Comparison of lidocaine and bronchodilator inhalation treatments for cough suppression in patients with chronic obstructive pulmonary disease

C-F Chong, C-C Chen, H-P Ma, Y-C Wu, Y-C Chen, T-L Wang

Background: This study aimed to assess and compare the effectiveness of lidocaine and bronchodilator inhalation treatments for rapid cough suppression in patients with chronic obstructive pulmonary disease (COPD).

Methods: Prospective comparison study carried out in a tertiary emergency department. Consecutive COPD patients presenting with intractable cough were randomly assigned to receive lidocaine or terbutaline inhalation treatments for cough suppression. Patients with dyspnoea, unstable vital signs, and pneumonia or neoplasm on chest x-ray were excluded. A subjective, 10 point questionnaire based cough severity score was used for assessing the outcome.

Results: The final study sample included 127 patients (mean (SD) age, 69.2 (12.1) years; 33.1% women) of whom 62 received nebulised lidocaine and 65 nebulised bronchodilator. The cough severity score was significantly reduced one hour after inhalation treatment with both lidocaine and bronchodilator, with no significant difference in efficacy. Common but mild side effects in the lidocaine group included oropharyngeal numbness and bitter taste, and, in the bronchodilator group, tremor and palpitation. Dyspnoea, dizziness, and nausea and vomiting were equally uncommon in both groups. None of these problems caused any of the patients to discontinue their treatments and no allergic reactions were reported.

Conclusions: Both lidocaine and bronchodilator inhalation treatments are equally effective for short term cough suppression in patients with COPD.

METHODS

Study population

Over a six month period in 2003, we prospectively enrolled consecutive adult patients who presented to a teaching hospital ED with intractable cough. The criteria for inclusion were:

- subjective complaint of intractable cough
- clear and alert mental state
- documented past medical history of COPD
- verbal consent for cough suppression via inhalation treatment.

We excluded patients with:

- unstable initial vital signs
  - systolic blood pressure <90 mm Hg or
  - pulse rate <50 or >120 per minute or
  - respiratory rate <10 or >30 breaths per minute
- respiratory distress (laboured breathing)
- hypoxaemia (oxygen saturation <90%) documented on pulse oximetry
- evidence of pneumonia or neoplasm on chest x-ray.

Study design and questionnaire survey

We randomly assigned blinded eligible patients to receive prescriptions for either lidocaine or bronchodilator inhalation for cough suppression. We used opaque sealed envelopes to

Cough is an explosive, defensive mechanism, which clears foreign material and excess mucus accumulating in the tracheobronchial tree. Patients who experience intractable coughing frequently visit their family doctors or chest physicians, despite the widespread availability of over the counter antitussive medications. The primary goals of treatment are facilitation of expectoration, elimination of airway irritation, and suppression of stimulation of cough receptors.1,2

Chronic obstructive pulmonary disease (COPD) is characterised by airflow obstruction with symptoms related to breathing, such as cough, exertional dyspnoea, expectoration, and wheeze. Episodes of intractable cough may occur in conjunction with airway hyperresponsiveness and may be treated with inhaled sympathomimetic bronchodilators.4,5 Lidocaine, when administered via nebuliser, has been shown to be safe and effective in suppressing cough related to airway procedures such as bronchoscopy6,7 and in the treatment of refractory cough in several broad categories of patients (those with infective, obstructive, restrictive, or neoplastic disease).8,9

Intractable cough can influence daily activity, and complications such as pneumothorax, syncopal episodes, and cardiac arrhythmias may be devastating. Rapid relief of severe cough is important because if left untreated, cough can become a vicious cycle of “cough”, “airway irritation”, and “stimulation of cough”. This study aimed to examine and compare short term effectiveness of lidocaine and bronchodilator inhalation treatments for cough suppression in patients with COPD during their visits to the emergency department (ED).
randomly assign the participating patients to one of the two study groups. The main investigator was not involved in any of the interventions and was blind to group allocation. The physicians prescribing the inhalation treatments were also blind to the allocation of treatments. The only health personnel not blinded to group allocation were the research nurses who delivered the inhalation treatments and distributed the questionnaires.

A specially designed questionnaire (fig 1) was completed by each patient to self-determine the severity of their cough before and one hour after the inhalation treatment. The subjective cough severity score was graded on a 10 point scale where no cough = 1 point and most severe cough = 10 points (fig 1). All the patients remained under surveillance for at least two hours after the inhalation treatment was complete.

The institutional review board determined that the study protocol met the criteria for exemption because both preparations are routinely used for cough suppression, the side effects are minor, and even if not participating in the study, the patients would have been prescribed one of the preparations. In addition, the patients gave witnessed verbal informed consent prior to enrolment.

