

· 标准与规范 ·

咳嗽变异性哮喘中医诊疗指南

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[摘要] 咳嗽变异性哮喘(CVA)是一种特殊类型的哮喘,以咳嗽为唯一或主要表现,存在气道高反应性和咳嗽高敏感性。CVA是慢性咳嗽的最常见病因,其发病率高,病程迁延,部分患者可转变为典型哮喘。现代医学推荐将吸入糖皮质激素联合支气管扩张剂、白三烯受体拮抗剂等作为CVA的主要治疗手段,但存在不良反应多、患者依从性差、停药后易复发等问题。中医药治疗CVA历史悠久,具有独特优势,但目前对于CVA的中医辨证仍缺乏循证医学证据。为促进CVA的中医规范化诊疗,制定符合循证医学原则的CVA病证结合诊疗指南尤为必要。指南项目组基于现有最佳循证医学证据、充分结合专家临床经验,经专家访谈、临床调研、证据检索与筛选、证据评价、形成推荐意见、指南起草、自评和征求意见、学会审核等程序充分讨论形成本指南。该指南以CVA患者为对象,从临床实际出发,提供了对CVA中医病因病机、诊断标准与评估方法、鉴别诊断、辨证论治、疗效评价、预防调护的指导和建议,适用于呼吸专科医师、内科医师、中医(中西医结合)医师、全科医师及相关护理人员 and 药师。该指南旨在规范CVA的中医证候诊断与治疗,为临床医师提供CVA中医标准化处理的策略与方法,充分发挥中医药治疗CVA的优势,助力CVA临床诊疗和科研水平的提高。

[关键词] 咳嗽变异性哮喘; 中医; 中西医; 诊疗指南

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Guideline on Traditional Chinese Medicine Diagnosis and Treatment of Cough Variant Asthma

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[Abstract] Cough variant asthma (CVA) is a special type of asthma characterized by cough as the sole or primary symptom, accompanied by airway hyperresponsiveness and cough hypersensitivity. CVA is the most common cause of chronic cough, with a high incidence and a protracted course, and some patients may progress to typical asthma. Modern medicine recommends inhaled glucocorticoids combined with bronchodilators, leukotriene receptor antagonists, and other agents as the mainstay of treatment for CVA. However, these therapies are often associated with multiple side effects, poor patient compliance, and frequent relapse after drug withdrawal. Traditional Chinese medicine (TCM) has a long history and unique advantages in the treatment of CVA, but there is still a lack of evidence-based medical support for TCM syndrome differentiation and treatment of this condition. To promote the standardized diagnosis and treatment of CVA in TCM, it is therefore particularly necessary to develop a disease-and-syndrome-based guideline in line with the principles of evidence-based medicine. The Guideline Project Team, drawing on the best available evidence and fully integrating clinical experience from experts, developed this guideline through extensive

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discussion and a systematic process, including expert interviews, clinical research, evidence retrieval and screening, evidence appraisal, formation of recommendations, drafting, self-assessment, solicitation of opinions, and review by the Association. Targeting CVA patients and grounded in clinical practice, the guideline provides guidance and recommendations on the TCM etiology and pathogenesis, diagnostic criteria and evaluation methods, differential diagnosis, syndrome differentiation and treatment, efficacy evaluation, and prevention and nursing of CVA. It is intended for respiratory specialists, internists, TCM practitioners (including integrative medicine physicians), general practitioners, as well as relevant nursing staff and pharmacists. This guideline aims to standardize TCM syndrome diagnosis and treatment for CVA, provide clinicians with strategies and methods for standardized TCM management, fully leverage the advantages of TCM in treating CVA, and help improve the clinical diagnosis, treatment, and research standards for this condition.

[Keywords] cough variant asthma; traditional Chinese medicine (TCM); integrated traditional Chinese and Western medicine; diagnosis and treatment guideline

