



STICHTING WERKGROEP ANTIBIOTICABELEID

Optimising antibiotic policies in the Netherlands, part VIII

Revised SWAB Guidelines for antimicrobial therapy of Community-acquired pneumonia

Dutch Working Party on Antibiotic Policy (SWAB), April 2005

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Abstract

The Dutch Working Party on Antibiotic Policy (Stichting Werkgroep Antibiotica Beleid, SWAB) develops national guidelines to optimize the quality of use of antibiotics and to contribute to the containment of antimicrobial resistance. An update of the SWAB guideline for Community-acquired Pneumonia (1998) was considered necessary due to changing resistance patterns of common pathogens and new developments in epidemiology, diagnostic tests and treatment strategies.

As opposed to the 1998 guideline, the current guideline is applicable to both primary and inpatient care. It was developed by a writing committee, composed of members of all professional organisations involved in the treatment of CAP. In the composition of the guideline, this committee followed Evidence Based Guideline Development recommendations.

Assessment of a patient's "severity of illness" at presentation is considered important, when choosing an optimal empirical antibiotic regimen for CAP. Severely ill patients should be treated with antibiotics covering the most important expected pathogens, including *Legionella spp.* Assessment of the severity of illness may be facilitated by the use of (validated) scoring systems like the PSI-score and CURB-65 score. Patients can also be stratified based on their location of treatment: out of hospital, at a normal ward or at an Intensive Care Unit.

Legionella urine antigen testing is considered an important tool in the process of deciding on an optimal antibiotic regimen for CAP.

Introduction

The Dutch Working Party on Antibiotic Policy (SWAB; Stichting Werkgroep Antibiotica Beleid), established by the Dutch Society for Infectious Diseases (VIZ), the Dutch Society of Medical Microbiologists (NVMM) and the Dutch Society for Hospital Pharmacists (NVZA), coordinates activities in the Netherlands aimed at optimization of antibiotic use, management of the development of antimicrobial resistance, and limitation of the costs of antibiotic use. By means of the evidence-based development of guidelines, SWAB offers local antibiotic- and formulary committees a guideline for the development of their own, local antibiotic policy.

Community-acquired pneumonia (CAP) is defined as an acute symptomatic infection of the lower respiratory tract which develops outside of a hospital or nursing home, whereby a new infiltrate is demonstrated on a chest X-ray. In primary care, the diagnosis is usually established on grounds of clinical criteria, such as those described in the practice guideline "Acute coughing" of the Dutch College of General Practitioners (NHG)¹.

The current guideline for community-acquired pneumonia is a revision of the SWAB guideline, published in 1998². Revision was considered necessary because of important new developments, including increased resistance of pneumococci against penicillins and macrolides, the development of new quinolones and new insights into epidemiology and diagnostics, partly as a result of the Legionella epidemic at the Westfriesian Flora in 1999.

In contrast to the previous version, this guideline is transmural and it is meant for the treatment of outpatients (by a general practitioner or at an outpatient hospital clinic) as well as hospitalized patients up to 72 hours after admission, and is in full accordance with the NHG practice guideline. The guideline is applicable for adult patients with a community-acquired pneumonia in the Netherlands with the exception of immunocompromised patients, such as those who have undergone organ transplantation, HIV-positive patients and patients receiving immunosuppressive therapy. The guideline focuses specifically on recommendations for the antibiotic treatment of CAP. Other aspects of care for the patient with CAP are described extensively in the 2003 guideline by the professional society for respiratory care physicians NVALT.³

Methods

This guideline was drawn up according to the recommendations for evidence based development of guidelines⁴ (EBRO) and AGREE instrument (www.agreecollaboration.org). The guidelines are derived from a review of literature based on 6 essential research questions about the treatment of CAP. Recommendations for the guideline were assigned a degree of evidential value according to the handbook of the Dutch Institute for Healthcare Improvement (CBO)⁵; level 1 means that the conclusion or recommendation is supported by at least two independent randomized studies of good quality or by a meta-analysis; level 2: supported by at least two randomized trials of moderate quality or insufficient size or another comparative study (non-randomized, cohort studies, patient control studies); level 3: not supported by research of the above-mentioned levels and level 4: based on the opinion of members of the guideline committee.

For each question a review of existing (inter)national guidelines was performed by the main author (JS) for purposes of orientation.^{2,6-10} In addition, a literature search was performed in the PubMed database (January 1966 to January 2005) for each research question, as well as in the Cochrane Register of Controlled Trials (CENTRAL), in Clinical Evidence[®] and Sumsearch[®] engine. When scientific verification could not be found, the guideline text was formulated on the basis of the opinions and experiences of the members of the guideline committee. For the research question about the choice of optimum therapy, the interactive Informatrix[®] procedure was carried out by the members of the guideline committee as a supplementary consensus procedure.¹¹ Preparation of the guideline text was carried out by a multidisciplinary committee consisting of experts, delegated from the professional societies for infectious diseases (VIZ), medical microbiology (NVMM), hospital pharmacists (NVZA), pulmonary diseases (NVALT), and general practice (NHG). After consultation with the

members of the involved professional societies via a web-based module, the final guideline was drawn up by the delegates and SWAB.

Review of the literature

In order to develop recommendations for an optimal treatment of CAP, answers were sought to six key questions:

1. Which are the causative microorganisms of CAP in the Netherlands and what is their susceptibility to commonly used antibiotics?
2. Is it possible to predict the causative agent of CAP on the basis of simple clinical data at first presentation?
3. Which prognostic factors (e.g. co-morbidity, age, medical history) are important for the choice of initial treatment?
4. Is the severity of disease upon presentation of importance for the choice of initial treatment?
5. What is the optimum initial treatment for patients with CAP?
6. What is the role of rapid diagnostic tests in the initial treatment decision for patients with CAP?

1a. What is the aetiology of CAP in the Netherlands?

In the limited number of studies in ambulatory patients the most commonly demonstrated causative agent was *S. pneumoniae*, followed by *H. influenzae* and *M. pneumoniae*, while an unknown diagnosis is present in 40-50% of all patients.¹²⁻²² (table 1) Only in a small number of studies, serology, cultures, as well as PCR techniques were performed.^{21;23} MacFarlane found *S. pneumoniae* as the most common bacterial pathogen in 54 of 173 patients in whom a pathogen was isolated. In 55/173 cases *Chlamydia pneumoniae* and in 23/173 *M. pneumoniae* were found.²³ In a Dutch primary care study, of 145 patient episodes with lower respiratory tract infections (LRTI) 53 (37%) were caused by a viruses (predominantly *Influenza A*) while in 43 cases (30%) a bacterial pathogen was detected. (*H. influenzae* in 9%, *M. pneumoniae* in 9% en *S. pneumoniae* in 6%). In the patient group with an infiltrate on chest X-ray (28 patients), bacterial pathogens were found in 10 patients, viral in 5, and in 11 not any causative microorganism was found²¹. The frequency of *Chlamydia* infections may be overrated due to false positive serology results in patients with concurrent upper respiratory tract infections and/or asymptomatic colonisation.^{24;25} Bacterial pathogens (e.g. *H. influenzae*) are also common colonisers of the respiratory tract: it is often not possible to reliably discriminate whether an isolated agent is a coloniser or the true cause of infection. Comparison of the relative frequency of causative agents is dependent upon the sensitivity and specificity of the tests used in the studies and whether there was an epidemic at the time (e.g. *M. pneumoniae*). Various studies have identified a high percentage of atypical causative agents; however often no information is available about "classical" bacterial causative agents (for example, sputum cultures were not performed).¹⁵

The etiological spectrum of agents that cause CAP among patients who were admitted to a general hospital ward is comparable throughout the world^{16;17;26-54} and agrees closely with the data from Dutch studies (table 2).^{32;55-57} *S. pneumoniae* is the most commonly identified pathogen (demonstrated in 18.5%-41.8%), *H. influenzae* (3.4%-8%) and *M. pneumoniae* (5.4%-12.6%) take second place. Recent studies attribute a larger percentage in the spectrum of causative agents to *Legionella spp.* and *Chlamydia pneumoniae*. In the Netherlands, the number of registered *Legionella* infections has increased from about 40 per year before 1999 to 222 per year in 2003.^{58;59} In a Spanish study, transthoracic needle aspiration was performed to identify the etiological agent of CAP in patients where the causative agent could not be detected with conventional methods. In approximately one third of these patients *S. pneumoniae* was isolated as pathogen.⁶⁰ This finding confirms that pneumococcus is probably the most common cause of CAP, suggesting that in the group of unknown pathogens for CAP about one third can be attributed to *S. pneumoniae*.

Among patients with CAP who are admitted to the Intensive Care, the most frequently identified pathogens are *S. pneumoniae* (16%-28%) as well as *Legionella spp.* (4%-24%), *S. aureus* (5%-14%) and enterobacteriaceae

(0%-10).^{52;61-73} (table 3) Specifically the incidence of enterobacteriaceae as causative agent is probably overestimated due to colonisation. In addition, in various etiological studies it is not clear whether a distinction is made between CAP and pneumonia in a patient from a nursing home, which is considered etiologically to be a nosocomial pneumonia in the Netherlands. In a small Dutch retrospective study on severe CAP *S. pneumoniae* was most frequently isolated (35%).⁷⁴ In 5% (3/62) *Legionella spp* was found. A Spanish study confirmed that, in patients who were admitted to ICU, *S. pneumoniae*, *Legionella spp* and *H. influenzae* are most frequently detected pathogens. *Pseudomonas* (6,6% vs. 1,0%, $p < 0.05$) and *Legionella spp.* (15,1% vs. 7,1%, $p < 0.05$) were found more commonly in patients who required intubation than in those who did not.⁷⁵ Several studies put the importance of these specific causative agents for severe CAP into perspective⁷⁶⁻⁷⁸: Park *et al.* could not demonstrate a difference in the incidence of *Legionella spp.* in a study comparing patients with severe CAP and those with mild CAP.⁷⁸

