stands now, has added little to what we already knew about chronic cough. It behooves the authors to take that next step and construct an approach to this common symptom using their diagnostic criteria, and then validate that approach prospectively.

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Cough Syncope Treated With Imidapril in an Elderly Patient With Dysphagia

To the Editor:

In response to the article by Palombini et al (August 1999), regarding the pathogenic triad in chronic cough, I bring up a case of cough syncope associated with dysphagia, in which cough syncope was successfully treated with the angiotensin-converting enzyme (ACE) inhibitor. A 75-year-old man of stocky build was admitted to the hospital with a 3-year history of syncope during and immediately after coughing bouts. One year before admission, he had suffered more than one attack of cough syncope per day. He was a lifetime nonsmoker. Physical examination revealed scattered rhonchi on both lung bases. Spiromgrams were normal, but analysis of blood gas on admission revealed slight hypoxemia (PaCO₂, 65 mm Hg), hypercarbia (PaCO₂, 48 mm Hg) breathing room air, and pH of 7.40. A chest radiograph showed mild pulmonary infiltrates at both lung bases. Both ECG and EEG were unremarkable. MRI angiograph showed no stenoses in both common carotids and vertebral arteries. However, MRI of the brain demonstrated multiple lacunar infarctions in bilateral basal ganglia lesions. After admission, the patient was suspected of having swallowing problems because of coughing and choking with oral feeds. Swallowing ability was assessed by asking the patient to drink 50 mL of water steadily from a beaker. He developed choking and coughing while attempting to drink the water. Administration of an ACE inhibitor, imidapril (a 5-mg tablet daily), was started. Cough syncope subsided 1 week after treatment with the ACE inhibitor, and the patient had no difficulty in swallowing 50 mL of water. During 1 year of follow-up with ACE-inhibitor therapy, coughing bouts did not occur, and he did not have attacks of cough syncope.

It is well recognized that cough is commonly encountered in patients receiving ACE inhibitors, and the ACE inhibitor has been reported to cause cough syncope in a patient with essential hypertension. However, ACE inhibitors also improve symptomless dysphagia and reduce the rate of pneumonia in patients with cerebral infarction. Since the clinical circumstances of our case imply that the patient suffered cough syncope due to dysphagia associated with cerebral infarctions, long-term therapy with ACE inhibitors may be effective in preventing cough syncope in dysphagic patients with cerebral infarctions.

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