咳嗽变异性哮喘(CVA)是一种特殊类型的哮喘,咳嗽是其唯一或主要临床表现,无明显喘息、气促等症状,但存在气道高反应性^[1-3]。CVA是慢性咳嗽最常见的病因,约占我国慢性咳嗽的32.6%^[4]。中国非典型哮喘(APAC)研究发现,与典型哮喘(CA)相比,CVA咽部症状常见、咳嗽敏感性更高^[5-6]。现代医学推荐使用吸入糖皮质激素联合支气管扩张剂、白三烯受体拮抗剂或短期口服糖皮质激素等方法治疗CVA。然而由于药物不良反应或禁忌症较多,患者依从性较差,导致治疗效果不理想,虽然大部分患者在用药后可在短时间内见效,但停止用药后咳嗽等症状往往会再次出现^[7-10]。中医药治疗CVA历史悠久,疗效确切,优势显著。然而目前对于CVA的辨证缺乏循证医学证据,因此有必要构建制定符合循证医学原则的CVA病证结合诊疗指南,更好地促进我国CVA的中医规范化诊疗。

《咳嗽变异性哮喘中医诊疗指南》(以下简称“本指南”)经中华中医药学会立项,并审议发布(团体标准立项编号20220743-BZ-CACM)。本指南遵循中医理论、辨证论治原则,通过改良德尔菲法确立临床问题,检索、梳理近30年中医治疗CVA的文献,结合国际公认的证据分级和推荐标准(GRADE方法)^[11],评价结果通过GRADE pro实践指南开发工具(GDT, <https://grade.pro.org/>)形成证据概要表。本指南在现有最佳证据的基础上,充分结合专家经验,并采用德尔菲法形成最终的推荐意见和共识建议。

本指南旨在规范CVA的中医证候诊断与治疗,为临床医师提供CVA中医标准化处理的策略与方法,充分发挥中医药治疗CVA的优势,助力CVA临床诊疗和科研水平的提高。本指南所列证型为临床常见证型,临床工作中如遇到不符合本辨证标准的特殊证型,可根据具体情况按照中医理论进行

辨证。本指南将在临床推广应用中不断完善,在循证医学证据的支持下定期修订。

1 范围

本指南提供了对CVA中医病因病机、诊断标准与评估方法、鉴别诊断、辨证论治、疗效评价、预防调护的指导和建议,适用于呼吸专科医师、内科医师、中医(中西医结合)医师、全科医师及相关护理人员 and 药师。

2 规范性引用文件

证据推荐级别及证据水平,参照GRADE分级与推荐意见强度^[12]、《中医临床诊疗术语 第2部分:证候》^[13]。

3 术语和定义

下列术语和定义适用于本指南。

CVA以慢性咳嗽为唯一或主要临床表现,无明显喘息、气促等症状,患者肺通气功能测定可正常,需行支气管激发试验才能发现可变性气流受限,此外部分CVA患者随疾病进展可出现喘息和气道高反应。CVA可归属于中医学“咳嗽”范畴,根据不同的临床表现特点又分为“风咳”“哮喘”“痉咳”“呛咳”“顿咳”“顽咳”“久咳”等。

4 诊断标准与评估方法(共识建议)

4.1 诊断标准 参照2024年全球哮喘防治倡议(GINA)指南^[1]、2006年ACCP循证临床实践指南^[14]、《支气管哮喘防治指南(2020年版)》^[15]、《咳嗽的诊断与治疗指南(2021)》^[2]、《中国咳嗽基层诊疗与管理指南(2024年)》^[16]等制定CVA诊断标准,符合以下即可诊断:(1)慢性咳嗽(咳嗽持续时间>8周,以咳嗽为唯一或主要症状),常伴有明显的夜间刺激性咳嗽,感冒、冷空气、灰尘、油烟等容易诱发或加重咳嗽;(2)支气管激发试验阳性,或呼气峰流量(PEF)平均昼夜变异率>10%,或支气管舒张试验阳性;(3)除外其他疾病所引起的咳嗽,抗哮喘治疗有效。

4.2 评估方法

4.2.1 肺功能 肺通气功能及支气管激发试验对CVA的诊断有重要价值^[2]。支气管激发试验阳性是CVA诊断的主要标准,通常为吸入激发剂后第1秒用力呼气容积(FEV₁)下降 $\geq 20\%$ ^[17]。无条件开展支气管激发试验的医院可检测PEF变异率或进行支气管舒张试验。PEF平均变异率可作为诊断参考标准,PEF平均昼夜变异率(至少连续7 d每日PEF昼夜变异率之和/总天数7 d) $> 10\%$ 可支持CVA的诊断^[1]。支气管舒张试验阳性是指吸入支气管舒张剂后,FEV₁增加 $\geq 12\%$,且FEV₁绝对值增加 ≥ 200 mL。但CVA患者FEV₁及FEV₁占用力肺活量的比值(FEV₁/FVC)下降幅度较小,基本在正常范围,因此支气管舒张试验阳性率极低^[18-19]。支气管舒张剂治疗有效是CVA的一个重要临床特征,但仍有部分(30%~40%)CVA患者对单纯支气管舒张剂治疗反应不佳^[20-21]。此外,CVA患者可伴有小气道功能障碍^[22]。研究表明,小气道功能指标如用力呼气流量(FEF) 25/50/75占预计值百分比(FEF25/50/75% pred)能够提示气道高反应性,与呼出气一氧化氮(FeNO)联合评估时,结果更具指向性^[23-24]。

