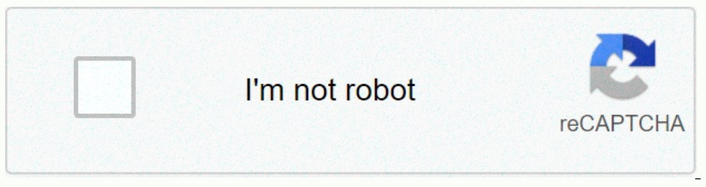

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Idsa cap guidelines 2017

ATS/IDSA Publishes Clinical Guidelines on Communities Acquiring Pneumonia Oct. 1, 2019— the American Thoracic Society and the American Infectious Diseases Association have published an official clinical guideline on adult diagnosis and treatment with community-acquired pneumonia (CAP) in Ats's Oct. 1 American Journal of Respiratory and Critical By definition, CAP is pneumonia obtained outside the hospital environment. Many things can cause pneumonia, which causes air cancer in the lungs to become inflamed, although the most often the bacteria or viruses are to blame. The guidelines make recommendations in response to the key results faced by doctors looking after patients with CAP, including diagnostic tests, care sites, selection of early empirical antibiotic therapy and subsequent management of the disease. The guidelines focus on unimunompromised adults. The latest guidelines replaced one from 2007, produced by both communities. While some recommendations made in the initial guidelines remain unchanged, the 2019 version reviewed recommendations for empirical treatment strategies and made additional recommendations for disease management. An important difference between the latest guidelines and 2007 guidelines is that it recommends more microscopic studies of respiratory tract samples in some subgroup patients to avoid unnecessary therapies for drug-resistant bacteria. CAP remains one of the leading causes of death in the world, said Grant Waterer, MBBS, PhD, co-chair of the guidelines committee and professor of medicine at the University of Western Australia. Not only has there been new data in the last decade, but there has now been a strong national and international focus on antibiotic surveillance. It is time to update the guidelines so that doctors can ensure they are still practicing evidence-based care. The 15-member panel that produced the guidelines included specialists in infectious diseases, pulmonology and evaluating medical studies. Using the Proposal Grading, Assessment, Development and Evaluation (GRADE) framework, the panel made recommendations in response to 16 clinical questions. What follows are samples of those questions and suggestions made in answering the questions. All questions and suggestions are available in the executive summary of the guidelines. Question 1. In adults with CAP, should Gram stains and a culture of lower respiratory reception are obtained at the time of diagnosis? We recommend not getting and sputum Gram culture routinely in adults with CAP managed in outpatient environments (strong recommendations, very low quality of evidence). We recommend getting pretreatment Gram and breathing respiratory recession culture on adults with CAP are dealt with in a hospital environment that: is classified as severe CAP, especially if they are intubated (strong recommendations, very low quality of evidence), or a. are being treated empirically empirically Methicillin-resistant Staphylococcus aureus (MRSA) or P. aeruginosa (strong recommendation, very low quality of evidence), or previously infected MRSA or P. aeruginosa, especially those with advance respiratory tract infections (conditional recommendations, very low quality of evidence), or hospitalized and received parental antibiotics in the last 90 days, unless local data has shown that infection with MRSA or P. aeruginosais is unlikely to be present Question 8. In an outpatient environment, which antibiotics are recommended for cap empirical treatment in adults? For adults with healthy outpatients without comorbidities listed below or risk factors for antibiotic-resistant pathogens (See Question 11), we recommend: Amoxicillin 1 grams three times a day (strong recommendation, medium quality of evidence), or Doxycycline 100 mg twice a day (conditional proposal, low quality evidence), or makrolide (azithromycin 500 mg on the first day then 250 mg per day or clarithromycin 500 mg twice a day or clarithromycin ER 1000 mg per day) only in areas with macrolide resistance & lt; 25% (conditional proposal, medium quality daily) only in areas with macrolide resistance & lt; 25% (conditional recommendations, medium quality per day) only in areas with macrolide resistance & lt; 25% (conditional recommendations, medium quality For outpatient adults who have comorbidities such as chronic heart , lungs, liver, or kidney disease; diabetes; alcoholism; malignancy; or asplenia; we recommend (without preferential order): Combined therapy: amoxicillin/clavulanate 500 mg / 125 mg three times a day, or amoxicillin/clavulanate 875 mg/125 mg twice a day, or 2000 mg/125 mg twice a day, or cephalosporin (cefpodoxime 200 mg twice a day or cefuroxime 500 mg twice a day); and makrolide (azithromycin 500 mg on the first day and then 250 mg per day, clarithromycin [500 mg twice a day or