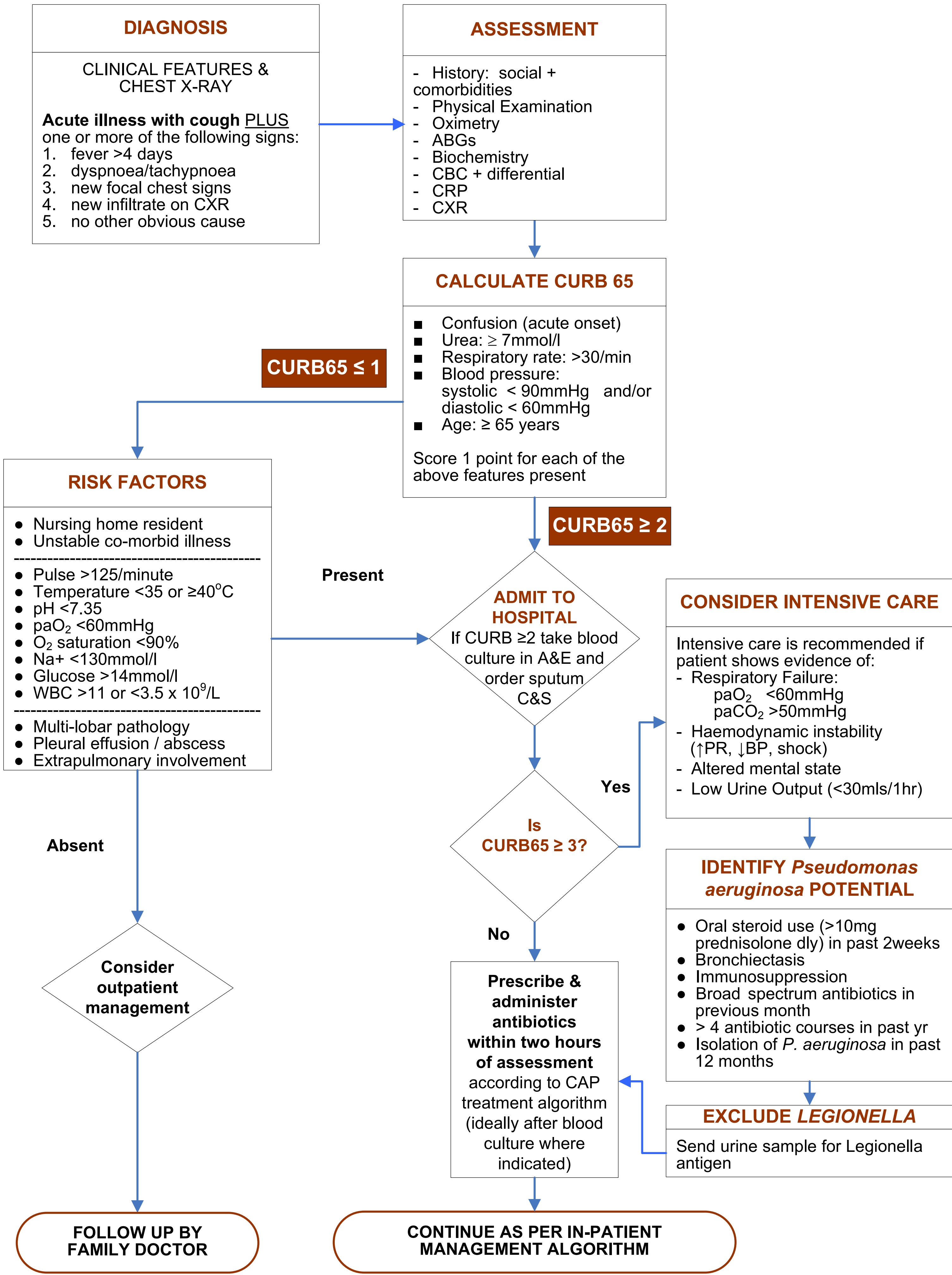
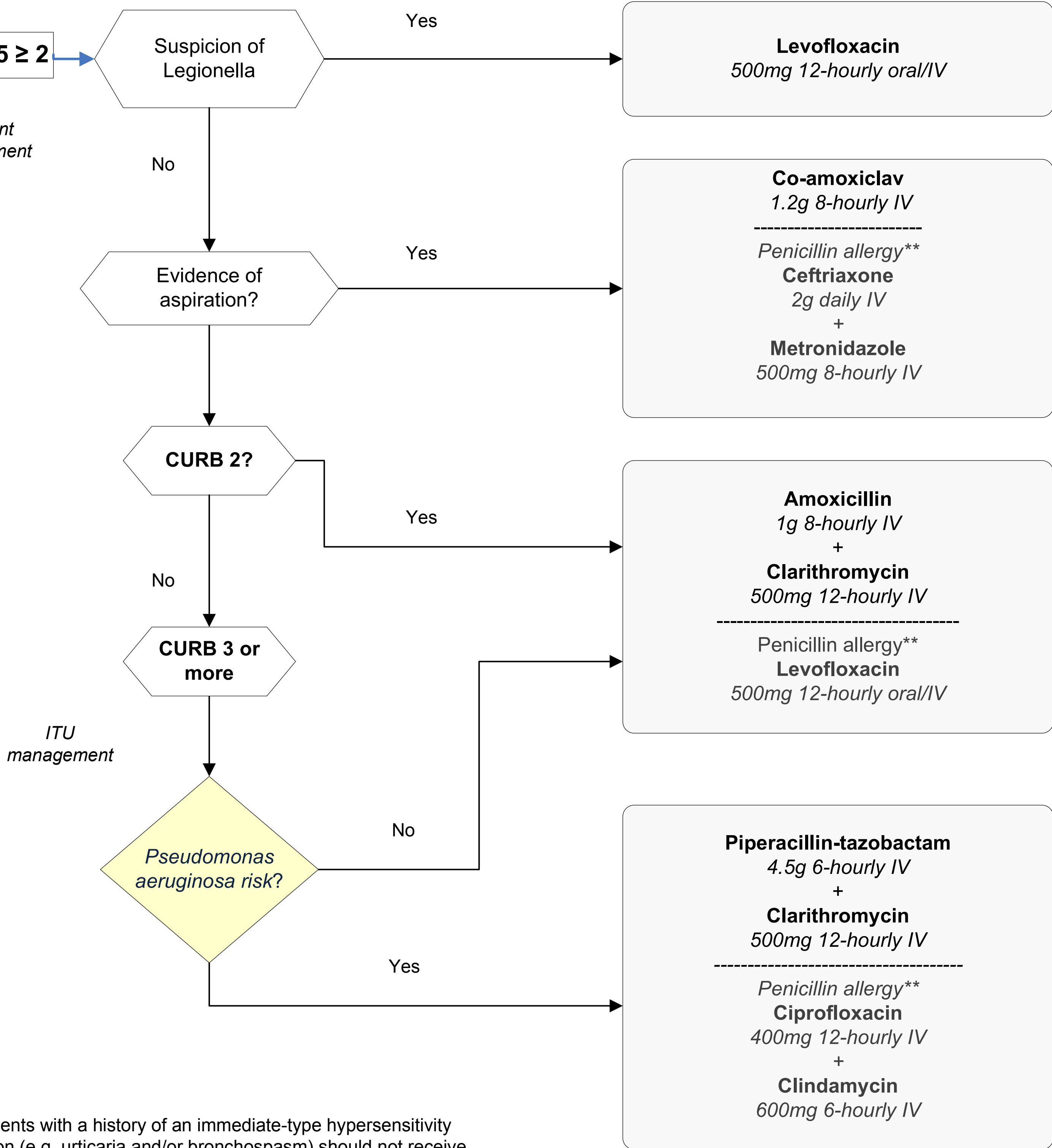
COMMUNITY ACQUIRED PNEUMONIA: INITIAL ASSESSMENT



