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Clinical medicine | January 2020 The new guidelines change the categorization, testing and prescription of pneumonia. While pneumonia is not a new disease, it is certainly an evolution, and new guidelines are trying to keep pace. Before the beginning of the antibiotic era around 1945, Streptococcus pneumoniae caused more than 90% of the cases of pneumonia (CAP) acquired by the adult community, according to an article of review published in November 2017 Clinical Infectious Diseases. Now, these organisms represent 30% or less of the adult cases of the CAP, according to the CDC. In patients requiring ospedalization, the percentage can be even lower. Only about 5% of 2.259 adults hospitalized with PAC had pneumococcal pneumonia in the CDC EPIC studio, published in July 2015 by the New England Journal of Medicine. A huge 62% of patients had no pathogen at all detected on the reaction of the polymerase chain, and 23% had detected only viral pathogens. In other words, this is not your grandmother's pneumonia. The guidelines evolved along with the disease, although slowly. More recently, in October 2019, the American Thoracic Society (ATS) and the Infectious Diseases Society of America (IDSA) updated their joint guideline on the diagnosis and treatment of adults with the PAC since 2007. While the new guideline shares many similarities with previous recommendations, there are several important differences. Among them, say goodbye to pneumonia associated with health (HCAP), and be looking for Pseudomonas aeruginosa andStaphylococcus aureus (MRSA). A new era of CAP management has arrived. Major changes Following the lead of the same joint guideline of 2016 companies on hospital-acquired and ventilated pneumonia (HAP/VAP), the new CAP guideline recommends abandoning the use of the HCAP category to guide therapy. In the 2005 ATS/IDSA guideline on HAP, VAP and HCAP, risk factors for multi-drug-resistant pathogens that cause HCAP included previous hospitalization for two days or more in the last 90 days and residence in a nursing home or in an extended care facility. The guideline introduced HCAP as a new category of nosocomial pneumonia. "It was not a success strategy," said Joshua P. Metlay, MD, PhD, FACP, one of the two main authors of the new CAP guideline. "It would have been difficult to see him at that time, but you could certainly see him now." This is because a substantial part of pneumonia patients admitted to hospitals met HCAP criteria, said the subspecialist of infectious diseases Richard T. Ellison III, MD, FACP, a professor at the University of Massachusetts medical School in Worcester, Mass. In turn, doctors began to regularly prescribe a broad spectrum of coverage for P. aeruginosa and MRSA, including the infamous combination of vancomycin and piperacillin/tazobactam, said. "Now there is evidence that this combination in particular has more risk of causing nephrotoxicity," said Dr. Ellison. "So I think these new guidelines will have a significant change in the way in whichare managed in the hospital environment." The new guideline narrows the criteria for the treatment of P. aeruginosa and MRSA. However, for some patients, covering these pathogens will be life-saving, said Dr. Metlay. "We have really tried to emphasize the importance of getting microbiological tests when you are going to cover for these pathogenic agents, because then at least 48 hours, if you have no proof of culture that those are pathogenic agents, you can de-escalate and stop the wider therapy." The new guideline only recommends covering for P. aeruginosa and MRSA in hospitalized patients based on local epidemiology and validated risk factors. While the previous guideline did not generally recommend the routine use of sputum cultures, the new guideline recommends obtaining them for patients with severe disease and for all inpatients treated empirically for P. aeruginosa or MRSA. Getting cultures can support antibiotic stewardship, said President IDSA Thomas M. File Jr., MD, MSc, MACP. "My grip is if a patient is prone to sputum, even in patients not always under surveillance, to send culture, as it can help with pathogen-direct therapy for de-escalation and possibly avoid unnecessary broad spectrum antibiotics," he said. "If pneumococcus pan-susceptible is isolated, [yes] can go with penicillin or amoxicillin." The new criteria to consider the P. aeruginosa or MRSA function as a kind of replacement for HCAP, according to Michael S. Niederman, MD, MACP, co-president2005 nosocomial pneumonia guidance committee that proposed HCAP and clinical director and associate head of the lung and critical care division at Weill Cornell Medicine in Roslyn, N.Y (Dr. File reports research funding from Nabriva and previous consultants for Melinta and bioMérieux. Dr. Niederman reports advice and advice for Merck, Pfizer, Nabriva and Paratek.) "I think that [change] was not a bad idea, but I think they went a little far away in some areas," said Dr. Niederman. For example, although the guidelines suggest that doctors