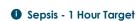
# The All Wales Secondary Care Community Acquired Pneumonia Guideline





#### **STEP 1 INFORMATION:**

**ASSESSMENT** 



#### Sepsis 6 bundle

Give stat doses as per high severity IV options.

Chest x-ray and CURB65 score within first hour if possible, but do not delay first dose of antibiotics

## No Sepsis - 4 Hour Target

- 1. Chest x-ray
- 2. CURB65 score
- 3. Antibiotics

## **STEP 2 INFORMATION:**

DIAGNOSE

#### 1 No new consolidation on chest x-ray

Look for alternative sources of infection.

Treat non-pneumonic exacerbations of COPD or bronchiectasis as per local guidance

Most patients with LRTI without consolidation do not benefit from antibiotics.

#### Consider treating with antibiotics if:

- Systemically very unwell
- CRP >100
- At high risk of complications due to major co-morbidity or immunocompromised
- Age 65+ with 2 of the following, or age 80+ with 1 of the following:
  - Hospital admission in last year
  - Diabetes
  - Heart failure
  - On oral steroids

## **STEP 3 INFORMATION:**

ASSESS SEVERITY AND MICROBIOLOGY

## Severity Assessment

1 point for each Document score in notes and on medication chart

Confusion (new) Urea >7mmol/l Resp rate ≥ 30/min **B**P <90mmHg systolic or ≤60 diastolic Age ≥65 years

Use **<u>clincal judgement</u>** alongside CURB65 score to determine severity.

## Consider treating as high severity if:

- Multi-lobar consolidation
- Immunocompromised
- Requiring critical care

If pregnant or breast-feeding, treat with:

- Amoxicillin PO 500mg TDS
- IV 1g TDS, +/- Erythromycin PO/IV 500mg QDS if high severity or atypical pathogen suspected

Remember TB and lung cancer can mimic CAP.

If influenza is suspected, follow local guidance.

#### Clinical Pathway



The All Wales Secondary Care Community Acquired Pneumonia Guideline

icst.info/the-all-wales-secondary-care-communityacquired-pneumonia-guideline

CAP: Community-acquired pneumonia

- CRP: C-reactive protein
- LRTI: Lower respiratory tract infection **NEWS:** National early warning score
- PO: Orally
- TB: Tuberculosis
- TDS: Three times a day QDS: Four times a day

#### STEP 1: ASSESSMENT

#### Suspected CAP

- LRTI symptoms
- Systemic upset (e.g. fever)
  - Focal chest signs

### Check for evidence of Sepsis

NEWS 6+ or critically unwell

0

Sepsis 1 Hour Target

No Sepsis

4 Hour Target

#### STEP 2: DIAGNOSIS

Consolidation on chest x-ray Confirmed CAP

No new consolidation on chest x-ray

#### STEP 3: ASSESS SEVERITY AND MICROBIOLOGY

#### CURB65 0-1

#### Low severity

Consider treatment in the community if appropriate

# **CURB65** 2 Moderate severity

Send sputum culture, blood cultures (if febrile or starting IV antibiotics), and consider urinary antigen tests for Pneumococcus and Legionella

# **CURB65 3+**

#### High severity - Oral and IV options

Send sputum culture, blood cultures (if febrile or starting IV antibiotics), and consider urinary antigen tests for Pneumococcus and Leaionella.

## CURB65 3+ or SEPSIS

### High severity - IV options

Send sputum culture, blood cultures (if febrile or starting IV antibiotics), and consider urinary antigen tests for Pneumococcus and Legionella.

## Early discussion with microbiology (+/- isolation) is advised if:

- Recent foreign travel
- Cavitating disease
- Previous isolates of resistant organisms

## STEP 4: TREAT

Five days of antibiotics is a sufficient course for most patients

## 1st line

# **Amoxicillin**

PO 500mg TDS

Amoxicillin PO 500mg TDS PLUS Clarithromycin PO 500mg BD

#### Amoxicillin PO 1g TDS PLUS Clarithromycin PO 500mg BD

If recent flu or chicken pox ADD

Flucloxacillin PO 500mg QDS

#### Amoxicillin IV 1g TDS PLUS **Clarithromycin** IV 500mg BD

If recent flu or chicken pox ADD

Flucloxacillin IV 1g QDS

## 2nd line

# Doxycycline

PO 200mg stat then 100mg OD

 Allergic to penicillin - Failed treatment with amoxicillin - Underlying lung disease - Atypical pathogen suspected

## Doxycycline

PO 200mg stat then 100mg OD

Allergic to penicillin

# Consider if:

Underlying lung disease

#### Co-trimoxazole PO 960ma BD

PLUS Clarithromycin PO/IV 500mg BD

#### Consider if: Allergic to penicillin

- Underlying COPD Already failed antibiotics in

#### Co-trimoxazole PO 960mg BD (first dose iv if sepsis) PLUS Clarithromycin

## PO/IV 500mg BD

Consider if: Allergic to penicillin - Underlying COPD Already failed antibiotics in the

## 3rd line

## Co-trimoxazole

PO 960ma BD

Reserve for patients who have failed treatment with doxycycline

#### Co-trimoxazole PO 960mg BD PLUS Clarithromycin PO 500mg BD

Reserve for patients with underlying lung disease who have failed treatment with doxycycline

## Levofloxacin

PO/IV 500mg BD Reserve for patients allergic to penicillin and Co-trimoxazole (septrin)

## OR

Tazocin IV 4.5g TDS PLUS **Clarithromycin** IV 500mg BD

Reserve for patients with previous pseudomonas infection or underlying bronchiectasis

### Levofloxacin

PO/IV 500mg BD Reserve for patients allergic to penicillin and Co-trimoxazole (septrin)

## OR

#### Tazocin IV 4.5g TDS PLUS Clarithromycin

IV 500mg BD

Reserve for patients with previous pseudomonas infection or underlying bronchiectasis

## STEP 5: REVIEW

Consider extending the course beyond 5 days based on clinical response. Most patients on IV antibiotics can be stepped down to oral antibiotics within 48 hours.