4.2.2 血常规 外周血嗜酸性粒细胞增高可见于部分CVA患者,有助于判断是否存在嗜酸性粒细胞性气道炎症^[25-27]。

4.2.3 痰细胞学 痰嗜酸性粒细胞比例升高($\geq 2.5\%$)有助于CVA的诊断^[2,28],观察痰细胞的比例可以更准确地明确气道炎症类型,从而降低因支气管激发试验假阴性导致的漏诊率^[29]。对于不能自然咳痰或干咳少痰的患者,可使用痰诱导技术获取痰液^[29]。与外周血嗜酸性粒细胞检测相比,诱导痰嗜酸性粒细胞检测具有更高的敏感性与特异性^[28]。建议采用高渗盐水进行超声雾化诱导痰细胞学检查,但应避免在48 h内反复对患者行高渗盐水雾化诱导^[30-31]。

4.2.4 FeNO FeNO可作为肺功能和痰细胞学检查的辅助手段,FeNO水平升高(≥ 32 ppb)提示激素敏感性咳嗽(如CVA)可能性大^[2,32]。FeNO水平与辅助型T细胞2(Th2)型炎症强度呈正相关,提示嗜酸性粒细胞性气道炎症,其他疾病如嗜酸性粒细胞性支气管炎也可见FeNO水平升高。

4.2.5 过敏原和血清免疫球蛋白E(IgE) 二者可用于检测变应性疾病,60%~70%的CVA患者存在特应质,故有助于CVA的诊断^[33]。过敏原检测有助于明确患者过敏原,指导患者尽量避免接触过

敏原^[2]。

5 鉴别诊断(共识建议)

5.1 嗜酸性粒细胞性支气管炎(EB) EB以慢性咳嗽为主要表现,呈刺激性干咳或伴少量黏痰,其痰嗜酸性粒细胞比例 $\geq 2.5\%$ 、FeNO水平可升高,口服或吸入糖皮质激素治疗有效,与CVA易混淆。但EB患者无气道高反应性,PEF变异率正常,支气管扩张剂治疗无效^[2]。

5.2 上气道咳嗽综合征(UACS) UACS涉及鼻、鼻窦、咽、喉等多部位的基础疾病,亦表现为慢性咳嗽,但以白天或体位转变后咳嗽为主,入睡后较少,常伴有鼻塞、鼻腔分泌物增加、咽后黏液附着感及鼻后滴流感,辅助检查支持鼻部和(或)咽喉疾病的诊断,针对基础疾病病因治疗后可缓解^[2,34]。可根据肺功能、痰细胞学检查、对抗哮喘治疗的反应与CVA鉴别。

5.3 变应性咳嗽(AC) AC临床症状与CVA相似,常表现为慢性刺激性干咳,多为阵发性,白天或夜间均咳,油烟、灰尘、冷空气、讲话等易诱发,伴咽痒。AC具有特应质,可有变应性疾病史或变应原接触史,变应原皮试阳性,血清总IgE或特异性IgE增高,糖皮质激素或抗组胺药物治疗有效。但AC患者痰嗜酸性粒细胞通常正常,无气道高反应性^[2]。

5.4 感染后咳嗽(PIC) 当呼吸道感染的急性期症状消失后,咳嗽仍然迁延不愈,持续3~8周,胸部影像学检查无明显异常者称之为PIC^[35-36]。单纯依靠感冒或上呼吸道感染的病史和咳嗽症状诊断PIC可能会造成CVA的漏诊,建议有条件时应进行支气管激发试验、痰细胞学检查等进一步鉴别^[2]。