	Great Britain ¹³ (1 study, n=236)		Rest of Europe ^{14;16-20} (6 studies, n=654)		North America ¹⁵ (1 study, n=149)	
	Mean (%)	95% BI	Mean (%)	95% BI	Mean (%)	95% BI
<i>S pneumoniae</i>	36,0	29,9 – 42,1	8,4	6,4 - 10,8	?	?
<i>H influenzae</i>	10,2	6,3 – 14,0	1,1	0,4 - 2,2	?	?
<i>Legionella spp</i>	0,4	0,01 - 2,3	2,8	1,6 - 4,3	0,7	0,01 – 3,7
<i>S aureus</i>	0,8	0,1 – 3,0	0	0,0 - 0,7	?	?
<i>M catarrhalis</i>	?		0	0,0 - 0,6	?	?
<i>Enterobacteriaceae</i>	1,3	0,3 – 3,7	0,2	0,0 - 1,0	?	?
<i>M pneumoniae</i>	1,3	0,3 -3,7	13,3	10,7 - 15,9	26,2	19,3 - 34,0
<i>C pneumoniae</i>	?	?	8,7	6,5 - 11,3	14,8	9,5 - 21,5
<i>C psittaci</i>	?	?	2,0	1,1 - 3,4	14,8	9,5 - 21,5
<i>C burnetii</i>	0	0 - 1,6	0,8	0,3 - 1,9	2,7	0,7 - 6,7
<i>Viruses</i>	13,1	8,8 – 17,4	12,4	9,9 - 14,9	8,1	4,2 - 13,6
<i>Influenza A & B</i>	8,1	4,9 – 12,3	6,3	4,5 - 8,4	6,0	2,8 - 11,2
<i>Mixed</i>	11,0	7,0 – 15,0	4,7	2,8 - 7,3	4,7	1,9 - 9,4
<i>Other</i>	1,7	0,5 – 4,3	2,0	1,1 - 3,4	0	0 - 2,5
<i>No pathogens</i>	45,3	39,0 – 51,7	53,7	49,8 - 57,5	50,3	42,0 - 58,6

Table1 Aetiology of CAP in outpatients

	Boersma ⁵⁶ n = 90	Bohte ³² n = 334	vanEerden (ATS 2002) n = 260	Oosterheert ⁵⁷ n = 302	Braun ⁵⁵ n = 157
<i>S. pneumoniae</i>	38%	27%	37%	25%	34%
<i>H. influenzae</i>	2%	8%	10%	2%	12%
<i>M. catarrhalis</i>	1%	1%	2%	2%	1%
<i>S. aureus</i>	1%	1%	5%	4%	3%
<i>Legionella spp.</i>	0%	2%	5%	3%	8%
<i>Enterobacteriaceae</i>	2%	0%	2% (<i>E. coli</i>)	-	2%
<i>M. pneumoniae</i>	4%	6%	8%	3%	24%
<i>Chlamydia spp</i>	6%	3%	< 1%	5%	4%
<i>Coxiella burnetii</i>	0%	0%	0%	-	1%
<i>Influenza A/B, parainfluenza</i>	7%	4%	2%	-	22%
<i>Other viruses</i>	4%	3%	2%	-	10%
<i>M. tuberculosis</i>	1%	0%	0%	-	1%
<i>Bordetella pertussis</i>	-	-	-	-	18%
<i>Other</i>	0%	0%	3%	14%	10%
<i>No pathogens</i>	38%	45%	24%	51%	13%

Table 2 Aetiology of CAP in Dutch hospitals (patients at a general ward)

	Great Britain ¹⁰ (4 studies, n=185)		Netherlands ⁷⁴ (1 study, n=62)		Europe ¹⁰ (10 studies, n=1148)	
	Mean (%)	95% BI	Mean (%)	95% BI	Mean (%)	95% BI
<i>S pneumoniae</i>	21,6	15,9 - 28,3	35	-	21,8	19,4 - 24,2
<i>H influenzae</i>	3,8	1,5 - 7,6	11	-	5,3	4,1 - 6,8
<i>Legionella spp</i>	17,8	12,6 - 24,1	5	-	5,5	4,2 - 7,2
<i>S aureus</i>	8,7	5,0 - 13,7	7	-	7,0	5,6 - 8,6
<i>M catarrhalis</i>	?	?	-	-	3,8	2,4 - 5,9
<i>Enterobacteriaceae</i>	1,6	0,3 - 4,7	11	-	8,6	7,1 - 10,4
<i>M pneumoniae</i>	2,7	0,9 - 6,2	0	-	2,0	1,3 - 3,0
<i>C pneumoniae</i>	?	?	-	-	6,6	2,5 - 13,8
<i>C psittaci</i>	2,2	0,6 - 5,4	-	-	0,9	0,4 - 1,9
<i>C burnetii</i>	0	0 - 2,0	-	-	0,7	0,3 - 1,4
<i>Viruses</i>	9,7	5,9 - 14,9	-	-	4,0	2,7 - 5,6
<i>Influenza A & B</i>	5,4	2,6 - 9,7	-	-	2,3	1,1 - 4,2
<i>Mixed infections</i>	6,0	3,0 - 10,4	-	-	5,0	2,4 - 9,1
<i>Others</i>	4,9	2,3 - 9,0	14	-	8,4	6,8 - 10,1
<i>No pathogens</i>	32,4	25,7 - 39,7	34	-	43,3	40,4 - 46,2

Table 3. Aetiology of severe CAP (ICU patients)

1b. What is the susceptibility of microorganisms that most commonly cause CAP in the Netherlands?

S. pneumoniae

Throughout the world increasing resistance of pneumococcus against penicillin has been noted. In the Netherlands this effect is as yet very limited (0.5%-1.0%), but increasing to 3.6% for patients admitted to a Pulmonology Department.^{79;80} Large scale use of macrolides has led to an increase in macrolide resistant pneumococci.^{81;82} Macrolide-resistance in the Netherlands is wide-spread: surveillance studies of hospital isolates report resistance percentages of 6.5%-10% for macrolides in 2002 versus 2%-3% in 1996.^{80;83} In Belgium, studies showed a 28.5% resistance of pneumococci against macrolides.⁸⁴ Tetracycline resistance of pneumococci in the Netherlands was 4.2% in 2001, which is about the same as in 1996. Valid data from a primary care setting are currently lacking. The prevalence of ciprofloxacin resistance in 2003 was 10%-24%. In 2001 there was (as yet) very little resistance against the new generation of quinolones such as levofloxacin and moxifloxacin.⁸³

H. influenzae

The prevalence of amoxicillin resistance of *H. influenzae* is about 9%-14% among patients admitted to a department of pulmonology.⁸⁰ Claritromycin resistance of *H. influenzae* over the past years has remained 18%-23%. An increase in the resistance of *H. influenzae* against macrolides was detected in isolates from pulmonology departments (2% in 1996; 6% in 2001, 4% in 2002). Susceptibility of *H. influenzae* is dependent on the chosen in-vitro cut-off points. In the Netherlands, there is no consensus upon this matter.

1. What are the most frequently occurring causative agents of CAP and what is their sensitivity for the most commonly used antibiotics?	Level of evidence
In view of the use of different diagnostic methods and study populations, the low percentage of demonstrated causative agents, asymptomatic carrier state, influence of epidemics and pre-treatment of the patient population, the incidence of causative agents of CAP is not easily determined. In almost all of these studies <i>S. pneumoniae</i> is the most common causative agent in the Netherlands (27-38%)	2
There are indications that in patients with severe CAP or patients who must be admitted to the Intensive Care Unit, in addition to <i>S. pneumoniae</i> , <i>Legionella spp</i> (4-24%) and <i>S. aureus</i> (5-14%) are encountered more frequently	2
<i>Mycoplasma pneumoniae</i> (1.3-34 %) and <i>Chlamydia spp</i> (1.3-21.5 %) occur in important percentages in the non-hospitalized population with CAP. The validity of the diagnostic methods for these causative agents is subject to discussion as well as the importance of co-infections with atypical and classical bacterial causative agents	2
In 2005 in the Netherlands, it is not necessary to take into account a decreased sensitivity of <i>S. pneumoniae</i> for penicillin, except for patients who have recently returned from a foreign country. There is an increase in the resistance of pneumococci against macrolides	2

2. Which co-morbid conditions and/or risk factors are important for the choice of initial treatment?

The pathogens that cause CAP can differ in populations with specific risk factors. There are no Dutch studies on this subject.

- The frequency of most causative agents among the elderly is not significantly different from that found for younger patients with mild as well as severe CAP. Probably however, *Legionella spp.*, *M. pneumoniae* and *Chlamydia pneumoniae* will be found less frequently in the elderly.^{28;41;52;85} In 2 small studies, an incidence of *M. pneumoniae* of about 16% was described for elderly patients versus 27%-40% for patients < 65 years of age.^{52;85} In one of these studies an Odds Ratio of 5.3 for pneumonia caused by *Mycoplasma pneumoniae* was described for patients < 60 years⁵²
- A Danish comparative study did not find a different pattern of the causative agents among COPD patients with CAP than in the general population, but the study had insufficient statistical power.⁴⁹ A Spanish study reported a higher frequency of *S. pneumoniae*, enterobacteriaceae and *Pseudomonas aeruginosa* and more mixed infections among patients with chronic lung conditions.⁵² There is an ongoing discussion about the true incidence of Gram-negative agents in COPD patients with CAP, because diagnosis based on the sputum culture often cannot reliably differentiate between colonization of the respiratory tract and true infection. There are no studies that confirm that CAP in COPD patients is caused more frequently by *H. influenzae* or *Moraxella catarrhalis* than in patients without COPD.⁸⁶ *Pseudomonas aeruginosa* remains a rare cause of CAP and can only be expected among patients with serious structural lung disease such as cystic fibrosis or bronchiectasis.⁸⁷
- Patients with diabetes mellitus have the same spectrum of causative pathogens of CAP as the normal population, although a pneumococcal pneumonia is more often accompanied by bacteremia.⁸⁸
- Enterobacteriaceae⁴¹ and anaerobes⁵², found in aspiration pneumonia⁸⁹, are more common among alcoholics; however, other studies report the more common occurrence of pneumococcal bacteremia^{52;88}, *Legionella spp.*⁹⁰ and other atypical agents. The results of studies on causative agents in alcoholics are neither in agreement nor consistent to the advantage of one or more specific pathogens.
- Most CAP studies do not include patients with aspiration pneumonia. In this group, enterobacteriaceae and anaerobes are more common.^{89;91}
- When *S. aureus* is isolated as the causative agent, 39% (of the hospitalized patients) to 50% (of those admitted to the Intensive Care Unit) have a concomitant influenza virus infection.^{26;43;45;54;61;62;64;73}

In many reports, a relationship between certain surrounding circumstances and the causative pathogen for CAP has been described. Specific information from the patient history may help to point out the probable pathogen¹⁰.

Legionella spp.: associated with travel in 52% (95 % CI 49-54), in 91% with travel abroad (95 % CI 87-94). Clusters only in 23% (95 % CI 19-26). Epidemics occur, related to water supply systems.

Chlamydia psittaci: contact with birds and animals, but human to human spread may occur: in UK only 20% of infections have a history of bird contacts. Epidemics are reported related to infected sources at work, e.g. poultry workers.

Coxiella burnetii: epidemics in relation to animal sources (usually sheep) but a history of occupational exposure is only present in 7.7%.