an extension of 1000 mg release once a day]) (strong recommendations, moderate quality evidence for combination therapy), or doxycycline 100 mg twice a day low quality evidence for combined therapy), or Monotherapy: fluoroquinolone respiratory (levofloxacin 750 mg per day, moxifloxacin 400 mg per day, or gemifloxacin 320 mg per day) (strong recommendations, moderate quality of evidence). Question 9. In the inpatient atmosphere, which antibiotic regimen is recommended for cap empirical treatment in adults without risk factors for MRSA and P. aeruginosa? In adults inpatients with severe CAP without risk factors for MRSA or P. aeruginosa (see Recommendation 10), we recommend the following empirical treatment regimens (without priority order): combination therapy with beta-lactam 1.5 to 3 g every 6 hours, cefotaxime 1 to 2 g every 8 hours, ceftriaxone 1 to 2 g, daily or ceftaroline 600 mg every 12 hours) and macrolides (azithromycin 500 mg daily or clarithromycin 500 mg twice a day) (strong reserves, high quality of evidence), or monotherapy with respiratory fluoroquinolone (levofloxacin 750 mg daily, moxifloxacin 400 mg daily) (strong high quality of evidence); The third option for adults with CAP that has contraindications to both previous regimens is: combined therapy with beta-lactam (ampicillin+sulbactam, cefotaxime, ceftaroline or ceftriaxone, dose as above) and doxycycline 100 mg twice a day (conditional proposal, Low quality In inpatient adults with severe CAP without risk factors for MRSA or P. aeruginosa, we recommend: beta-lactam plus makrolide (strong recommendation, moderate quality of evidence); or beta-lactam plus respiratory fluoroquinolone (strong recommendation, low quality of evidence). Question 11. In an inpatient setting, should adults with CAP and risk factors for MRSA or P. aeruginosa be treated with advanced spectrum antibiotic therapy rather than a standard CAP regimen? We recommend the use of previous categorization of healthcare-related pneumonia (HCAP) to guide the selection of advanced antibiotic coverage in adults with CAP (strong recommendation, moderate quality of evidence). We recommend that doctors only cover empiricals for MRSA or P. aeruginosa in adults with CAP if local risk factors are confirmed either for present pathogens (strong recommendations, moderate evidence quality). Empirical treatment options for MRSA include vancomycin (15 mg/kg per 12 hours, adjust based on levels), or linezolid (600 mg per 12 hours). Empirical treatment options for P. aeruginosa includes piperacillin-tazobactam (4.5 g per 6 hours), cefepime (2 g every 8 hours), ceftazidime (2 g per 8 hours), aztreonam (2 g every 8 hours), meropenem (1 g per 8 hours) or imipenem (500 mg per 6 hours). If the doctor now covers empiricals for MRSA or P. aeruginosa in adults with CAP based on published risk factors but does not have local etiological data, we recommend continuous empirical coverage while obtaining cultural data to establish if this pathogen is present to justify continuous treatment for this pathogen after the first few days of empirical treatment (stronger Question 12. In an inpatient environment, should adults with CAP be treated with corticosteroids? We recommend not to use corticosteroids routinely in adults with CAP (strong recommendations, moderate evidence quality). We recommend not to use corticosteroids routinely in adults with severe influenza pneumonia (conditional recommendations, low quality of evidence). We support the proposed Surviving Sepsis Campaign on the use of corticosteroids in patients with CAP and shock septic refractory. The authors of the guidelines wrote that it was disappointing how some of the main clinical questions have been studied adequate enough to allow strong recommendations on care standards. The guidelines emphasize many areas where further research is likely to be Care. Research can lead to new rapid diagnostic tests to identify the organisms that cause CAP, helping to determine the intensity of the treatment is best for each patient, compare the best therapies to treat CAP in outpatients, guide the treatment of high-risk patients dying from pneumonia and identifying a subset of patients, if any, that will benefit or are harmed by corticosteroid therapy. Given that CAP is an important cause of morbidity use, death and healthcare, greater research focus is needed, said Joshua Metlay, MD, PhD, co-chair of the guidelines committee and head of the General Internal Medicine Division at Massachusetts General Hospital. However, we believe that there is an adequate body of evidence that supports most of our recommendations and therefore adheres to it will produce better care and better outcomes for patients. Dr. Metlay added that the guidelines could not replace experienced clinical considerations and that doctors must have knowledge of their local ethological agents to provide high-quality care to patients with CAP. Cap.