

ANTIBIOTICS IN COMMUNITY ACQUIRED PNEUMONIA

K. Abdul Ghafur *

Community acquired pneumonia is one of the very common clinical scenarios where rational usage of antibiotic is extremely important to achieve good clinical outcome and to avoid inappropriate antibiotic use.

May I scribble down a few important points I gathered while reading 2009 BTS (British Thoracic society) guidelines. I have made some modifications to suit Indian clinical scenario.

1. CURB 65 score is a useful tool in assessing the severity of pneumonia.

2. Patients with CURB 65 score of 0 or 1 do not require hospitalisation, while patients with score of 2 need to be hospitalised, possibly in a short stay unit (Emergency room observation unit in Indian scenario and can be discharged home while stable, on oral antibiotics), score of 3 require urgent hospitalisation, score of 4 or 5 usually require ICU admission.

CURB65 SCORE

Confusion: New mental confusion

Urea: Raised Urea >7 mmol/l (for patients being seen in hospital).

Respiratory rate: Raised >30/min.

Blood pressure: Low blood pressure (systolic ,90 mm Hg and/or diastolic (60 mm Hg).

Age >65 years

EMPIRICAL ANTIBIOTIC CHOICE FOR ADULTS TREATED IN THE COMMUNITY

Amoxicillin is the ideal agent for treating patients with pneumonia who do not require hospitalisation. Clarithromycin or Doxycyclin are the alternative options especially in patients with penicillin allergy.

EMPIRICAL IN- HOSPITAL ANTIBIOTIC THERAPY FOR TREATING PNEUMONIA

Most of these patients can be managed with oral antibiotics. Oral Amoxicillin and a macrolide is the ideal choice in this scenario. Alternative options are oral levofloxacin or moxifloxacin or doxycycline.

When oral therapy is contraindicated, intravenous crystalline penicillin or ampicillin along with intravenous clarithromycin is a good combination. In penicillin allergic individuals who require IV antibiotics, IV levofloxacin alone or a second generation cephalosporin (eg.cefuroxime) or third generation cephalosporin (eg.cefotaxime or ceftriaxone) along with intravenous clarithromycin can be used.

In patients with high severity pneumonia intravenous co-amoxiclav along with clarithromycin can be given. Alternative options are second or third generation cephalosporins with a macrolide. When clinical improvement occurs, afebrile for more than 24 hours and no contraindication for oral therapy; those patients on IV therapy can be switched to oral. Those patients managed in the community or for most of the patients managed in the hospital with low or moderate severity uncomplicated pneumonia, 7 days of antibiotics is usually effective.

May I encourage the readers to go through the BTS guideline 2009 for a very interesting and thorough discussion on the subject.

* Dr.Abdul Ghafur.K , Consultant in Infectious Diseases and Clinical Mycology