Penicillin resistant *S. pneumoniae*: associated with travel history abroad.

<i>2. Which factors (such as co-morbidity, age, medical history) are important for the choice of an initial therapy?</i>	<i>Level of evidence</i>
In the case of aspiration, anaerobes and enterobacteriaceae are more often identified	2
CAP caused by <i>S. aureus</i> is often preceded by an influenza virus infection; however the incidence of an <i>S. aureus</i> pneumonia is very low among patients treated at home	2
<i>P. aeruginosa</i> as cause of CAP is only expected among patients with severe structural lung disease. There is no convincing evidence that <i>H. influenzae</i> and <i>M. catarrhalis</i> are more common causes of CAP among patients with COPD	2
For patients with CAP who recently visited a country with a high prevalence of penicillin-resistant pneumococci (PRSP), this must be taken into account when initial therapy is chosen	4
Information obtained from the medical history about geographical and environmental factors can be worthwhile when considering a particular causative agent of CAP, but it is not sensitive and specific enough to guide initial therapy.	2

3. Can the causative agent be predicted on the basis of clinical data at presentation?

Some specific causative agents are described to be associated with characteristic clinical symptoms, but the core question is whether it is possible to predict the causative agent at presentation on the basis of the symptoms. Bohte et al.⁹² describe an algorithm to differentiate between *S. pneumoniae* and "other" causative agents. One of the data essential for a correct prediction is a Gram stain of sputum; however, upon admission this is often not obtained or unreliable due to previous use of antibiotics. Previous studies by Farr⁹³ were also unable to confirm the prediction of the causative agent on the basis of clinical parameters. For patients with CAP admitted to the ICU, the clinical parameters appear to be of little use for the prediction of the etiological agent.⁶⁶ Sopena investigated whether *Legionella spp.* can be predicted reliably as causative agent on the basis of clinical signs.⁹⁰ In a multivariate analysis there was a significant difference for only one symptom (diarrhoea) in the occurrence of *Legionella* compared to the other causative agents. Results of other studies also did not show a consistent pattern of clinical symptoms for CAP caused by *Legionella spp.*⁹⁴⁻⁹⁷ Finally, studies show that the causative agent for elderly patients and patients with co-morbidities is even more difficult to predict than in the normal population.⁹⁸⁻¹⁰⁰

<i>Is it possible to predict the causative agents of CAP on the basis of the clinical data at first presentation?</i>	<i>Level of evidence</i>
Clinical presentation on admission is not sufficient for prediction of the causative agent of CAP. Concepts such as "typical" and "atypical" should not longer be used	2

4. Is the severity of disease at presentation of importance for the choice of initial treatment?

There are theoretical arguments for the classification of antibiotic therapy for patients with CAP according to the severity of illness at initial presentation. On the basis of the medical history and physical examination alone, it is impossible to reliably distinguish the causative agent. In addition, choosing an initial antibiotic regimen that is directed towards one specific agent with the intention to adjust therapy later on ("wait and see" policy), is clinically not justifiable for severely ill patients. A good example was the *Legionella* epidemic at the Westfriesian Flora whereby mortality was clearly associated with initial therapy that was directed against an incorrectly presumed causative agent. Besides, various studies have suggested that incorrect initial coverage of potential causative microorganisms, leads to increased mortality and longer hospital stay.¹⁰¹⁻¹¹⁰

The core question is: at which degree of "severity of illness" antibiotic therapy that provides coverage against both atypical and classical causative agents is required, assuming that in the event of severe CAP the prescription of initial narrow spectrum therapy and later adjustment ("wait and see" policy) is clinically not justifiable?

There are various scores that can predict the chance of death (30-day mortality) and/or ICU admission of patients with CAP (figures 1 and 2). The most easy-to-use scoring system is the modified British Thoracic Society rule, the so-called CURB-65 score (Confusion, Urea, Respiratory rate, Blood pressure, Age >65 years of age), recommended in the BTS guidelines 2004 update for the management of CAP (figure 1 and www.brit-thoracic.org.uk/guidelines).¹¹¹ For patients with no CURB-65 criteria at presentation, outpatient treatment is usually indicated. or, should the patient be admitted, he/she should be treated as non-severe (mild) pneumonia at a normal hospital ward (30 day mortality risk, 0.7%). The group with 1-2 CURB-65 criteria is usually admitted to a general hospital ward (30 day mortality risk, 3.2%-13%). Patients with 3 or more criteria have a high mortality risk and are therefore considered as severe CAP (30 day mortality risk, 17%-57%).

An alternate scoring system, the "Pneumonia Severity Index" (PSI) was validated in 2287 patients¹¹² Via a two-step procedure, including an elaborated scoring system in the second step, a risk profile is established leading to classification of the patient in one of 5 risk categories (figure 2). In this scoring system, 30 day mortality ranges from 0,1% in class 1 to 27% in risk class 5. From risk class 4 upward, mortality increases 10 fold compared to risk class 3. Validation studies showed that patients in risk class 1 and 2 could safely be treated as outpatients. Both scoring systems were validated in national and supranational databases, but never in a primary care setting.^{111;113;114}

<i>4. Is the severity of the disease at presentation of importance for the choice of initial treatment?</i>	<i>Level of evidence</i>
For severely ill patients, initial monotherapy directed against one specific causative agent with the intention to change therapy later ("wait and see") is clinically not justifiable	2
It is recommended to classify initial antibiotic therapy on the grounds of the severity of the disease at presentation	4
A validated scoring system that can predict mortality is useful for the determination of the severity of CAP. The Pneumonia Severity Index (Fine score) is the best validated and most widely used system of all scoring systems.	1
The CURB -65 is also useful for measuring severity of CAP	2

CURB-65 criteria:

Confusion: defined as a new disorientation in person, place or time

Urea > 7 mmol/l

Respiratory Rate \geq 30 / min

Blood pressure: Systolic Blood Pressure < 90 mmHg or Diastolic Blood Pressure \leq 60 mmHg

Age \geq 65

Core criteria	Score CURB - 65	30 d Mortality
No core criteria	0	0,7%
One core criterion	1	3,2%
Two core criteria	2	13%
Three core criteria	3	17%
Four core criteria	4	41,5%
Five core criteria	5	57%

Figure 1. CURB-65 score¹¹

Step 1: Patient with Community-acquired Pneumonia					
Older than 50 yrs?	no	Coexisting conditions?	no	Abnormalities on physical examination?	no, patient in Risk class I
↓		Neoplastic disease Liver disease Congestive heart failure Cerebrovascular disease Renal disease ↓		Altered mental status Respiratory Rate ≥ 30 / min Syst blood pressure < 90 mm Hg Temperature < 35°C or ≥ 40°C Pulse ≥ 125 / min ↓	
yes		yes		yes	
Risk Class II – V, dependent of score in step 2					
Step 2: Point scoring system					
Characteristic			Points assigned		
age			Age in years (male)		
			Age in years –10 (female)		
Underlying diseases					
Neoplastic disease			+30		
Liver disease			+20		
Congestive heart failure			+10		
Cerebrovascular disease			+10		
Renal disease			+10		
Physical examination					
Altered mental status			+20		
Respiratory Rate ≥ 30 / min			+20		
Systolic blood pressure < 90 mm Hg			+20		
Temperature < 35°C or ≥ 40°C			+15		
Pulse ≥ 125 / min			+10		
Laboratory and radiological findings					
arterial pH < 7.35			+30		
urea ≥ 11,0 mmol/L			+20		
sodium < 130 mmol/L			+20		
glucose ≥ 14,0 mmol/L			+10		
hematocrit < 30%			+10		
Partial oxygen pressure < 60 mm Hg			+10		
Pleural effusion			+10		
Mortality (30 days) per PSI risk class					
Risk class		Total score		Mortality	
I		Not applicable		0.1%	
II		≤ 70		0.6%	
III		71-90		0.9%	
IV		91-130		9.3%	
V		> 130		27.0%	

Figure 2. Pneumonia Severity Index¹¹²

5. What is the optimum treatment of patients with CAP?

Recent developments

In recent literature there are indications that treatment with a combination of a macrolide plus a beta-lactam antibiotic or monotherapy with a 4th generation quinolone yields a survival benefit and a decreased hospital stay for patients with mild to moderately severe CAP compared to reference monotherapy e.g. with a 3rd generation cephalosporin.¹⁰³ The differences in favour of combination therapy or monotherapy with a 4th generation quinolone in uncontrolled, mainly retrospective studies^{103;109;115;116} can partially be explained by selection bias: prescription on the basis of the severity of the illness at first clinical presentation. In addition, the resistance pattern for pneumococci in the United States (where most of the large retrospective studies were carried out) could be the reason that combination therapy in these studies scored better than monotherapy. In the Netherlands however there is limited penicillin-resistance. A number of retrospective studies suggested that even in the event of proven penicillin-sensitive pneumococcal pneumonia, better results are obtained with combination therapy.^{107;117;118} A recent prospective study confirmed this, although this latter report is subject to important methodological flaws: it is a non-randomized study, including 10% nosocomial pneumonia patients and HIV patients and only 20% of patients were over 65 years of age¹¹⁹. Various, as yet unproven, hypotheses have been proposed to explain this effect: synergism between antibiotics, an anti-inflammatory effect of macrolides and the presence of combinations of infections¹²⁰.

