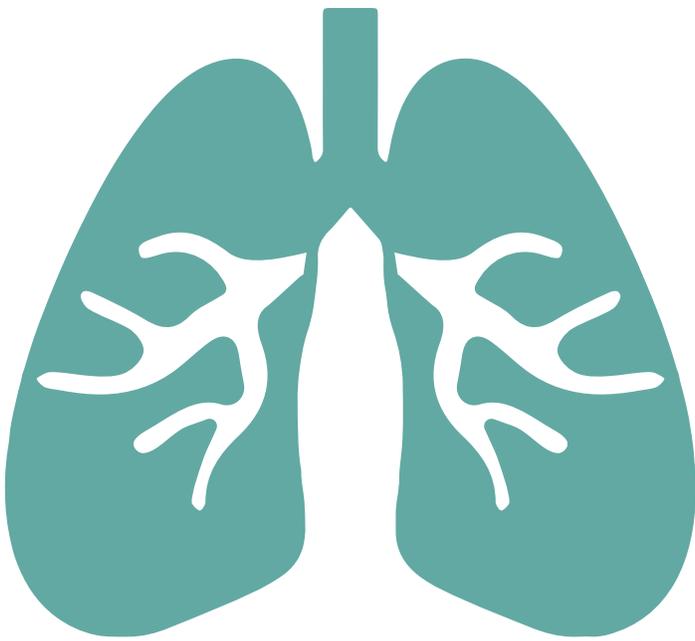


# Treatment of Community-Acquired Pneumonia





## Overview

This document details the Hospital Medicine Safety (HMS) consortium recommendations for empiric therapy and duration of treatment for HMS eligible (hospitalized, non-intensive care unit) patients with community acquired pneumonia (CAP).

The treatment recommendations highlighted in this document are not meant to be a comprehensive guideline. Many aspects of the management of CAP are not covered in this document, including items such as appropriate diagnostic testing, criteria for the timing of IV to oral step down, discharge criteria, etc. HMS recommendations regarding these aspects of pneumonia care may subsequently be developed based on findings from ongoing data collection at HMS hospitals, but for now, please refer to national or locally developed CAP guidelines.



## Intended Use

- These recommendations are intended for **non-ICU patients** with CAP who are not severely immunosuppressed and do not have risk factors for multidrug-resistant (MDR) organisms (see appendix for select risk factors).
- Hospitals should choose their preferred regimen among the options provided based on antimicrobial stewardship/infectious diseases recommendations, hospital formulary restrictions, and hospital antibiograms.



# Empiric Treatment for Community-Acquired Pneumonia

## HMS Preferred

- Ampicillin-Sulbactam **PLUS** Azithromycin, Clarithromycin, or Doxycycline
- Ceftriaxone or Cefotaxime **PLUS** Azithromycin, Clarithromycin, or Doxycycline

## Alternative but HMS Non-Preferred

- Levofloxacin<sup>1</sup>
- Moxifloxacin<sup>1</sup>

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## Aspiration Pneumonia

- Anaerobic coverage is not routinely warranted in non-critically ill patients with aspiration pneumonia.
- Anaerobic coverage may be appropriate in patients with cavitary or necrotizing pneumonia, empyema, complicated parapneumonic effusion, lung abscess, or post-obstructive pneumonia. The regimens for appropriate anaerobic coverage are not included in this guideline.



## Empiric Oral Step-Down Therapy: When no etiologic pathogen identified for Community-Acquired Pneumonia<sup>2</sup>

Amoxicillin  
Amoxicillin/clavulanate  
Cefpodoxime  
Cefdinir  
Cefditoren  
Cefuroxime

} +/- Azithromycin, Doxycycline, or Clarithromycin<sup>3</sup>

*Alternatives: Levofloxacin, Moxifloxacin in setting of severe PCN allergy*



## Duration of Therapy<sup>4</sup>

### Uncomplicated CAP

- 5 days<sup>5</sup>
- Therapy can be continued for patients who are febrile or clinically unstable<sup>6</sup> on day 5 of treatment

### Complicated CAP<sup>7</sup>

- 7 days<sup>8,9</sup>
- Therapy can be continued for patients who are febrile or clinically unstable<sup>6</sup> on day 7 of treatment