5.5 胃食管反流性咳嗽(GERC) GERC属于胃食管反流病(GERD)的一种特殊类型^[37-38],可见咳嗽及反酸、胸骨后烧灼感或暖气等典型反流症状,大多发生于日间、直立位及体位变换时,进食酸性及油腻食物可诱发或加重。本病食管反流监测酸暴露时间(AET) $> 6\%$ 或反流与咳嗽症状的相关概率(SAP) $\geq 95\%$,抗反流治疗后咳嗽明显减轻或消失。临床可根据GERC咳嗽性质、对质子泵抑制剂治疗的反应、肺功能、痰细胞学检查等与CVA鉴别。

5.6 血管紧张素转换酶抑制剂(ACEI)诱发的咳嗽 ACEI引起的咳嗽典型症状以阵发性、持续性干咳为主,常伴有咽部症状及白黏痰^[25]。ACEI引起的咳嗽常与剂量无关,咳嗽发生的时间与用药时间不定,停用药物后通常可在1~4周内缓解,但部分患者可能持续3个月以上^[39-41]。患者胸部影像学、血常

规、痰培养等检查均无异常,且大多数研究认为ACEI不影响患者的肺功能。详细的病史询问及ACEI停药后症状消失有助于鉴别诊断。

6 中医病因病机(共识建议)

咳嗽变异性哮喘的主要病因病机为宿根内伏,遇感引触,内外合邪,肺气上逆而作咳。若素有风邪伏肺,外风引动,内外相合,风扰气逆,风摇钟鸣而作咳;若素有痰饮内停,易受外邪侵袭,寒饮相搏,肺失宣降则上逆为咳;若为饮食、气候所伤,内外合邪,湿热蕴结,三焦气机不畅,枢机不利,肺气宣肃失司,上逆而咳;若情志不遂,肝郁化火,木火刑金,风火相煽,上逆侮肺,咳嗽阵作;若久咳迁延不愈,耗气伤阴,母病及子,肺肾亏虚,气逆而咳^[42-44]。

7 证候诊断(共识建议)

参照《咳嗽中医诊疗专家共识意见(2021)》^[45]、《实用中医内科学》^[46]、《中医病证诊断疗效标准》^[47],符合主证2项、次证≥3项,结合舌脉即可诊断。

7.1 风扰气逆证 主证为①干咳无痰或少痰,②咽痒;次证为③遇风诱发,④骤发骤止,⑤言语引咳,⑥鼻塞、流涕、喷嚏,⑦鼻痒或眼痒;舌脉为舌淡红,苔薄,脉浮或浮弦。

7.2 痰饮伏肺证 主证为①咳嗽痰多,②痰白稀薄或呈泡沫状;次证为③遇冷易咳,④胸闷气短,⑤形寒畏冷,⑥倦怠乏力,⑦口不渴,或渴喜热饮;舌脉为舌淡苔白滑或白腻,脉弦紧或浮紧。

7.3 湿热蕴肺证 主证为①干咳无痰或痰少而黏,②咳声重浊;次证为③胸闷气短,④脘痞腹胀,⑤头身困重,⑥口干口苦口黏,⑦大便黏滞不爽;舌脉为舌苔黄腻,脉滑数。

7.4 肝火犯肺证 主证为①呛咳少痰,②咳嗽多与情绪波动相关;次证为③平素急躁易怒,④咳时面红目赤,⑤痰滞咽喉,咳之难出,⑥咽干口苦,⑦咳引胸胁作痛;舌脉为舌红苔薄黄,脉弦数。

7.5 气阴两虚证 主证为①干咳无痰或少痰,②气短;次证为③神疲乏力,④口干咽燥,⑤声音嘶哑,⑥自汗或盗汗,⑦咳而遗尿;舌脉为舌红少苔,脉细数。

8 治疗

8.1 辨证方药

8.1.1 风扰气逆证 治法:祛风宣肺,降逆止咳。

方药:苏黄止咳汤^[48-52](证据级别C级证据;强推荐),药物组成:炙麻黄、地龙、前胡、五味子、牛蒡

子、紫苏叶、枇杷叶、紫苏子、蝉蜕。

若咳嗽声重,气急,咳痰稀薄色白,伴鼻塞,流清涕,舌淡红苔薄白,脉浮紧者,选用三拗汤^[53-56](《太平惠民和剂局方》,证据级别C级证据;弱推荐),药物组成:麻黄、苦杏仁、甘草。