Many prospective trials have been carried out to compare the efficacy of 4th generation quinolones or macrolides with that of beta-lactam antibiotics. The results of these trials are not in agreement. File et al. compared levofloxacin with a 2nd or 3rd generation cephalosporin, with or without erythromycin in an unblinded trial.¹²¹ The cure rates were 96% for the levofloxacin group and 90% for the beta-lactam group. Finch et al. carried out a similar unblinded multicentre trial in which moxifloxacin was compared with amoxicillin – clavulanate with or without claritromycin; the cure rates were 93.4% and 85.4%, respectively (p = 0.004).¹²² These results appeared to be independent of severity of CAP and of the combination with a macrolide. Comparable studies, however, did not demonstrate a treatment advantage for levofloxacin versus ceftriaxone (Norrby¹²³), moxifloxacin versus amoxicillin (Petitpretz¹²⁴), sparfloxacin versus amoxicillin (Aubier¹²⁵) or the combination of ceftriaxone and azitromycin versus levofloxacin.¹²⁶ A recent meta-analysis in patients with mild to moderately severe pneumonia did not reveal any difference in outcome between treatment with a beta-lactam and treatment with an antibiotic, that is active against atypical pathogens (relative risk for therapeutic failure 0.97; CI 0.87-1.07).¹²⁷ A systematic review of trials in hospitalized patients with CAP showed no benefit of survival or clinical efficacy of empirical regimes with “atypical” coverage, but the included trials were mostly comparisons of quinolone monotherapy and betalactam monotherapy. Not a single trial was found comparing a betalactam to a betalactam combined with a macrolide or quinolone¹²⁸. Almost all of the trials were carried out in areas where penicillin resistance of pneumococci is common and are therefore not applicable in the Netherlands. The only Dutch trial (Bohte¹²⁹) has insufficient power to demonstrate significant differences between the treatment groups, although there was a trend toward higher effectivity of azitromycin compared to penicillin. Two randomized trials demonstrated that doxycycline as initial monotherapy for mild CAP is equivalent to a beta-lactam or a quinolone (fleroxacin).^{130;131}

Severe CAP

No randomized double-blind placebo-controlled trials to investigate initial treatment of patients with severe CAP have been carried out. Some retrospective studies suggest a reduction in mortality for treatment of severe CAP with combination therapy consisting of a beta-lactam antibiotic and a macrolide or quinolone.^{103;132} In a recent prospective study, the subset of patients with severe CAP (Fine risk category IV and V) exhibited a clinical cure rate of 87.0% (20/23) for gemifloxacin versus 83.3% (20/24) for ceftriaxon/cefuroxim (NS).¹³³ In Finch’s study about half of the patients had severe CAP (265/538). In this subgroup, the cure rate for moxifloxacin was 92.2%

versus 84.7% for the control group (amoxicillin-clavulanate potassium, with or without claritromycin).¹²² Other studies reported identical results for ceftriaxone and erythromycin versus levofloxacin (92.3% versus 94.1%) for moderately severe and severe CAP¹²⁶ and penicillin plus ofloxacin versus amoxicillin-clavulanate with erythromycin¹³⁴ for severe CAP.

In view of the high risk of mortality and the reduction in mortality achieved with early causal therapy for infection with *Legionella spp*, it would seem clinically irresponsible to await the effect of initial monotherapy with beta-lactam antibiotics for patients who present with severe CAP.

Quinolone therapy

There are sufficient indications that *S. pneumoniae* can become resistant to quinolones during monotherapy with these drugs¹³⁵. There is concern about the development of resistance and cross-resistance due to the large-scale use of the newer fluoroquinolones¹³⁶. Development of resistance appears to occur specifically in the event of systematic underdosage (as occurred in South East Asia). In the USA and Europe the percentage resistance against levofloxacin is practically zero, versus 7-8% in South East Asia.

There are theoretical arguments to prefer moxifloxacin on the basis of its high intrinsic activity against pneumococci¹³⁷ (due to the elevated anti DNA gyrase and topoisomerase IV activity, the need to acquire 2 mutations before the MIC increases and diminished efflux from the bacterial cell), and its favourable pharmacodynamic characteristics¹³⁸ (AUC₀₋₂₄ /MIC ratio >100, associated with reduced selection of antimicrobial resistance), a favourable MPC (Mutant Prevention Concentration) profile¹³⁹, and good penetration into tissues¹⁴⁰⁻¹⁴².

Prolongation of the QT interval has been described for moxifloxacin.¹⁴³ This is relevant in patients with severe CAP and underlying cardiac abnormalities, or concurrent use of medication that prolongs the QT interval.

5. What is the optimum empirical treatment of patients with CAP?	Level of evidence
There are indications that doxycycline as empirical therapy is equivalent to monotherapy with a beta-lactam for mild pneumonia	2
Macrolides and beta-lactam antibiotics are equally effective as treatment for CAP but because of the increasing risk of resistance of pneumococci for macrolides, macrolides should not be recommended	2
For patients with a mild to moderately severe pneumonia, treatment with a beta-lactam antibiotic is equivalent to an antibiotic with activity against atypical causative agents	1
No prospective studies have shown a benefit in survival or clinical efficacy of empirical regimes with “atypical” coverage compared to those without “atypical coverage” in hospitalized patients with CAP	1
There are no prospective trials studying monotherapy with a beta-lactam antibiotic compared to therapy with a betalactam in combination with a macrolide or in combination with a quinolone	1
Retrospective studies suggest that empirical treatment with a combination of a macrolide plus a beta-lactam antibiotic or monotherapy with a 4 th generation quinolone for patients with mild to moderately severe CAP will lead to improved survival and shortened hospitalization in comparison to monotherapy with beta-lactams	2
Early causal therapy for infections with <i>Legionella spp</i> decreases mortality. It is therefore recommended that patients with severe CAP should be treated with empirical combination therapy which is directed against both <i>S. pneumoniae</i> and <i>Legionella spp</i> .	2
There are theoretical arguments to have a preference for moxifloxacin when a 4 th generation quinolone is chosen	3

6. What is the role of rapid diagnostic tests in the initial treatment decision for patients with CAP?

Gram-stain of sputum

The preparation of a rapid Gram stain of sputum can contribute to faster determination of the causative agent and possibly therefore also to early streamlining of the initial therapy.¹⁴⁴ There are no prospective comparative studies that have investigated the results of a rapid Gram stain as only criterion for immediate streamlining (or not) to narrow spectrum therapy.

Legionella urinary antigen test

Detection of *L. pneumophila* antigens in urine is now generally available. With the current test (Immunochromatographic assay, Binax Now®) only *L. pneumophila* type 1 can be detected.¹⁴⁵ In the early phase of the disease the test can be false-negative. The sensitivity is about 70%-80% and the specificity 95%-100%.^{145;146} The sensitivity of the urine test increases to 88%-100% for patients with severe CAP.¹⁴⁷ A negative antigen test does not exclude legionellosis. In the Dutch Bovenkarspel study a positive antigen test at presentation was associated with a higher mortality and a high percentage of IC admissions. Coverage of the *Legionella spp.* within the first 24 hours resulted in a risk reduction of 38% for death or ICU admission.¹⁰⁵ The test can be performed in unconcentrated urine within 15 minutes. In concentrated urine (recommended) it will take 2 hours. Antigen tests are not influenced by previous antimicrobial therapy.¹⁴⁸

Pneumococcal urinary antigen test

The pneumococcal antigen test in urine can be performed easily and quickly (< 15 minutes). Compared to conventional methods for diagnosis of pneumococcal pneumonia sensitivity varies from 50% to 80%.¹⁴⁹⁻¹⁵² In a prospective study of 452 patients with CAP the test was false positive for 16/156 patients (10%) despite the confirmed presence of another causative agent.¹⁵³ The pneumococcal antigen test can contribute to a more rapid determination of the causative agent and possibly therefore to early streamlining of the initial therapy, but it is not yet sufficiently validated to be able to use it as a definite decision tool.

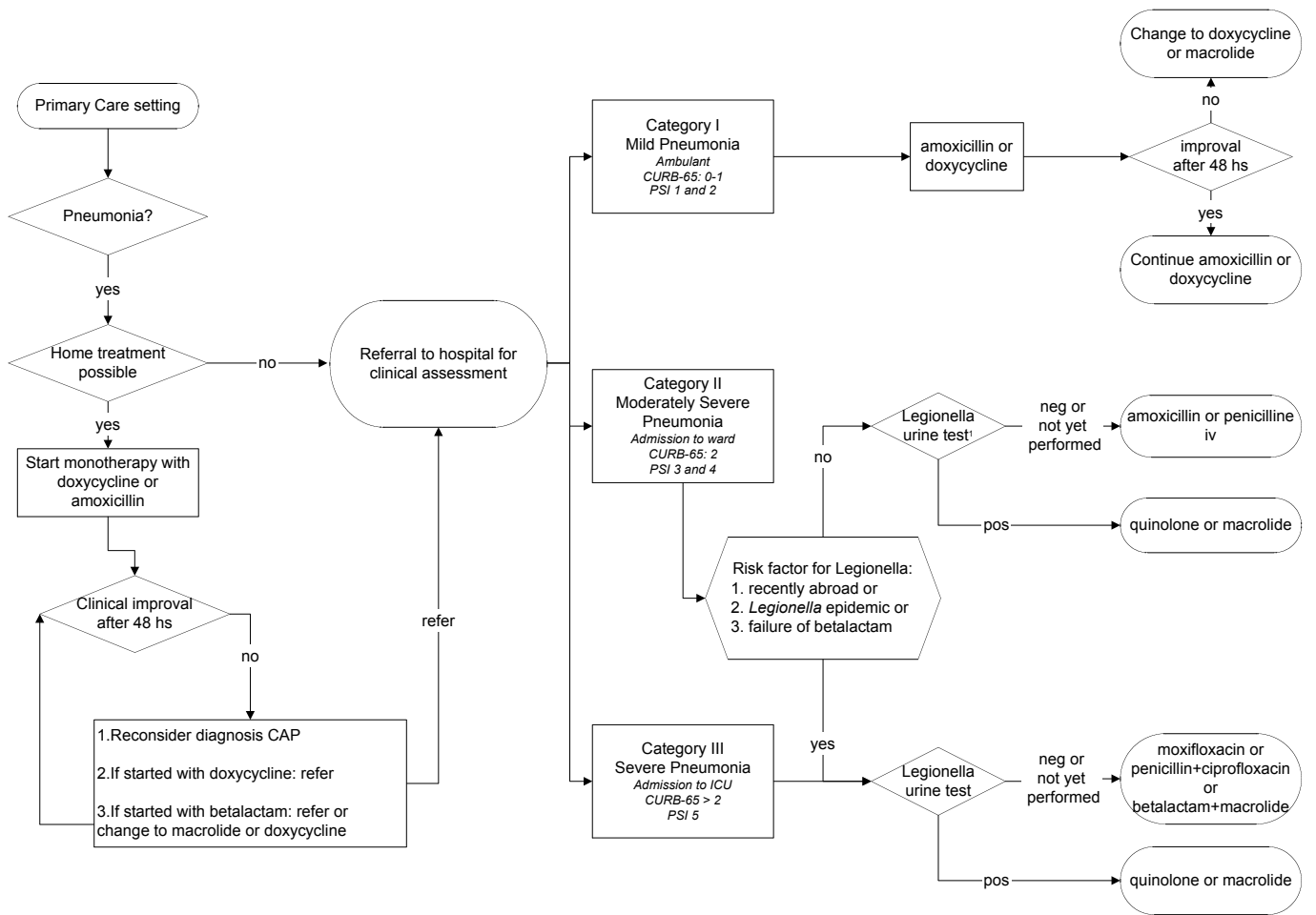
6. What is the role of rapid diagnostics for the empirical treatment of CAP?	Level of evidence
It is worthwhile to carry out a urinary antigen test for <i>Legionella spp</i> for all patients with severe CAP, if a Legionella infection is suspected in an epidemic setting or if there is no response to empirical treatment with a beta-lactam antibiotic	2
In the early phase of the disease the urinary antigen test for <i>Legionella spp</i> can be false negative. Sensitivity is not optimal (70-80 %), especially in mild pneumonia	2
The rapid Gram stain on sputum can give an early indication of the cause of the CAP. The test is however not sufficiently validated to be used as a decisive diagnostic tool	3
The pneumococcal antigen test for urine has reasonable sensitivity and good specificity for the presence of pneumococcal pneumonia. The test is however insufficiently validated to be used as a decisive diagnostic tool.	2