SPTAR MATER DEI

Community Acquired Pneumonia
Antibiotic treatment



** Patients with a history of an immediate-type hypersensitivity reaction (e.g. urticaria and/or bronchospasm) should not receive any beta-lactams (including cephalosporins) or carbapenems.

Contact an Antibiotic Team member for advice

Consider oral switch when patient improves

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COMMUNITY ACQUIRED PNEUMONIA: IN-PATIENT MANAGEMENT

MONITOR RESPONSE

1. Resolution of respiratory symptoms:
   – cough
   – fever
   – shortness of breath
2. Improvement of oxygenation
3. Normalisation of WCC
4. Decrease in CRP
5. Improvement of clinical signs / CXR

Satisfactory response at day 3?

NO → If unresolving – consider

YES → Assess IV to oral switch

IF UNRESOLVING - CONSIDER

1. Alternative diagnosis: - pulmonary embolism - congestive heart failure - neoplasm - vasculitis - sarcoidosis - drug reaction - alveolitis 2. Other pathogens - tuberculosis - viruses - fungi (parasites in expats) 3. Empyema 4. Bronchial obstruction 5. Extra pulmonary spread of infection 6. Antibiotic Resistance	1. Repeat CXR 2. CT thorax ± CTPA 3. Bronchoscopy (incl BAL) 4. Mediastinoscopy 5. Lung biopsy	Consult ID Physician / Microbiologist

Clinical response → Assess IV to oral switch

ASSESS IV TO ORAL SWITCH

Patient should show:

1. Eating a regular / modified diet or receiving enteral nutrition
2. Functional GI tract
3. Resolution of fever
4. Reduction of WBC / CRP

Exclusion Criteria:

- Unable / refuses to swallow
- Risk of aspiration
- Severe nausea, vomiting, diarrhoea
- Immunocompromised

DISCHARGE CRITERIA

1. Afebrile
2. Haemodynamically stable:
   - Pulse: < 100/min
   - Systolic: > 90mmHg
3. Adequate respiratory status & oxygenation:
   - O_2 sat: >90%
   - Resp rate: 16-24/min
4. Functioning GI tract

Repeat CXR in 4-6 weeks, especially in older smokers