若咳嗽频剧,咽喉干痒或疼痛,身热不甚,口微渴,苔薄黄,脉浮数者,选用桑菊饮^[57-59](《温病条辨》,证据级别D级证据;弱推荐),药物组成:桑叶、菊花、苦杏仁、连翘、薄荷、桔梗、甘草、芦根。

若身热头痛,干咳无痰,气逆而喘,咽喉干燥,鼻燥,心烦口渴,胸满胁痛,舌干少苔,脉浮数,采用桑杏汤^[60-61](《温病条辨》,证据级别D级证据;弱推荐),药物组成:桑叶、浙贝母、淡豆豉、栀子皮、梨皮、苦杏仁、北沙参,或采用清燥救肺汤^[62](《医门法律》,证据级别D级证据;弱推荐),药物组成:桑叶、煅石膏、甘草、胡麻仁、阿胶、枇杷叶、人参、麦门冬、苦杏仁。

若患者咳嗽,干咳无痰或少痰,咽干咽痒,声音嘶哑,或有气短,舌红少津,脉数。选用桑梅止咳方^[63-64](证据级别D级证据;弱推荐),药物组成:桑叶、桑白皮、乌梅、白芍、五味子、桔梗、炒苦杏仁、炙枇杷叶、地骨皮、炙甘草。

中成药:①苏黄止咳胶囊(证据级别C级证据;强推荐)^[65-68],用法用量:口服,每次3粒(0.45 g/粒),每日3次。本品含有麻黄,高血压、心脏病患者慎用;运动员慎用。②三拗片(证据级别C级证据;弱推荐)^[69-71]。用法用量:口服,一次2片(0.5 g/片),每日3次。本品含有麻黄,高血压、心脏病患者慎用;运动员慎用。

8.1.2 痰饮伏肺证 治法:温肺化饮,祛痰止咳。

方药:小青龙汤^[72-85](《伤寒论》,证据级别C级证据;强推荐),药物组成:麻黄、白芍、细辛、炙甘草、干姜、桂枝、五味子、半夏。

若咽喉不利,痰多色白,舌淡苔白腻,脉浮紧者,选用射干麻黄汤^[86-97](《金匱要略》,证据级别C级证据;强推荐),药物组成:射干、麻黄、生姜、细辛、紫菀、款冬花、五味子、大枣、半夏。

若胸膈满闷,咽部不利,如有异物梗阻,舌苔白润或白滑,脉弦缓或弦滑,则用半夏厚朴汤^[98-102](《金匱要略》,证据级别C级证据;弱推荐),药物组成:半夏、厚朴、茯苓、生姜、苏叶。

若咳嗽气逆,痰多胸痞,舌苔白腻,脉滑,则用三子养亲汤加减^[103-105](《韩氏医通》,证据级别D级证据;弱推荐),药物组成:紫苏子、白芥子、莱菔子。

若邪气入里化热,身热不解,咳逆气急,汗出,口渴,舌苔薄白或黄,脉滑而数者,选用麻杏石甘汤^[106-115](《伤寒论》,证据级别C级证据;弱推荐),药物组成:炙麻黄、苦杏仁、炙甘草、石膏。

中成药:①小青龙颗粒(证据级别D级证据;弱推荐)^[116],用法用量:开水冲服,每次1袋,1袋13 g,每日3次。本品含有麻黄,高血压、心脏病患者慎用;运动员慎用。②寒喘祖帕颗粒(证据级别C级证据;弱推荐)^[117-119],用法用量:口服,每次1袋(12 g/袋),每日2次。目前暂时缺乏该药用于孕妇、哺乳期女性的安全性证据,故此类患者应慎用;运动员慎用。

8.1.3 湿热蕴肺证 治法:清热利湿,降逆止咳。

方药:宣肺化湿止咳汤^[120-122](证据级别D级证据;弱推荐)或三仁止咳方^[123-124](共识建议),药物组成:宣肺化湿止咳汤:炙麻黄、连翘、赤小豆、苦杏仁、桑白皮、豆蔻、前胡、桔梗、枇杷叶、厚朴、甘草;三仁止咳方:苦杏仁、白蔻仁、薏苡仁、清半夏、厚朴、射干、芦根、滑石、炙枇杷叶、桑白皮、甘草。