Application of the evidence into a practical guideline

Based on the conclusions from the systematic review described, the committee has designated the following as basic assumptions:

1. The "severity of disease" in patients with pneumonia is important for the choice of an optimum initial treatment strategy. For severely ill patients, initial monotherapy - directed toward one specific causative agent with the intention to change the therapy later ("wait and see") - is clinically not justifiable. A good example was the *Legionella* epidemic at the Westfriesian Flora whereby mortality was clearly associated with initial therapy that was directed against an incorrectly presumed causative agent. Besides, various studies have suggested that incorrect initial coverage of potential causative microorganisms, leads to increased mortality and longer hospital stay. The choice was made to classify patients into 3 categories: mild, moderately severe and severe pneumonia.
2. Classification according to "severity of disease" on the basis of a validated scoring system is to be preferred. For this purpose the Pneumonia Severity Index¹¹² or the CURB-65 score¹¹¹ are suggested. Equally, a more pragmatic classification in three categories may be used: treatment at home; admission to a general medical ward and admission to an Intensive Care Unit. The user of the guideline may choose the scoring system which he/she prefers.
3. The *Legionella* urine antigen test plays an important role: this test can contribute to important policy decisions on initial treatment.

On the basis of these considerations, the committee drew up the following guideline. A flow chart for the guideline is shown in figure 3. Table 4 presents an overview of the various antibiotic regimens.



¹always perform a Legionella urine antigen test in patients with a PSI score 4 or presence of 2

Figure 3 Flow chart of guideline recommendations on antibiotic treatment of CAP

Mild pneumonia (Category I)

Mild CAP is defined as pneumonia with a PSI score of 1 or 2 or the presence of 0 or 1 CURB-65 criteria. These patients can usually be treated at home. Patients with mild CAP who are admitted to the hospital for reasons other than a strictly medical indication also fall in category 1. For this group, initial therapy with a narrow spectrum beta-lactam antibiotic or doxycycline is recommended. The choice of a drug active against the most frequently occurring causative agent (*S. pneumoniae*) is essential in this case. For this purpose, oral doxycycline or amoxicillin is suitable. Feneticillin is not considered a first choice in view of the lower resorption. As a result of the increasing resistance of pneumococci against macrolides⁸⁰ (6.5%-10% in 2002 versus 2%-3% in 1996), monotherapy with macrolides is discouraged unless there is a penicillin allergy or it is not possible to administer doxycycline because of pregnancy or lactation. In that case, either clarithromycin (not for pregnant women) or azithromycin are preferred instead of erythromycin, because of its gastrointestinal side-effects. For patients in category I who receive amoxicillin or penicillin as initial therapy but do not improve within 48 hours, therapy is switched to monotherapy with a macrolide or doxycycline. If at the start of therapy doxycycline was administered, then failure of therapy means that macrolides cannot be given. In that case, referral to a hospital must be considered. If there is a clinical suspicion of *Legionella spp.*, then the Legionella urine antigen test must be carried out and initial therapy must be adjusted.

Moderately severe pneumonia (Category II)

Moderately severe CAP is defined as pneumonia with a PSI score of 3 or 4 or the presence of two CURB-65 criteria or CAP, necessitating admission to a general ward on clinical grounds. The initial therapy for this category consists of monotherapy with a beta-lactam antibiotic: the first choice is penicillin iv or amoxicillin iv. Doxycycline is not a first choice for this group in view of the 4%-5% resistance of *S. pneumoniae* against doxycycline. Broad spectrum antibiotics such as amoxicillin-clavulanate, cefuroxime, ceftriaxone or cefotaxime should not be considered because the expected pathogens do not justify the broader spectrum. Macrolides are not recommended because of the increasing pneumococcal resistance. In the case of penicillin-allergy, the best choice is a 2nd or 3rd generation cephalosporin or a 4th generation quinolone.

For patients in category II with a PSI score of 4 or 2 CURB-65 criteria, a urinary Legionella antigen test must be performed within 12 hours of admission. If the test is positive, therapy must be switched to monotherapy directed against *Legionella spp.* If a patient of category II satisfies one or more of the risk factors listed below or needs to be admitted to an Intensive Care Unit, then therapy that also covers *Legionella spp.* must be initiated immediately (as in category III): 1. recent visit to a foreign country, 2. comes from an epidemic setting of *Legionella spp.* infections, 3. treated for more than 48 hours with a beta-lactam antibiotic in adequate dosages and without indications of disturbed resorption or non-compliance without improvement in clinical condition.

Severe pneumonia (Category III)

Severe CAP can be defined in various ways: as CAP with a PSI score of 5, or CAP with three or more CURB-65 criteria or CAP requiring admission to an Intensive Care Unit on clinical grounds. In this group, therapy is always directed against *S. pneumoniae* and against *Legionella spp.* For this purpose there are 4 equally acceptable choices. The choice is dependent, on the one hand, on the risk of development of antimicrobial resistance at the population level; on the other hand, the costs, the ease of administration and the profile of side-effects play an important role. On the basis of proven effectivity against all expected causative agents, its easy use and limited side-effects, monotherapy with a 4th generation quinolone (levofloxacin or moxifloxacin) is feasible. On the basis of the high intrinsic activity against pneumococci, the favourable pharmacodynamic characteristics and the good penetration into tissues, moxifloxacin is preferred. Potential prolongation of the QT interval should be taken into account as a side-effect. A second possibility is combination therapy with penicillin G and ciprofloxacin. The combinations of penicillin and a macrolide or (2nd or 3rd generation) cephalosporin plus macrolide are

equal 3rd and 4th choices. In this respect the unfavourable pharmacodynamics and side-effects of erythromycin iv (including prolongation of the QT interval) should be weighed against the potential development of resistance due to the use of quinolones.

For all patients in category III, a Legionella urinary antigen test is carried out as a routine procedure within 12 hours of admission. If the test is positive, monotherapy directed against *Legionella spp.* is prescribed. If the test is negative, the patient is still treated further with combination therapy (coverage of both *S. pneumoniae* and *Legionella spp.*) because the sensitivity of the urinary antigen test is not 100%.

	Antibiotic	iv-po	dose	freq	Comment
Category I					Macrolides should not be used as initial therapy. They can be used in the event of penicillin allergy and when doxycycline cannot be used due to pregnancy or lactation. If doxycycline is given, start with a loading dose of 200 mg.
1 st choice	Amoxicillin	oral	500-750 mg	q6-8h	
	Doxycycline	oral	100 mg	qd	
2 nd choice	Feneticilline	oral	500 mg	q6h	In the event of penicillin allergy, give a 2 nd or 3 rd generation cephalosporin or moxifloxacin.
Category II					
1 st choice	Penicillin	IV	1 ME	q6h	
2 nd choice	Amoxicillin	IV	1000 mg	q6h	In the event of aspiration, the possibility of anaerobes or enterobacteriaceae should be taken into account: penicillin is replaced by amoxicillin-clavulanate.
Category III					
Monotherapy	Moxifloxacin	IV / oral	400 mg	qd	
Combination therapy	Penicillin	IV	1 ME	q4h	In the case of fulminant pneumonia after an episode of influenza penicillin is replaced by a beta-lactam antibiotic with activity against <i>S. aureus</i> .
	Ciprofloxacin	IV / oral	400 mg (po 500 mg)	q12h	
Combination therapy	Penicillin	IV	1 ME	q2h	Patients with demonstrated colonization of the respiratory tract with <i>Pseudomonas spp</i> receive penicillin & ceftazidime or ciprofloxacin for category II and penicillin & ciprofloxacin for category III.
	Erythromycin	IV	500 mg	q6h	
Combination therapy	Ceftriaxone or Cefotaxime	IV IV	2000 mg 1000 mg	qd q6h	For patients with CAP who recently visited a country with a high prevalence of penicillin-resistant <i>S. pneumoniae</i> (PRPS) the dose of penicillin is increased to 2 IU q4h (or continuous infusion) or 2000 mg ceftriaxone qd is given
	Erythromycin	IV	500-1000 mg	q6h	

Table 4. Guideline for the choice of initial therapy for community-acquired pneumonia

Co-morbidity and risk factors

A review of the literature reveals no associations between specific pathogens and co-morbidity and/or risk factors (COPD, diabetes mellitus, alcoholism), with the exception of the situations described below; therefore there is no justification for adaptation of the initial therapy for these patients.

In the event of aspiration of gastric contents, an infection with anaerobes and enterobacteriaceae can develop. Such patients are treated in accordance with the guideline, replacing penicillin or amoxicillin by amoxicillin-clavulanate. In the event of a fulminant pneumonia after an episode of influenza, the possibility of *S. aureus* as causative agent must be considered. Such patients are treated in accordance with the guideline except that the beta-lactam antibiotic chosen must be active against *S. aureus* (not in primary care: patients should be admitted). Patients with demonstrated colonization of the respiratory tract with *Pseudomonas spp.* are treated in accordance with the recommendations except that an antibiotic with anti-pseudomonas activity is added.

For patients with CAP who have recently visited countries with a high prevalence of penicillin-resistant *S. pneumoniae* (PRSP), this should be taken into account when choosing the initial therapy: the dose of initial therapy is increased to 2 million IU penicillin 6 times daily or either cefotaxime or ceftriaxone is chosen as beta-lactam antibiotic.