Inhalation treatment
The patients inhaled aerosol with a nebuliser driven by compressed oxygen using a mouthpiece. For the lidocaine group, the aerosol solution was prepared by diluting 1 mg/kg cardiac lidocaine with saline solution to achieve a total volume of 4 ml. For the bronchodilator group, the same volume of aerosol solution was prepared by mixing 2 ml terbutaline (Bricanyl 5 mg; AstraZeneca, Sweden) with 2 ml saline solution. The overall nebulisation time was 15–25 minutes per treatment. All patients were asked not to eat or drink for one hour after the inhalation treatment. No other antitussive agents were prescribed in the ED prior to completion of the questionnaire.

Statistical analysis
Parametric interval data are presented as mean (SD) and were compared using the \( t \) test. Non-parametric interval data are presented as median (25th–75th interquartile range) and were compared using Wilcoxon’s matched pairs test (between dependent groups) or the Mann–Whitney U test (between independent groups). Categorical data are presented as number (%) and were compared using the \( \chi^2 \) test. We defined the outcome measures for the study as the differences within and between the treatment groups with regard to the changes in the cough severity scores between baseline and one hour post-inhalation. All analyses were carried out with STATISTICA version 6.0 (Statsoft, Inc.). Statistical significance was set at \( p < 0.05 \) (two tailed).

RESULTS
Figure 2 illustrates the enrolment and allocation of the patients to the two study groups. Of 554 patients with intractable dry cough, 182 patients with a history of COPD were recruited for the study. Of these, 55 were then excluded based on the exclusion criteria (see Methods and fig 2). The final study population included 127 patients (mean (SD) age, 69.2 (12.1) years; 33.1% women) of whom 62 were allocated at random to receive inhaled lidocaine and 65 to receive inhaled bronchodilator for cough suppression. Patient characteristics and clinical data of the two groups were statistically similar (table 1). Most patients from both groups had already taken over the counter oral “cough medicines” before their visit to the ED, and most of them actually had experience of treatment with nebulised bronchodilator in the
past. Over 80% had some degree of wheezing on auscultation although respiratory distress was absent.

Baseline cough scores before treatment were similar in the lidocaine and bronchodilator groups and that the cough severity score of patients in both groups reduced significantly to a similar extent one hour post-inhalation from a median score of 8 to 3 points (table 2). The adverse effects observed after the inhalation treatments are listed in table 3. Frequency of oropharyngeal numbness and bitter taste was significantly higher in the lidocaine than in the bronchodilator group (61.3% vs 4.6%, p<0.01; and 54.8% vs 6.2% p<0.01, respectively). On the other hand, the bronchodilator group had a much higher proportion of tremor (92.3% vs 4.8%, p<0.01) and palpitation (90.8% vs 8.1%, p<0.01). Dyspnoea, dizziness, and nausea and vomiting were equally uncommon in both the groups. No patient discontinued the treatment because of any of the abovementioned problems and we did not observe any allergic reactions.

**DISCUSSION**

In Taiwan, it is not uncommon for patients to visit the ED because of intractable cough. A significant proportion of these patients (33% in our cohort) have a documented history of COPD.

Cough is a subjective symptom that is difficult to quantify. Measurements of cough severity are inconsistent and not well established. Hence, we did not use any specific measurement criteria to define “intractable cough” in our study. We considered eligible patients as those who had unmanageable cough severe enough for them to seek help from the ED. The study of cough has inherent limitations for several reasons: cough is influenced by psychological factors; isolated cough is poorly reproducible; and spontaneous resolution occurs. Consequently, a previously unpublished, linear 10 point questionnaire score was used as a tool for patients to subjectively determine the severity of their cough. Although it has not been validated against objective criteria, this cough severity score assumes a linear scale that is easy to conceptualise.

Table 1 | Baseline demographic of the patients participating in the present study

