

Antibiotics in CAP IDSA vs. ATS

Preston Kramer, MD
Infectious Diseases F3

Resolved:

Empiric antibiotics should be given to (certain) patients with non-severe CAP who test positive for a respiratory virus



CAP: The Controversy

DRAMA!!

JOURNAL ARTICLE

CORRECTED PROOF

We Dissent: Lessons From the 2025 Community-Acquired Pneumonia (CAP) Guidelines

Leila S Hojat , Maryrose R Laguio-Vila, Liam R Sullivan, Valerie M Vaughn

[Author Notes](#)

Clinical Infectious Diseases, ciaf626, <https://doi.org/10.1093/cid/ciaf626>

Published: 04 December 2025 **Article history** ▼

CAP: The Controversy

- In 2026, the ATS released new CAP guidelines, which the IDSA declined to endorse
- What the ATS guidelines recommend:
 - Outpatients w/ CAP +virus w/o comorbidities: No antibiotics
 - Outpatients w/ CAP +virus w/ comorbidities: Yes* antibiotics
 - Inpatients w/ non-severe CAP +virus: Yes antibiotics

Antibiotics for "viral CAP"

- Everyone agrees that antibiotics are not helpful for viral infections
- The real question: Who has viral CAP?
- Viral-bacterial coinfection is a known phenomenon
 - 3% of patients in the EPIC study had both virus and bacteria co-detected²
 - 13% of patients in EPI-CARES cohort had both virus+bacteria detected¹

1. *Unpublished data*

2. *Jain S et al., N Engl J Med. 2015 Jul 30;373(5):415-27.*

Who has viral CAP?

- Per IDSA's own prior guidelines, sputum culture and blood cultures are NOT recommended except in severe CAP
- Multiplex PCR is \$\$\$ and no clear guidance on who with non-severe CAP should get it
- 2026 ATS Guidelines¹:
*“The decision whether to administer empiric antibacterial therapy to a patient with pneumonia who has a positive test result for a virus is **difficult**[...] This is a conditional recommendation because the balance between benefit and harm of empiric antibiotics will vary on the basis of clinical context”*

1. Jones BE et al. Am J Respir Crit Care Med. 2026 Jan 1;212(1):24-44.

Sure we said it too, but TIMES HAVE ChAnGeD!

From the IDSA response to the ATS guidelines¹:

“Prior CAP guidelines primarily included recommendations for use of empiric antibiotics for all pneumonias because there were no widely available, rapid, easily performed, accurate, and cost-effective methods to test patients for viral and bacterial pathogens at the point of service.”

- Are they rapid? Are they accurate? Are the cost-effective?

1. M Klompas et al., *Clinical Infectious Diseases*, Volume 82, Issue 4, 15 April 2026, Pages 622–624

Nope, not really

From the IDSA response to the ATS guidelines¹:

“[...]multiplex polymerase chain reaction, urinary antigens for bacteria, and surrogate serum markers for bacterial infections, are valuable diagnostic tools that can provide results quickly, allowing clinicians to identify the pathogen driving the patient's illness in a clinically meaningful timeframe.”

- Upper respiratory multiplex PCR: \$\$\$ and only tests for atypicals (or no bacteria at all)
- Urine antigens: Not available everywhere, controversy over clinical utility
- Legionella urine Ag only detects serotype 1 (actual prevalence?)
- Pneumococcus urine Ag not available in many places (Swedish sends to Phoenix)
- “Surrogate serum biomarkers”:is that you, procalcitonin?

So what are we actually saying?

- Ok fine so we don't know when people are co-infected, but it doesn't matter...
- Of course sometimes it will matter...but for whom??

 IDSA

No complications?

- Outcomes from the Biebelberg study¹ looked out to 30 days...what about long-term complications of recurrent bacterial pneumonia? (bronchiectasis)
- Observational study, not an RCT
- If 0 days of antibiotics made no difference, why was that hidden away in the sensitivity analysis?
- Sensitivity analyses used ICD-10 codes for CAP

1. Biebelberg B, et al. *Clin Infect Dis*. 2026 Apr 30;82(4):630-638.