Oral therapy

An early switch from intravenous to oral antibiotic therapy for CAP as soon as clinical improvement occurs (e.g. decrease in fever and respiratory rate, hemodynamic stability, decrease in leukocyte count) is safe and cost-effective.^{57;154;155} Pneumonia caused by *S. aureus* or *Pseudomonas aeruginosa*, a non-drained lung empyema or lung abscess, and disturbed gastrointestinal resorption are contra-indications for oral therapy.^{3;10}

Optimum duration of therapy

There are as yet no controlled studies on the optimum duration of treatment for the various forms of pneumonia. The trend is to shorten the duration of treatment on the basis of the clinical response.¹⁵⁶ For moderately severe CAP, there was no evident difference in outcome between patients treated for 7 days for 10 days.¹⁵⁷ Based on experience, a pneumococcal pneumonia is treated up to 72 hours after normalization of the temperature. In the event of complications, such as empyema, longer treatment is recommended and the primary drainage is indicated.¹⁵⁸ It is recommended that pneumonia caused by *S. aureus* be treated for at least 14 days, pneumonia caused by *L. pneumophila*, *M. pneumoniae* or *Chlamydia spp.* 14 to 21 days.⁸

Treatment in the case of a known causative agent

In the event of a culture proven causative agent, pathogen-directed antibiotic treatment is to be preferred at all times. *S. pneumoniae* is most susceptible for penicillin G. A penicillin-resistant *S. pneumoniae* can as a rule be treated effectively with a high dosage of penicillin G^{159;160}, if necessary via a continuous infusion, or either 2nd or 3rd generation cephalosporin or 4th generation fluoroquinolone. Most experience with the treatment of *Legionella spp.* infections was acquired with erythromycin. In connection with the reduced activity of erythromycin in both in vitro and in intracellular models as well as in animal experiments, the newer macrolides and fluoroquinolones are considered the antibiotics of first choice for treatment of infections with *Legionella spp.*^{148;161;162}

Pathogen	Oral	Intravenous
<i>S. pneumoniae</i>	1. amoxicillin 2. feneticillin 3. macrolide or doxycycline ⁽¹⁾	1. penicillin G 2. amoxicillin 3. 2 nd of 3 rd gen. cephalosporin or 4 th generation quinolone ⁽¹⁾
<i>H. influenzae</i> Beta-lactamase negative	1. amoxicillin 2. macrolide or doxycycline ⁽¹⁾	1. amoxicillin 2. 2 nd of 3 rd gen. cephalosporin ⁽¹⁾
Beta-lactamase positive	1. amoxicillin-clavulanate 2. doxycycline or macrolide ⁽¹⁾	1. amoxicillin-clavulanate 2. 2 nd of 3 rd gen. cephalosporin
<i>Legionella spp.</i>	1. quinolone 2. azitromycin or claritromycin 3. doxycycline	1. quinolone 2. erytromycin
<i>M. pneumoniae, C. psittaci, C. pneumoniae</i>	1. doxycycline 2. macrolide	1. doxycycline 2. macrolide
<i>S. aureus (non-MRSA)</i>	1. flucloxacillin 2. amoxicillin-clavulanate 3. 1 st generation cephalosporin	1. flucloxacillin 2. amoxicillin-clavulanate 3. 1 st generation cephalosporin 4. vancomycin ⁽¹⁾ ± aminoglycoside or rifampicin
<i>P. aeruginosa</i>	1. ciprofloxacin	1. ceftazidim 2. ciprofloxacin
<i>K. pneumoniae</i>	1. amoxicillin-clavulanate 2. trimethoprim / sulfamethoxazole	1. amoxicillin-clavulanate 2. 2 nd or 3 rd gen. cephalosporin 3. trimethoprim / sulfamethoxazole
<i>Anaerobe bacteria</i> ⁽²⁾	1. amoxicillin-clavulanate 2. clindamycin 3. metronidazole	1. amoxicillin-clavulanate 2. clindamycin 3. metronidazole

⁽¹⁾ in the event of penicillin allergy ⁽²⁾ usually polymicrobial

Table 5. Pathogen directed therapy in CAP (based on IDSA, BTS en NVALT guidelines^{3;10;162;163})

Quality indicators

Quality indicators can be used by hospitals and professionals to measure the quality and hence, the change of quality of care provided.¹⁶⁴ Using a formal procedure, we formulated draft indicators of the appropriate use of antibiotics for CAP based on the 1998 SWAB guidelines, and selected established indicators, issued in international guidelines and the literature.^{165;166} To assess the evidence base (grades A-D) of every indicator, review of literature was performed. Grade A recommendations were considered valid. In case of grade B, C and D recommendations, an expert panel performed an iterated consensus procedure on (i) clinical relevance to patient health (ii) relevance to reducing antimicrobial resistance and (iii) cost-effectiveness. Experts were allowed to change or add indicators at their discretion before re-evaluation of the indicator set in a second round. To assess applicability in daily practice, feasibility of data collection, discriminatory capacity and reliability were determined in a data set of 443 hospital patients with CAP. (Schouten *et al. CID in press*) Based on the updated review of literature, presented in this article, one indicator was added (indicator 8: use of a validated scoring system to assess severity of illness at initial presentation) and one indicator was altered (indicator 9: Urine antigen testing against *Legionella spp* should be performed upon clinical suspicion *and / or in severely ill patients*). This resulted in a total of 9 quality indicators for antibiotic use in CAP

Quality indicators
1. Timely initiation of antibiotic therapy (within 4 h after presentation)
2. Choosing an antibiotic regimen according to national guidelines
3. Adapting dose and dose interval of antibiotics to renal function
4. Switching from iv to oral therapy, according to existing criteria and when clinically stable
5. Changing broad spectrum empirical into pathogen-directed therapy (streamlining therapy)
6. Taking two sets of blood samples for culture
7. Obtaining sputum samples for Gram stain and culture
8. Use a validated scoring system (PSI score or CURB-65 score) to assess severity of illness
9. Urine antigen testing against <i>Legionella spp</i> upon clinical suspicion or in severely ill patients

Table 6. Quality indicators for empirical antibiotic therapy in patients with CAP

Implementation of the Guideline

SWAB is preparing a strategy for implementation of its' guidelines in clinical practice, which will be integrated into the development of every future guideline. Many studies have shown that implementation strategies are more likely to be effective if they are preceded by an analysis of the environment to be addressed, the characteristics of the target group, and the factors that stimulate and hamper change, as well as insight into the aspects that show the greatest deviation from the proposed behaviour.¹⁶⁷

The SWAB has performed such an analysis (*Schouten et al, unpublished*). In addition, the chairpersons of local antibiotic committees in 24 Dutch hospitals were interviewed (*Bos et al., SWAB 2003*). The most important recommendations of from study were:

1. New or revised guidelines should be disseminated systematically in a uniform manner. Distribution by conventional mail and e-mail alerts that refer to the SWAB guideline on the website (ww.swab.nl) were preferred by the target group. Publication in the "Nederlands Tijdschrift voor Geneeskunde" as the only strategy was not considered sufficient to reach the whole target group.
2. Transparency of the procedure of (evidence based) guideline development is required.
3. Coordination of guideline development activities with other professional societies and prevention of conflicting statements with their guidelines, as has been done for the present CAP guideline.

In addition, SWAB is preparing a 'National Antibiotic Guide' based on the SWAB guidelines, which will be distributed via the internet and downloadable for PDA. Hospital antibiotic policy committees will be able to adapt the national electronic guide to their local policies.

Potential conflicts of interest

The composition of this guideline was supported by a grant of the Dutch Ministry of Health (VWS). Potential conflicts of interest disclosed: M. Bonten, lecturer and consultant for Aventis and Pfizer; BJ Kullberg, consultant for Pfizer; R. Jonkers, financial support for conference attendance from Bayer; A. Sachs, research grant from Pfizer. The other authors have disclosed no conflicts of interest.

Applicability

This guideline was developed and approved by representatives of the professional medical societies mentioned in the introduction and methods sections, and represents the current professional standard in April, 2005. The guideline contains general recommendations. It is possible that, in individual cases, these recommendations do not apply. Applicability of the guideline in clinical practice resorts to the responsibility of every individual practitioner. Facts or circumstances may occur, in which deviation of the guideline is justified, in order to provide optimal quality of care for the patient.

References

1. Verheij TJ, Salome PL, Bindels PJ, Chavannes AW, Ponsioen BP, Sachs AP. NHG-standaard Acute hoesten. *Huisarts en Wetenschap* 2003;**46**:496-506.
2. van Kasteren ME, Wijnands WJ, Stobberingh EE, Janknegt R, van der Meer JW. [Optimization of the antibiotics policy in the Netherlands. II. SWAB guidelines for the antimicrobial therapy of pneumonia in patients at home. The Netherlands Antibiotic Policy Foundation]. *Ned.Tijdschr.Geneeskd.* 1998;**142**:952-6.
3. NVALT (National Society for Respiratory Physicians). Guideline for Diagnosis and Treatment of Community-acquired Pneumonia (CAP). Alphen aan den Rijn: Van Zuiden Communications, 2003.
4. Everdingen JJE, Burgers JS, Assendelft WJJ, Swinkels JA, Barneveld TA van ea. Evidence-based richtlijnontwikkeling. Een leidraad voor de praktijk. Houten: Bohn Stafleu van Loghum, 2004.
5. CBO. Richtlijnontwikkeling binnen het kwaliteitsinstituut voor de gezondheidszorg CBO. handleiding voor werkgroepleden. Utrecht: CBO, 2000.
6. Niederman MS, Mandell LA, Anzueto A, Bass JB, Broughton WA, Campbell GD *et al.* Guidelines for the management of adults with community-acquired pneumonia. Diagnosis, assessment of severity, antimicrobial therapy, and prevention. *Am J Respir Crit Care Med* 2001;**163**:1730-54.
7. Mandell LA, Bartlett JG, Dowell SF, File TM, Jr., Musher DM, Whitney C. Update of practice guidelines for the management of community-acquired pneumonia in immunocompetent adults. *Clin.Infect.Dis.* 2003;**37**:1405-33.
8. Bartlett JG, Dowell SF, Mandell LA, File Jr TM, Musher DM, Fine MJ. Practice guidelines for the management of community-acquired pneumonia in adults. Infectious Diseases Society of America. *Clin Infect.Dis.* 2000;**31**:347-82.
9. ERS Task Force Report. Guidelines for management of adult community-acquired lower respiratory tract infections. European Respiratory Society. *Eur.Respir J* 1998;**11**:986-91.
10. BTS Guidelines for the Management of Community Acquired Pneumonia in Adults. *Thorax* 2001;**56** **Suppl 4:IV1-64**:IV1-64.
11. Janknegt R. Using health outcomes data to inform decision-making: formulary committee perspective. *Pharmacoeconomics.* 2001;**19** **Suppl 2**:49-52.
12. Hopstaken RM, Nelemans P, Stobberingh EE, Muris JW, Rinkens PE, Dinant GJ. Is roxithromycin better than amoxicillin in the treatment of acute lower respiratory tract infections in primary care? A double-blind randomized controlled trial. *J Fam Pract* 2002;**51**:329-36.
13. Woodhead MA, Macfarlane JT, McCracken JS, Rose DH, Finch RG. Prospective study of the aetiology and outcome of pneumonia in the community. *Lancet* 1987;**1**:671-4.