<table>
<thead>
<tr>
<th></th>
<th>Lidocaine group (n = 62)</th>
<th>Bronchodilator group (n = 65)</th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (years), mean (SD; range)</td>
<td>68.5 (12.4; 47–95)</td>
<td>69.9 (11.9; 46–92)</td>
<td>0.54</td>
</tr>
<tr>
<td>Women*</td>
<td>22 (35.5)</td>
<td>20 (30.8)</td>
<td>0.57</td>
</tr>
<tr>
<td>Prior over the counter antitussives*</td>
<td>53 (85.3)</td>
<td>58 (89.2)</td>
<td>0.53</td>
</tr>
<tr>
<td>Wheeze on auscultation*</td>
<td>58 (93.6)</td>
<td>55 (83.6)</td>
<td>0.11</td>
</tr>
<tr>
<td>Experience of nebulised bronchodilator use*</td>
<td>52 (83.9)</td>
<td>56 (86.2)</td>
<td>0.72</td>
</tr>
<tr>
<td>Vital signs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Systolic blood pressure (mm Hg)†</td>
<td>129.1 (21.4)</td>
<td>128.8 (24.3)</td>
<td>0.95</td>
</tr>
<tr>
<td>Pulse rate (bpm)†</td>
<td>96.0 (15.8)</td>
<td>92.3 (14.3)</td>
<td>0.17</td>
</tr>
<tr>
<td>Respiratory rate (breaths/min)†</td>
<td>19.4 (3.9)</td>
<td>19.9 (3.8)</td>
<td>0.48</td>
</tr>
<tr>
<td>Body temperature (°C)†</td>
<td>36.8 (1.0)</td>
<td>36.7 (1.0)</td>
<td>0.47</td>
</tr>
</tbody>
</table>

*Values are number (%). †Continuous data are given as mean (SD).

Table 2 | Intra and intergroup comparison of the cough severity scores

<table>
<thead>
<tr>
<th></th>
<th>Lidocaine group (n = 62)</th>
<th>Bronchodilator group (n = 65)</th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Score before treatment</td>
<td>8 (7–9)</td>
<td>8 (7–8)</td>
<td>0.21</td>
</tr>
<tr>
<td>Score after treatment</td>
<td>3 (2–3)</td>
<td>3 (2–5)</td>
<td>0.44</td>
</tr>
<tr>
<td>p value</td>
<td>&lt;0.01</td>
<td>&lt;0.01</td>
<td></td>
</tr>
</tbody>
</table>

*The score of cough severity (fig 1) ranged from 1 (no cough) to 10 points (most severe cough) and are given as median (25th–75th interquartile range) and compared using Wilcoxon’s matched pairs test (between dependent groups) or the Mann–Whitney U test (between independent groups).

Table 3 | Interrroup comparison of the adverse effects

<table>
<thead>
<tr>
<th></th>
<th>Lidocaine group (n = 62)</th>
<th>Bronchodilator group (n = 65)</th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tremor</td>
<td>3 (4.8)</td>
<td>40 (92.3)</td>
<td>&lt;0.01</td>
</tr>
<tr>
<td>Palpitation</td>
<td>5 (8.1)</td>
<td>59 (90.8)</td>
<td>&lt;0.01</td>
</tr>
<tr>
<td>Oropharyngeal numbness</td>
<td>38 (61.3)</td>
<td>3 (4.6)</td>
<td>&lt;0.01</td>
</tr>
<tr>
<td>Bitter taste</td>
<td>34 (54.8)</td>
<td>4 (6.2)</td>
<td>&lt;0.01</td>
</tr>
<tr>
<td>Dyspnoea</td>
<td>5 (8.1)</td>
<td>4 (6.2)</td>
<td>0.67</td>
</tr>
<tr>
<td>Nausea/vomiting</td>
<td>4 (6.5)</td>
<td>3 (4.6)</td>
<td>0.65</td>
</tr>
<tr>
<td>Dizziness</td>
<td>2 (3.2)</td>
<td>4 (6.2)</td>
<td>0.44</td>
</tr>
</tbody>
</table>

*Values are number (%).
lidocaine inhalation, namely, oropharyngeal numbness and used (1 mg/kg). Only transient topical effects occurred with the serum levels in our patients because of the small doses used (1 mg/kg). Only transient topical effects occurred with lidocaine inhalation, namely, oropharyngeal numbness and bitter taste. All of these side effects are mild and well tolerated.

Our study has a number of limitations that need to be addressed. Firstly, we included a narrow spectrum of patients—only those with a documented past medical history of COPD. Most of these patients had wheezing on auscultation and were accustomed to bronchodilator inhalation. Secondly, the research nurses who delivered the inhalation treatments and distributed the questionnaires were not blinded. Thirdly, only short term outcomes were assessed—that is, one hour after therapy. However, we did not consider long term outcome in the study design because stable COPD patients treated for cough at an ED will not stay long enough for further evaluation. Finally, this study was carried out at a single institution. These findings should be corroborated in patients attending multiple institutions.

We conclude that both lidocaine and bronchodilator inhalation treatments are equally effective for short term cough suppression in patients with COPD. Perhaps inhaled lidocaine could be another treatment option for patients with COPD and intractable cough that cannot be controlled by other means.

CONTRIBUTORS

C-F Chong developed the study protocol, organised and interpreted the data, and wrote the paper. C-C Chen, H-P Ma, Y-C Wu, and Y-C Chen collected the data and helped in data entry. T-L Wang supervised all aspects of the study.

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REFERENCES