若湿重而热象不显,症见咳嗽,胸闷气短,头身困重,困倦乏力,便溏,舌淡苔白腻,脉濡滑或濡缓,则用麻杏苡甘汤^[125-126](《金匮要略》,证据级别D级证据;弱推荐),药物组成:炙麻黄、苦杏仁、薏苡仁、炙甘草。

8.1.4 肝火犯肺证 治法:清肝泻肺,化痰止咳。

方药:泻白散(《小儿药证直诀》)合黛蛤散^[127-128](《医说》,共识建议),药物组成:桑白皮、地骨皮、粳米、炙甘草、青黛、海蛤壳。

若咳嗽因情志而发,痰黏难咯,胸闷咽堵,两胁胀痛,舌淡苔薄腻,脉弦,则用柴朴汤^[129-130](证据级别D级证据;弱推荐),药物组成:柴胡、黄芩、半夏、生姜、厚朴、茯苓、紫苏子、党参、大枣、炙甘草。

8.1.5 气阴两虚证 治法:益气养阴,降逆止咳。

方药:补肺汤加减^[131](《永类铃方》,证据级别D级证据;弱推荐),药物组成:人参、黄芪、熟地黄、麦冬、五味子、桑白皮、紫菀、炙甘草。

若阴虚明显,症见干咳无痰或少痰,声音嘶哑,咽干口渴,舌红少苔,脉细数,则用沙参麦冬汤加减^[132-134](《温病条辨》,证据级别D级证据;弱推荐),药物组成:沙参、麦冬、玉竹、天花粉、桑叶、防风、五味子、炙甘草。

疗程^[76, 122, 129, 131, 135]:采用中药汤剂或中成药进行治疗时,其疗程一般以2~4周为宜,具体疗程根据临床实际情况而定(共识建议)。

8.2 中医外治法 中医外治法,包括冬病夏治穴位贴敷、毫针刺法、埋线、改良无痛麦粒化脓灸、耳穴压豆等,在改善CVA临床症状,提高生活质量,延缓病情进展等方面具有一定的辅助作用,临床可根据患者实际情况选择应用。

8.2.1 冬病夏治穴位贴敷(三伏贴)(证据级别D级证据;强推荐)^[136-138] 选取穴位:大椎、肺俞(双)、定喘(双)、肾俞(双)、丰隆(双)。

药物:以白芥子、细辛、延胡索、甘遂为基本方(《张氏医通》白芥子散)。

疗程:每次敷贴4~8 h,以3次为1个疗程,三伏天每伏各取1 d(建议选择每伏第1天),可连续治疗3个疗程(即3个夏天)。

注意事项:①贴药后避免挤压,局部皮肤有灼热、发红、轻度水泡等为正常现象,一般不需要处理,多可自行缓解,下次贴敷时可适当缩短贴敷时间;②若出现敷贴部位皮肤疼痛难忍,立即停止敷贴;③若局部皮肤出现大水疱,排尽渗液后消毒,外用无菌纱布包扎,以防感染,必要时到医院处理;④治疗当天不宜冷水浴,治疗期间禁食辛辣、生冷、油腻的食物及鱼虾等发物。

8.2.2 毫针刺法(证据级别C级证据;弱推荐)^[139-144]

选取穴位:主穴:肺俞(双)、列缺(双)、足三里(双)。配穴:若气喘胸闷者,取定喘、膻中;若咳痰质黏者,加鱼际、丰隆;若气短乏力者,加气海、关元、肾俞。

疗程:每日1次或隔日1次,10次为1个疗程,疗程之间可休息1~3 d。

注意事项:①操作时注意针刺的深度和进针角度,辨经脉、脏腑虚实选用适当的针刺手法;②防止发生断针;③晕针患者禁用。

8.2.3 埋线(证据级别C级证据;弱推荐)^[145] 选取穴位:肺俞(双)、膻中、定喘(双)。

操作:准备工具,使用3-0号1 cm医用羊肠线(或胶原蛋白线),装入经过消毒处理的9号腰穿针(针芯尖端已磨平)前端内。对背部的穴位则采用向脊柱斜刺。每穴进针约1寸,施行捻转得气后,边推针芯边退针管,使羊肠线埋入穴位皮下,线头不得外露。消毒针孔后,外敷无菌敷料,胶布固定24 h。

