

ANMC Inpatient Adult Community-Acquired Pneumonia (CAP) Guideline

Risk Factor Considerations

- Structural lung disease such as bronchiectasis or exacerbations of COPD with multiple courses of antibiotics and/or chronic steroid use may warrant coverage for *Pseudomonas aeruginosa*
- Receipt of IV antibiotics in preceding 90 days is a risk factor for multi-drug resistant organisms (MRDO)

****NOTE:** The following are **NOT** predictive of multi-drug resistant pneumonia and should **NOT** be used alone as an indication for empiric broad-spectrum coverage:

- Hospitalized in an acute care hospital for 2 or more days within 90 days of infection
- Resided in a nursing home or long term care facility
- Received recent chemotherapy or wound care in last 30 days
- Attended a hemodialysis clinic in the last 30 days

Treatment Recommendations

Infection	Treatment	Duration
Community-acquired PNA	<p>Preferred Therapy:</p> <ul style="list-style-type: none"> ○ Ceftriaxone 1g IV q24h (Cefepime 1g IV q8h extended infusion if risk factors for MRDOs) AND Azithromycin 500mg PO/IV q24h x3 days <p>Type 1 β-Lactam Allergy:</p> <ul style="list-style-type: none"> ○ Levofloxacin 750mg PO/IV q24h +/- Aztreonam 2g IV q8h* 	<ul style="list-style-type: none"> ○ 5 days for patients without immunosuppression or structural lung disease ○ 7 days for patients with moderate immunosuppression or structural lung disease ○ 10-14 days for poor clinical response, initial inappropriate tx, or significant immunosuppression ○ Patients should be afebrile for 48-72hr and demonstrate signs of clinical stability before therapy is discontinued
<p>Aspiration Pleuropulmonary Syndrome (Anaerobic coverage is clearly indicated only in the classic aspiration pleuropulmonary syndrome in pts with a h/o LOC as a result of EtOH/drug overdose or after seizures in pts with concomitant gingival disease or esophageal motility disorders)</p>	<p>Preferred Therapy:</p> <ul style="list-style-type: none"> ○ Ampicillin/Sulbactam 3g IV q6h (monotherapy) ○ If MRDO risk factors- Piperacillin/Tazobactam 3.375g IV q8h extended infusion (monotherapy) <p>Penicillin Allergic (Not Type-1):</p> <ul style="list-style-type: none"> ○ Ceftriaxone 1g IV q24h AND ○ Metronidazole 500mg PO/IV q8h <p>Type 1 β-Lactam Allergy:</p> <ul style="list-style-type: none"> ○ Moxifloxacin 400mg PO q24h ○ If MRDO risk factors- Levofloxacin 750mg PO/IV q24h AND Aztreonam 2g IV q8h AND Clindamycin 600mg IV q8h 	
<p>If MRSA PNA is suspected due to severe, life-threatening CAP, add vancomycin or linezolid to above regimen</p>	<p>Vancomycin Loading Dose:</p> <ul style="list-style-type: none"> ○ <50 kg: Vancomycin 1gm IV x 1 (then RPh to dose) ○ 50-70 kg: Vancomycin 1.5gm IV x 1 (then RPh to dose) ○ >70 kg: Vancomycin 2gm IV x 1 (then RPh to dose) <p>OR</p> <p>Linezolid 600mg PO/IV BID</p>	
Suspected or confirmed Influenza	Oseltamivir 75mg PO BID*	○ 5 days
Oral options to consider for de-escalation of β-lactam	<p>Preferred Therapy</p> <ul style="list-style-type: none"> ○ Amoxicillin 1g PO TID^ ○ Augmentin 875mg BID <ul style="list-style-type: none"> ▪ Add additional amoxicillin 1 g BID to Augmentin for CAP complicated by empyema, asplenia or Strep pneumo PenG MIC 2-4 <p>For Non-Type I PCN Allergic Patients</p> <ul style="list-style-type: none"> ○ Cefuroxime axetil 500mg PO BID 	○ Total duration (IV + PO) as above

Notes

- *If risk factors present consider addition of aztreonam, or if FQ exposure in previous 90 days
- ^Strep pneumo and/or cefinase negative H.flu / M.cat use high-dose **amoxicillin**
- Procalcitonin should be ordered if question of pneumonia diagnosis or acute exacerbation of COPD, see Procalcitonin guideline for further guidance.
- ∞ Higher doses of Tamiflu have not been associated with improved outcomes