should get local data about whether P. aeruginosa or MRSA is prevalent in their patients with CAP, Dr. Niederman said it is not likely to happen. While the intention of antibiotic stewardship is good, he said, "I am worried that there are patients who epidemiologically would be at risk and could benefit, but will not get that therapy [for P. aeruginosa or MRSA] because no one has a knowledge of local risk factors, as recommended in the guideline." However, the new emphasis on getting sputum evaluations should allow hospitals to use those objective data to ascertain their local epidemiology, said Dr. Ellison, who is also hospital epidemiologist at UMass Memorial Medical Center. "I think there has been less pressure to try to get sputum samples in the last decade, and this is really about to strengthen the need for us to get culture data," he said. Yet, there arefake-negative sputum cultures, with different causes, and in some chronically ill patients, a sputum culture can reflect colonizing and not infecting organisms, said Dr. Niederman. For example, the patient may have already been started on antibiotics, or the sample may be poor, which may be a problem in patients not inubrifed especially, he said. "If you have to deal with someone who is old and weak ... it can be quite difficult to get them," Dr. Ellison agreed, adding that it is ideal to have a nurse or another staff coach the patient to provide a good specimen, rather than simply to put a cup of collection next to the bed. Treatment Recommendations As for empirical therapy for patients with CAP, it has not changed much from the previous guideline. "Empirical treatment recommendations for inpatients are very similar to what they were," said Dr. Metlay, who is the head of the division of general internal medicine at the Massachusetts General Hospital in Boston. "Although we recently had new antimicrobial agents on the market ... there were not many data suggesting that old drugs should not continue to be used." For adults hospitalized with CAP not always having risk factors for P. aeruginosa or MRSA, the guideline recommends an empirical treatment with a beta-lactam plus a macrolide or with a respiratory fluoroquinolone. For patients who have documented allergies or contraindications to both macrolides and a third option is the combination therapy with a beta-lactam and doxycycline. In ICU, patients should not receive monotherapy. "It's not new, but it's a very important point that hospitalists need to be aware," said Dr. Niederman. For those who have a severe PAC without risk factors for P. aeruginosa or MRSA, the guideline recommends a standard treatment regimen for combination with a beta-lactam and macrolide or beta-lactam and a respiratory fluoroquinolone, with stronger evidence for the first. "I agree. My thought is a better choice than a macrolide," said Dr. Niederman. "There are more data about it as the second drug, and ... There have been many concerns about the side effects of quinolone. However, if Legionella is likely or proven, a quinolone can be a better option like the second medication." Fluoroquinolones has tested time in terms of effectiveness, but there are more and more questions about their safety. Since 2008, the antibiotic class has been invaded by FDA warnings on several risks, including tendinopathy, hypoglycemic coma, and side effects of mental health. Some critics have questioned whether the guideline pushes strong enough for steward fluoroquinolones. Subspecialist Brad Spellberg, MD, FACP, argued that drugs should not have been included as first-line options to treat PAC. "Using an oral agent that is active against P. aeruginosa to treat pneumococcal pneumonia and micoplasma is irrelevant ... they needreserved and preserved for patients who need gram-negative oral therapy," he said. Respiratory fluoroquinolones (e.g. moxifloxacin and levofloxacin), however, are not so effective against P. aeruginosa as, say, ciprofloxacin, and are active against the Legionella species, of the Chlamydia species, and Mycoplasma, observed Dr. Ellison. "These three pathogenic agents are not so covered by doxycycline or certainly penicillins, so this is the reason" fluoroquinolones are recommended by the guideline. He recognized that macrolides also provide coverage for that bug group. When developing the guidelines, Dr. Metlay and colleagues found that treatment with fluoroquinolones is still very effective for patients with CAP, he said. "There is no data suggesting that the results are worse – perhaps better in some settings – so it would be difficult to remove those drugs as part of our recommended standard therapy for pneumonia patients." It is true that fluoroquinoloni are safe and effective for the CAP, Dr. Spellberg accepted. "Is this the point? No. The problem is how the results of the tests are applied in the real world, where resistance to antibiotics is an important concern. "They must be interpreted in the context of proper clinical practice," he said. Dr. Metlay added that when there are multiple treatment options, the guideline does not approve one