## Footnotes

1. Preferred for patients with cephalosporin allergy, allergy to both macrolides and doxycycline/tetracycline, or severe penicillin allergy [hives, angioedema, anaphylaxis, drug reaction with eosinophilia and systemic symptoms (DRESS), stevens-johnson syndrome (SJS), toxic epidermal necrolysis (TENS)]
2. If an etiologic organism is identified based on diagnostic testing, we recommend targeted, narrow spectrum treatment using local susceptibility data.
3. There is debate regarding the continuation of atypical coverage for clinically improving patients with CAP when legionella, mycoplasma, and chlamydia spp. have not been identified as an etiology. The IDSA/ATS CAP guideline supports the addition of a macrolide or doxycycline to a beta-lactam for initial empiric CAP treatment. However, many studies supporting the addition of atypical coverage focused on therapy administered during the first 24 hours of hospitalization. A large clinical trial has not been performed addressing continuation of atypical coverage beyond 24-72 hrs when an etiology has not been identified. Therefore, clinicians can individualize treatment after clinical improvement taking into account pneumonia severity, patient specific factors, and institution specific preferences.
4. Patients with legionella pneumonia, empyema, parapneumonic effusion, cavitary pneumonia, lung abscess, necrotizing pneumonia, thoracic surgery during hospitalization, pleural drainage catheters, bacteremia, or opportunistic infections (e.g. PCP pneumonia) are not addressed in the following recommendations.
5. If patient is afebrile for 48 hrs and has no more than 1 sign of clinical instability by day 5 of treatment.

6. *Signs of clinical instability: oxygen saturation < 90% or new oxygen requirement, heart rate > 100 beats/minute, respiratory rate > 24 breaths/minute, systolic blood pressure < 90 mmHg, altered mental status (different than baseline).*
7. *Patients with structural lung disease (e.g. bronchiectasis, pulmonary fibrosis, interstitial lung disease), moderate/severe COPD (excluding COPD exacerbation without pneumonia), documented pneumonia with MRSA, MSSA, or pseudomonas (or other non-fermenting gram-negative pneumonia), or immunosuppressed.*
8. *If patient is afebrile for 48 hrs and has no more than 1 sign of clinical instability by day 7 of treatment. Note: azithromycin duration should be no more than 5 days.*
9. *Some experts recommend 7 days of therapy for immunosuppressed patients and patients with structural lung disease or moderate/severe COPD. However, data supporting 5 days versus 7 days of therapy for such patients is lacking and either duration would be considered appropriate assuming criteria for clinical stability is met.*



## Appendix

### Suggested Antibiotic Dosing<sup>1</sup>:

<b>Drug Name</b>	<b>Dose</b>	<b>Route</b>	<b>Frequency</b>
Amoxicillin	1 g	PO	3 x daily
Amoxicillin/clavulanate XR	875 mg - 2 g	PO	2 x daily
Ampicillin Sulbactam	3 g	IV q	6 hours
Azithromycin	500 mg	PO/IV	on day 1
	250 mg	q 24	once daily x 4 days
Cefdinir	300 mg	PO	2 x daily
Cefditoren	400 mg	PO	2 x daily
Cefotaxime	1 g	IV q	8 hours
Cefpodoxime	200 mg	PO	2 x daily
Ceftriaxone	1 g	IV q	24 hours
Cefuroxime	500 mg	PO	2 x daily
Clarithromycin	500 mg	PO	2 x daily
Doxycycline	100 mg	PO	2 x daily
Levofloxacin	750 mg	PO/IV	1 x daily
Moxifloxacin	400 mg	PO/IV	1 x daily

1. *Suggested dosing only. Please individualize based on renal function or other pertinent clinical factors.*

## **Select Risk Factors for MDR Organisms**

- Coming from a nursing home or long term care facility
- Hospitalized  $\geq 2$  days in the last 90 days
- IV chemotherapy, IV antibiotics, home wound care, or hemodialysis in the 30 days prior to admission

## **Severely Immunosuppressed**

- AIDS (CD4 count  $< 200$  cells/microL)
- Neutropenia (ANC  $\leq 0.5$  K/uL)
- Cystic fibrosis
- Solid organ and bone marrow transplant recipients
- Receiving 2 or more immunosuppressive agents
- Congenital or acquired immunodeficiency, except HIV positive with CD4  $> 200$



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