety of possible underlying causes and judicious in our choice of special investigations. While anecdotally it seems that patients are less expectant of antibiotics than they used to be, GPs often still feel pressured to prescribe for coughs that they know won't respond to medication. A recent paper from Israel found that 25% of parents bringing their coughing, URTI ridden child to a primary care clinic expected antibiotics.[3] Several other authors, however, have questioned whether the pressure to prescribe resides mainly in the doctor's mind. Important Australian work by Cockburn and Pit in 1997 showed that we were 10 times more likely to prescribe unnecessarily if we thought the patient expected us to.[4] If the patient actually did have this expectation, they were only three times more likely to get their script. This point has recently been reiterated in British studies.[5,6] Maybe we should try harder to elicit our patients' true expectations.

And speaking of the importance of good doctor-patient communication in the diagnosis and management of cough, a recent paper from India is somewhat seminal.[7] It reports the case of a 27 year old woman who presented with a 6 month history of fever and productive cough. She had been treated empirically for 4 months with antibiotics and antituberculous drugs, but to no avail. Eventually, a chest radiograph was done that showed collapse of the right upper lobe due to a foreign body. A bronchoscopy was performed and an inhaled condom was duly removed.

When diagnosing cough, we can never underestimate the importance of a good history.

References

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