疗程:每10 d进行1次治疗,3次为1个疗程。连续进行2个疗程。

注意事项:①全程保持无菌操作,羊肠线(或胶原蛋白线)及操作器械过敏者禁用;②避开血管针

刺,防止出血,注意防止刺伤重要器官;③操作后保持创面清洁,定期随访,根据疗效评估是否继续治疗或调整方案。

8.2.4 改良无痛麦粒化脓灸(证据级别B级证据;弱推荐)^[146] 选取穴位:肺俞、膏肓、足三里,每次治疗时取一侧腧穴。

操作:将艾绒搓成两头尖中间粗的麦粒状艾炷(长0.5 cm,最大直径0.1 cm)备用。患者先取俯卧位艾灸肺俞和膏肓,再取仰卧位艾灸足三里,穴位处皮肤常规消毒后,涂抹少量凡士林(以能粘住艾炷,使之不歪斜或掉落为度),将艾炷立在穴位处,点燃后嘱患者认真感受灸感,待艾炷燃尽后再行下一壮,治疗结束后用棉球将穴位处擦拭干净。

疗程:首次治疗每穴灸5壮,之后每次灸3壮,间隔3 d施灸1次,待一侧灸疮发出及干瘪或痂退后,再取对侧腧穴治疗,共治疗8周。

注意事项:①蒿草过敏、晕灸及瘢痕体质者禁用;②灸疮发出后注意不要抓挠,避免感染或减少艾灸的有效刺激时长。

8.2.5 耳穴压豆联合中药治疗(共识建议)^[147] 耳部取穴:肺(双)、神门(双)、咽喉(双)、气管(双)及平喘点(双)。

操作方法:采用耳穴探穴棒在上述穴位处寻找敏感点并标记,耳轮消毒后,将王不留行籽贴于相应的耳穴上,并嘱患者适当按压药籽3~5 min,每天按压4次,交替按压两耳。

疗程:每2 d更换王不留行籽,共治疗4周。

注意事项:①胶布不应潮湿,不应污染,尽量避水,如因出汗等压丸掉落,应及时更换耳穴压丸;②耳部皮肤娇嫩,按压力度适中,不宜过重,避免皮肤破溃感染;③材料过敏者禁用,耳穴局部有湿疹、溃疡、冻疮时该穴禁用。

9 疗效评价(共识建议)

CVA的疗效评价指标主要包括^[2,14,16,148-149]①咳嗽的评估(详见增强出版附加材料):简易咳嗽程度评分(CET)、视觉模拟评分(VAS)、咳嗽专用生活质量问卷(CQLQ)、莱切斯特咳嗽问卷(LCQ);②中医证候积分(评估量表见增强出版附加材料);③肺功能:如FEV₁、FVC、FEV₁/FVC、PEF等;④气道炎症指标:外周血嗜酸性粒细胞计数、血清总IgE、FeNO;⑤其他评价指标:吸入剂作为按需使用的吸入次数、复发率等。

10 预防调护(共识建议)

(1)起居调护:注意休息,保证睡眠充足,不可

过于疲劳,注意气温冷暖变化,适时增减衣被,慎防受凉感冒^[150]。保持室内空气清新及环境卫生,避免粉尘、烟雾、花粉等刺激,远离过敏原^[151]。

(2)饮食调护:宜清淡富有营养、易消化食物,忌用生冷辛辣、肥甘厚腻之品^[152-153],禁食海鲜、坚果等明确过敏的食物^[154]。

(3)情志调护:医护需与患者建立有效沟通,确立医患互信关系,给予患者心理疏导,调节消极情绪,使患者保持积极乐观的生活态度^[155-156]。

(4)运动锻炼:鼓励患者适当活动,坚持运动,在医护指导下进行深呼吸锻炼,或进行六字诀、易筋经、五禽戏、八段锦等功法练习^[157]。从小运动量开始,锻炼时间根据个人体质而定,以隔天运动为宜,避免在不良环境下(如空气污染、过寒过热等)进行户外运动^[158]。

(5)健康宣教:强化知识宣教,制定健康教育计划^[152]。医护主导,患者和家属积极配合,普及疾病相关知识,讲解治疗方案、护理方案等^[153]。嘱患者日常生活中远离过敏原与刺激性因素,养成良好的饮食及作息习惯,保持充足的睡眠与休息;告知患者治疗期间相关注意事项,以保证治疗计划的顺利实施^[159]。

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[利益冲突] 本指南所有参与者不存在任何利益冲突。

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