

**Session Summary for 27 February 2018**

Didactic: TASP Toolkit Pneumonia, Theodore Wright, MD.

1. 41 site participants today!!
2. Etiology:
	1. 27% of cases are viral and 14% of cases are bacterial.
	2. 62% of cases are not identified and may be from non-infectious etiology in a significant proportion.
3. Variants:
	1. HCAP removed from HAP/VAP guidelines.
	2. HAP = Develops >48 hours after admission and no signs or symptoms of pneumonia on admission.
	3. VAP = Pneumonia that develops >48 hours after intubation and no signs or symptoms of pneumonia prior to intubation.
	4. CAP = Think strep pneumo, or less likely mycoplasma.
	5. HAP/VAP = consider pseudomonas and other GNR as well as MRSA.
4. Use CURB-65 or PSI to decide admission.
5. Think about RF for GNR or resistant organisms.
	1. DRIP score is 81% accurate at predicting a drug resistant pathogen.
	2. RF for PCN resistant strep pneumo include chronic disease of the lung, heart, liver, or kidneys. Diabetes mellitus, alcoholism, malignancy, or immunosuppression are also RF. As is recent abx use in the last 90 days.
6. Outpatient Tx of CAP:
	1. Azithro 500 mg x 1 and then 250 mg daily for 4 days. Alternative is doxycycline. Consider using doxycycline if your community has high rates of macrolide resistant strep pneumo.
	2. If RF for drug resistant strep pneumo then use Amox 1000 mg po TID or levofloxacin. This should be in addition to azithromycin.
7. Inpatient tx of CAP:
	1. Ceftriaxone 1 gm IV daily plus azithromycin 500mg x 1 then 25 mg daily.
	2. Duration is 5 days.
	3. Switch to orals for CAP on discharge if afebrile for 48-72 hours and only 1 clinical sign of instability.
		1. Clinical signs of instability include T > 37.8, HR >100bpm, RR >24, SBP < 90 mmHg, SaO2 <90% , confusion, inability to maintain oral intake.
	4. If no RF for resistant strep pneumo then on discharge use amox 500 mg po TID or 875 mg po BID. Stop azithro after 1.5 gm total dose. If RF for strep pneumo PCN resistance then change to amox 1000 mg po TID.
8. Tx of HAP/VAP:
	1. No RF for MRSA use cefepime 2 gm IV Q8H.
	2. If RF for MRSA, known colonization, or hospital prevalence >20% then add vancomycin 25-30 mg/kg IV x 1 then 15 ,g/kg IV Q8H-Q12H with goal trough 10-20.
	3. Consider double covering pseudomonas if your community has a high prevalence of cefepime resistant pseudomonas and the patient has a high risk for mortality or is failing to improve on a signle agent and culture data is still unavailable.
9. De-escalate abx if no staph aureus or GNR are found.
10. If MRSA nares culture or sputum negative then stop MRSA coverage.
11. Duration of HAP/VAP treatment is 7 days.