14. Almirall J, Morato I, Riera F, Verdaguer A, Priu R, Coll P *et al.* Incidence of community-acquired pneumonia and Chlamydia pneumoniae infection: a prospective multicentre study. *Eur.Respir J* 1993;**6**:14-8.
15. Marrie TJ, Peeling RW, Fine MJ, Singer DE, Coley CM, Kapoor WN. Ambulatory patients with community-acquired pneumonia: the frequency of atypical agents and clinical course. *Am J Med* 1996;**101**:508-15.
16. Michetti G, Pugliese C, Bamberg M, Ori BM, Villa R, Maggi L *et al.* Community-acquired pneumonia: is there difference in etiology between hospitalized and out-patients? *Minerva Med* 1995;**86**:341-51.
17. Blanquer J, Blanquer R, Borrás R, Nauffal D, Morales P, Menéndez R *et al.* Aetiology of community acquired pneumonia in Valencia, Spain: a multicentre prospective study. *Thorax* 1991;**46**:508-11.
18. Melbye H, Berdal BP, Straume B, Russell H, Vorland L, Thacker WL. Pneumonia--a clinical or radiographic diagnosis? Etiology and clinical features of lower respiratory tract infection in adults in general practice. *Scand.J.Infect.Dis.* 1992;**24**:647-55.
19. Berntsson E, Lagergard T, Strannegard O, Trollfors B. Etiology of community-acquired pneumonia in out-patients. *Eur.J.Clin.Microbiol.* 1986;**5**:446-7.
20. Almirall J, Bolibar I, Vidal J, Sauca G, Coll P, Niklasson B *et al.* Epidemiology of community-acquired pneumonia in adults: a population-based study. *Eur.Respir.J.* 2000;**15**:757-63.
21. Graffelman AW, Knuistingh NA, le Cessie S, Kroes AC, Springer MP, van den Broek PJ. Pathogens involved in lower respiratory tract infections in general practice. *Br.J Gen Pract* 2004;**54**:15-9.
22. Macfarlane JT, Colville A, Guion A, Macfarlane RM, Rose DH. Prospective study of aetiology and outcome of adult lower-respiratory-tract infections in the community. *Lancet* 1993;**341**:511-4.
23. Macfarlane J, Holmes W, Gard P, Macfarlane R, Rose D, Weston V *et al.* Prospective study of the incidence, aetiology and outcome of adult lower respiratory tract illness in the community. *Thorax* 2001;**56**:109-14.
24. Gaydos CA, Roblin PM, Hammerschlag MR, Hyman CL, Eiden JJ, Schachter J *et al.* Diagnostic utility of PCR-enzyme immunoassay, culture, and serology for detection of Chlamydia pneumoniae in symptomatic and asymptomatic patients. *J Clin Microbiol.* 1994;**32**:903-5.
25. Hyman CL, Roblin PM, Gaydos CA, Quinn TC, Schachter J, Hammerschlag MR. Prevalence of asymptomatic nasopharyngeal carriage of Chlamydia pneumoniae in subjectively healthy adults: assessment by polymerase chain reaction-enzyme immunoassay and culture. *Clin Infect.Dis.* 1995;**20**:1174-8.
26. Community-acquired pneumonia in adults in British hospitals in 1982-1983: a survey of aetiology, mortality, prognostic factors and outcome. The British Thoracic Society and the Public Health Laboratory Service. *Q.J.Med.* 1987;**62**:195-220.
27. Aubertin J, Dabis F, Fleurette J, Bornstein N, Salamon R, Brottier E *et al.* Prevalence of legionellosis among adults: a study of community-acquired pneumonia in France. *Infection* 1987;**15**:328-31.

28. Ausina V, Coll P, Sambeat M, Puig I, Condom MJ, Luquin M *et al.* Prospective study on the etiology of community-acquired pneumonia in children and adults in Spain. *Eur.J Clin Microbiol.Infect.Dis.* 1988;**7**:342-7.
29. Bates JH, Campbell GD, Barron AL, McCracken GA, Morgan PN, Moses EB *et al.* Microbial etiology of acute pneumonia in hospitalized patients. *Chest* 1992;**101**:1005-12.
30. Berntsson E, Blomberg J, Lagergard T, Trollfors B. Etiology of community-acquired pneumonia in patients requiring hospitalization. *Eur.J Clin Microbiol.* 1985;**4**:268-72.
31. Blasi F, Cosentini R, Raccanelli R, Rinaldi A, Denti F, Loprete F *et al.* Emerging pathogens of community-acquired pneumonia: a two-year prospective study. *J Chemother.* 1995;**7 Suppl 4**:115-6.:115-6.
32. Bohte R, van Furth R, van den Broek PJ. Aetiology of community-acquired pneumonia: a prospective study among adults requiring admission to hospital. *Thorax* 1995;**50**:543-7.
33. Burman LA, Trollfors B, Andersson B, Henrichsen J, Juto P, Kallings I *et al.* Diagnosis of pneumonia by cultures, bacterial and viral antigen detection tests, and serology with special reference to antibodies against pneumococcal antigens. *J Infect.Dis.* 1991;**163**:1087-93.
34. Fang GD, Fine M, Orloff J, Arisumi D, YU VL, Kapoor W *et al.* New and emerging etiologies for community-acquired pneumonia with implications for therapy. A prospective multicenter study of 359 cases. *Medicine (Baltimore)* 1990;**69**:307-16.
35. Gomez J, Banos V, Ruiz GJ, Soto MC, Munoz L, Nunez ML *et al.* Prospective study of epidemiology and prognostic factors in community-acquired pneumonia. *Eur.J Clin Microbiol.Infect.Dis.* 1996;**15**:556-60.
36. Holmberg H. Aetiology of community-acquired pneumonia in hospital treated patients. *Scand.J Infect.Dis.* 1987;**19**:491-501.
37. Hone R, Haugh C, O'Connor B, Hollingsworth J. Legionella: an infrequent cause of adult community acquired pneumonia in Dublin. *Ir.J Med Sci.* 1989;**158**:230-2.
38. Karalus NC, Cursons RT, Leng RA, Mahood CB, Rothwell RP, Hancock B *et al.* Community acquired pneumonia: aetiology and prognostic index evaluation. *Thorax* 1991;**46**:413-8.
39. Levy M, Dromer F, Brion N, Leturdu F, Carbon C. Community-acquired pneumonia. Importance of initial noninvasive bacteriologic and radiographic investigations. *Chest* 1988;**93**:43-8.
40. Lim I, Shaw DR, Stanley DP, Lumb R, McLennan G. A prospective hospital study of the aetiology of community-acquired pneumonia. *Med J Aust* 1989;**151**:87-91.
41. Logroscino CD, Penza O, Locicero S, Losito G, Nardini S, Bertoli L *et al.* Community-acquired pneumonia in adults: a multicentric observational AIPO study. *Monaldi Arch Chest Dis.* 1999;**54**:11-7.
42. Lorente ML, Falguera M, Nogues A, Gonzalez AR, Merino MT, Caballero MR. Diagnosis of pneumococcal pneumonia by polymerase chain reaction (PCR) in whole blood: a prospective clinical study. *Thorax* 2000;**55**:133-7.

43. Macfarlane JT, Finch RG, Ward MJ, Macrae AD. Hospital study of adult community-acquired pneumonia. *Lancet* 1982;**2**:255-8.
44. Marrie TJ, Durant H, Yates L. Community-acquired pneumonia requiring hospitalization: 5-year prospective study. *Rev.Infect.Dis.* 1989;**11**:586-99.
45. McNabb WR, Shanson DC, Williams TD, Lant AF. Adult community-acquired pneumonia in central London. *J R.Soc.Med* 1984;**77**:550-5.
46. Menendez R, Cordoba J, de La CP, Cremades MJ, Lopez-Hontagas JL, Salavert M *et al.* Value of the polymerase chain reaction assay in noninvasive respiratory samples for diagnosis of community-acquired pneumonia. *Am J Respir Crit Care Med* 1999;**159**:1868-73.
47. Neill AM, Martin IR, Weir R, Anderson R, Chereshsky A, Epton MJ *et al.* Community acquired pneumonia: aetiology and usefulness of severity criteria on admission. *Thorax* 1996;**51**:1010-6.
48. Ortvqvist A, Hedlund J, Grillner L, Jalonen E, Kallings I, Leinonen M *et al.* Aetiology, outcome and prognostic factors in community-acquired pneumonia requiring hospitalization. *Eur.Respir J* 1990;**3**:1105-13.
49. Ostergaard L, Andersen PL. Etiology of community-acquired pneumonia. Evaluation by transtracheal aspiration, blood culture, or serology. *Chest* 1993;**104**:1400-7.
50. Pareja A, Bernal C, Leyva A, Piedrola G, Maroto MC. Etiologic study of patients with community-acquired pneumonia. *Chest* 1992;**101**:1207-10.
51. Ruf B, Schurmann D, Horbach I, Fehrenbach FJ, Pohle HD. Incidence and clinical features of community-acquired legionellosis in hospitalized patients. *Eur.Respir J* 1989;**2**:257-62.
52. Ruiz M, Ewig S, Marcos MA, Martinez JA, Arancibia F, Mensa J *et al.* Etiology of community-acquired pneumonia: impact of age, comorbidity, and severity. *Am J Respir Crit Care Med* 1999;**160**:397-405.
53. Socan M, Marinic-Fiser N, Kraigher A, Kotnik A, Logar M. Microbial aetiology of community-acquired pneumonia in hospitalised patients. *Eur.J Clin Microbiol.Infect.Dis.* 1999;**18**:777-82.
54. White RJ, Blainey AD, Harrison KJ, Clarke SK. Causes of pneumonia presenting to a district general hospital. *Thorax* 1981;**36**:566-70.
55. Braun JJ, de Graaff CS, de Goey J, Zwinderman AH, Petit PL. [Community-acquired pneumonia: pathogens and course in patients admitted to a general hospital]. *Ned.Tijdschr.Geneeskd.* 2004;**148**:836-40.
56. Boersma WG, Lowenberg A, Holloway Y, Kuttscrutter H, Snijder JA, Koeter GH. Pneumococcal capsular antigen detection and pneumococcal serology in patients with community acquired pneumonia. *Thorax* 1991;**46**:902-6.
57. Oosterheert. Diagnosis and treatment of community-acquired lower respiratory tract infections. Dissertation 151-170. 2005.