above the other. "You must make an individual decision, and this decision includes weighing some of theseas well as the benefits," he said, guide where there was no one the new guideline addresses four key issues that were not raised in the previous guidelines: procalcitonin, corticosteroids, rapid molecular tests and new antibiotics. in 2017, fda approved an expanded indication for the first procalcitonin test to help doctors in making the decision to stop antibiotic treatment in patients with lower respiratory infections. The higher the level of biomarker infection in the blood, the higher the risk of bacterial infection. "The data is quite convincing through numerous clinical studies that if you use procalcitonin to allow early de-escalation or cessation of therapy, you will decrease the oo of antibiotics by about 25.5% without any change in clinical or death cure," said Dr. spellberg, who is official medical head at the county of los Angeles-University of the medical center of Southcalton California. this because the biomarker has been shown to be effective in environments where the average duration of therapy exceeds the five-seven recommended days, the guideline said. "We thought that in general, if you are going to agree with this and give five days as your standard duration, then really there is no role to measure procalcitonin as well, because there is no evidence that you can further reduce that by usingDr. Metlay said. Dr. File, however, said that he found the useful test, especially when a patient tests positive for a virus and has a very low procalcitonin level, suggesting a very low probability of concomitant bacterial infection. "This probably represents monoinfection with a virus, giving us confidence to stop antibiotics well before five days," he said. Although the guidelines did not address this, procalcitonin may also be a valuable tool to help decide which patients to put in ICU, Dr. Niederman noted. In a study, published in the CHEST of October 2016, hospitalized patients who have a high level of procalcitonin and met three minor criteria for the severe CAP ended in 36% of the ICU, compared to 13% for those who have met three minor criteria, but had a low level of procalcitonin. "To me, procalcitonin added a lot of value to understand who to put in ICU," he said. Another new driving area is corticosteroids, which were very discussed for patients with severe CAP. The guideline recommends not to use them in general, and especially not for the CAP linked to influence, although they can be considered in patients with septic refractory shock. Most experts have accepted this recommendation. However, Dr. Niederman indicated a randomized test published in February 2015 by JAMA, which showed that steroids decrease treatment in patients with severe pneumonia plus a high inflammatory response (e.g., high C-reactive protein level). "I thinka little too simple to say no [patients with] severe pneumonia should get steroids," he said. "I believe that [those with] severe pneumonia with a high level of inflammation should." The guideline also offers a limited support for new nucleic acid amplification tests. It mentions that many of those who are available can identify the cause of pneumonia, but "require rigorous tests to assess the impact" on treatment decisions and clinical results. "Personally, we found these tests very useful but agree more studies are needed to assess the impact," said Dr. File, who is also professor of internal medicine, teacher teacher, and the chair of the infectious disease section at the Northeast Ohio Medical University in Rootstown, Ohio. "We are in a revolution of development of these new rapid tests, and suspicious within the near future, we will have these studies." Finally, the guideline said that the most recent antibiotics approved to treat the CAP by the FDA require additional research. These drugs include omadacycline (a tetracycline agent,) lefamulin (a pleuromutiline agent/action rotation mechanism,) and delafloxacin (a new fluoroquinolone.) There is no mention of how or when considering these new agents, Dr. File noted. "This is probably partly due to the fact that these were all just approved recently." In fact, the delafloxacin was approved in October 2019, just after the publication of the guideline. For need, new drugs have been designed to be equal to existing onesDr. Niederman noticed. "They didn't show a specific reason we have to use them," he said. "Regardless, I think, since some people are allergic to beta-lattam and that some people do not want to take quinolones, it is good to have non-beta-lattam alternatives, non-fluoroquinolone." Dr. Ellison added that their cost will probably be much higher than other medications currently available. "Every of these provide some advantages regarding the spectrum," Dr. File said new antibiotics. "I hope there can be a follow-up of the guidelines with some further guidance for these agents. " idsa pneumonia guidelines summary. idsa guidelines for vap. idsa guidelines for pneumonia

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