58. Incidentie Legionella spp. *Infectieziektenbulletin* 2004.
59. Den Boer JW, Friesema IH, Hooi JD. [Reported cases of Legionella pneumonia in the Netherlands, 1987-2000]. *Ned.Tijdschr.Geneeskd.* 2002;**146**:315-20.
60. Ruiz-Gonzalez A, Falguera M, Nogues A, Rubio-Caballero M. Is Streptococcus pneumoniae the leading cause of pneumonia of unknown etiology? A microbiologic study of lung aspirates in consecutive patients with community-acquired pneumonia. *Am J Med* 1999;**106**:385-90.
61. The aetiology, management and outcome of severe community-acquired pneumonia on the intensive care unit. The British Thoracic Society Research Committee and The Public Health Laboratory Service. *Respir Med* 1992;**86**:7-13.
62. Alkhayer M, Jenkins PF, Harrison BD. The outcome of community acquired pneumonia treated on the intensive care unit. *Respir Med* 1990;**84**:13-6.
63. Almirall J, Mesalles E, Klamburg J, Parra O, Agudo A. Prognostic factors of pneumonia requiring admission to the intensive care unit. *Chest* 1995;**107**:511-6.
64. Hirani NA, Macfarlane JT. Impact of management guidelines on the outcome of severe community acquired pneumonia. *Thorax* 1997;**52**:17-21.
65. Leroy O, Santre C, Beuscart C, Georges H, Guery B, Jacquier JM *et al.* A five-year study of severe community-acquired pneumonia with emphasis on prognosis in patients admitted to an intensive care unit. *Intensive Care Med* 1995;**21**:24-31.
66. Moine P, Vercken JB, Chevret S, Chastang C, Gajdos P. Severe community-acquired pneumonia. Etiology, epidemiology, and prognosis factors. French Study Group for Community-Acquired Pneumonia in the Intensive Care Unit. *Chest* 1994;**105**:1487-95.
67. Olaechea PM, Quintana JM, Gallardo MS, Insausti J, Maravi E, Alvarez B. A predictive model for the treatment approach to community-acquired pneumonia in patients needing ICU admission. *Intensive Care Med* 1996;**22**:1294-300.
68. Ortvqvist A, Sterner G, Nilsson JA. Severe community-acquired pneumonia: factors influencing need of intensive care treatment and prognosis. *Scand.J Infect.Dis.* 1985;**17**:377-86.
69. Pachon J, Prados MD, Capote F, Cuello JA, Garnacho J, Verano A. Severe community-acquired pneumonia. Etiology, prognosis, and treatment. *Am Rev.Respir Dis.* 1990;**142**:369-73.
70. Rello J, Quintana E, Ausina V, Net A, Prats G. A three-year study of severe community-acquired pneumonia with emphasis on outcome. *Chest* 1993;**103**:232-5.
71. Sorensen J, Forsberg P, Hakanson E, Maller R, Sederholm C, Soren L *et al.* A new diagnostic approach to the patient with severe pneumonia. *Scand.J Infect.Dis.* 1989;**21**:33-41.
72. Torres A, Serra-Batlles J, Ferrer A, Jimenez P, Celis R, Cobo E *et al.* Severe community-acquired pneumonia. Epidemiology and prognostic factors. *Am Rev.Respir Dis.* 1991;**144**:312-8.

73. Woodhead MA, Macfarlane JT, Rodgers FG, Laverick A, Pilkington R, Macrae AD. Aetiology and outcome of severe community-acquired pneumonia. *J Infect.* 1985;**10**:204-10.
74. Vegelin AL, Bissumbhar P, Joore JC, Lammers JW, Hoepelman IM. Guidelines for severe community-acquired pneumonia in the western world. *Neth.J Med* 1999;**55**:110-7.
75. Rello J, Bodi M, Mariscal D, Navarro M, Diaz E, Gallego M *et al.* Microbiological testing and outcome of patients with severe community-acquired pneumonia. *Chest* 2003;**123**:174-80.
76. El Solh AA, Sikka P, Ramadan F, Davies J. Etiology of severe pneumonia in the very elderly. *Am J Respir Crit Care Med* 2001;**163**:645-51.
77. Oosterheert JJ, Bonten MJ, Hak E, Schneider MM, Hoepelman AI. Severe community-acquired pneumonia: what's in a name? *Curr.Opin.Infect.Dis.* 2003;**16**:153-9.
78. Park DR, Sherbin VL, Goodman MS, Pacifico AD, Rubinfeld GD, Polissar NL *et al.* The etiology of community-acquired pneumonia at an urban public hospital: influence of human immunodeficiency virus infection and initial severity of illness. *J Infect.Dis.* 2001;**184**:268-77.
79. de Neeling AJ, Overbeek BP, Horrevorts AM, Ligtvoet EE, Goettsch WG. Antibiotic use and resistance of *Streptococcus pneumoniae* in The Netherlands during the period 1994-1999. *J Antimicrob.Chemother.* 2001;**48**:441-4.
80. SWAB. NethMap 2004, Consumption of antimicrobial agents and antimicrobial resistance among medically important bacteria in the Netherlands. 2004.
81. Pihlajamaki M, Kotilainen P, Kaurila T, Klaukka T, Palva E, Huovinen P. Macrolide-resistant *Streptococcus pneumoniae* and use of antimicrobial agents. *Clin Infect.Dis.* 2001;**33**:483-8.
82. Bronzwaer SL, Cars O, Buchholz U, Molstad S, Goettsch W, Veldhuijzen IK *et al.* A European study on the relationship between antimicrobial use and antimicrobial resistance. *Emerg.Infect.Dis.* 2002;**8**:278-82.
83. Mouton JW, Jansz AR. The DUEL study: a multi-center in vitro evaluation of linezolid compared with other antibiotics in the Netherlands. *Clin.Microbiol.Infect.* 2001;**7**:486-91.
84. Lagrou K, Peetermans WE, Verhaegen J, Van Lierde S, Verbist L, Van Eldere J. Macrolide resistance in Belgian *Streptococcus pneumoniae*. *J Antimicrob.Chemother.* 2000;**45**:119-21.
85. Lim WS, Macfarlane JT, Boswell TC, Harrison TG, Rose D, Leinonen M *et al.* Study of community acquired pneumonia aetiology (SCAPA) in adults admitted to hospital: implications for management guidelines. *Thorax* 2001;**56**:296-301.
86. Torres A, Dorca J, Zalacain R, Bello S, el Ebiary M, Molinos L *et al.* Community-acquired pneumonia in chronic obstructive pulmonary disease: a Spanish multicenter study. *Am.J Respir.Crit Care Med.* 1996;**154**:1456-61.

87. Arancibia F, Bauer TT, Ewig S, Mensa J, Gonzalez J, Niederman MS *et al.* Community-acquired pneumonia due to gram-negative bacteria and pseudomonas aeruginosa: incidence, risk, and prognosis. *Arch.Intern.Med.* 2002;**162**:1849-58.
88. Marrie TJ. Bacteraemic pneumococcal pneumonia: a continuously evolving disease. *J Infect.* 1992;**24**:247-55.
89. Leroy O, Vandenbussche C, Coffinier C, Bosquet C, Georges H, Guery B *et al.* Community-acquired aspiration pneumonia in intensive care units. Epidemiological and prognosis data. *Am J Respir Crit Care Med* 1997;**156**:1922-9.
90. Sopena N, Sabria-Leal M, Pedro-Botet ML, Padilla E, Dominguez J, Morera J *et al.* Comparative study of the clinical presentation of Legionella pneumonia and other community-acquired pneumonias. *Chest* 1998;**113**:1195-200.
91. Mier L, Dreyfuss D, Darchy B, Lanore JJ, Djedaini K, Weber P *et al.* Is penicillin G an adequate initial treatment for aspiration pneumonia? A prospective evaluation using a protected specimen brush and quantitative cultures. *Intensive Care Med* 1993;**19**:279-84.
92. Bohte R, Hermans J, van den Broek PJ. Early recognition of Streptococcus pneumoniae in patients with community-acquired pneumonia. *Eur.J Clin Microbiol.Infect.Dis.* 1996;**15**:201-5.
93. Farr BM, Kaiser DL, Harrison BD, Connolly CK. Prediction of microbial aetiology at admission to hospital for pneumonia from the presenting clinical features. British Thoracic Society Pneumonia Research Subcommittee. *Thorax* 1989;**44**:1031-5.
94. Woodhead MA, Macfarlane JT. Comparative clinical and laboratory features of legionella with pneumococcal and mycoplasma pneumonias. *Br J Dis.Chest* 1987;**81**:133-9.
95. Miller AC. Early clinical differentiation between Legionnaires' disease and other sporadic pneumonias. *Ann.Intern Med* 1979;**90**:526-8.
96. Helms CM, Viner JP, Sturm RH, Renner ED, Johnson W. Comparative features of pneumococcal, mycoplasmal, and Legionnaires' disease pneumonias. *Ann.Intern Med* 1979;**90**:543-7.
97. Granados A, Podzamczar D, Gudiol F, Manresa F. Pneumonia due to Legionella pneumophila and pneumococcal pneumonia: similarities and differences on presentation. *Eur.Respir J* 1989;**2**:130-4.
98. Riquelme R, Torres A, el Ebiary M, de la Bellacasa JP, Estruch R, Mensa J *et al.* Community-acquired pneumonia in the elderly: A multivariate analysis of risk and prognostic factors. *Am J Respir Crit Care Med* 1996;**154**:1450-5.
99. Metlay JP, Schulz R, Li YH, Singer DE, Marrie TJ, Coley CM *et al.* Influence of age on symptoms at presentation in patients with community-acquired pneumonia. *Arch Intern Med* 1997;**157**:1453-9.
100. Marrie TJ. Pneumonia in the elderly. *Curr.Opin.Pulm.Med* 1996;**2**:192-7.
101. Barlow GD, Lamping DL, Davey PG, Nathwani D. Evaluation of outcomes in community-acquired pneumonia: a guide for patients, physicians, and policy-makers. *Lancet Infect.Dis.* 2003;**3**:476-88.

102. Battleman DS, Callahan M, Thaler HT. Rapid antibiotic delivery and appropriate antibiotic selection reduce length of hospital stay of patients with community-acquired pneumonia: link between quality of care and resource utilization. *Arch Intern Med* 2002;**162**:682-8.
103. Gleason PP, Meehan TP, Fine JM, Galusha DH, Fine MJ. Associations between initial antimicrobial therapy and medical outcomes for hospitalized elderly patients with pneumonia. *Arch Intern Med* 1999;**159**:2562-72.
104. Heath CH, Grove DI, Looke DF. Delay in appropriate therapy of Legionella pneumonia associated with increased mortality. *Eur.J Clin Microbiol.Infect.Dis.* 1996;**15**:286-90.
105. Lettinga KD, Verbon A, Weverling GJ, Schellekens JF, Den Boer JW, Yzerman EP *et al.* Legionnaires' disease at a Dutch flower show: prognostic factors and impact of therapy. *Emerg.Infect.Dis.* 2002;**8**:1448-54.
106. Malone DC, Shaban HM. Adherence to ATS guidelines for hospitalized patients with community-acquired pneumonia. *Ann.Pharmacother.* 2001;**35**:1180-5.
107. Martinez JA, Horcajada JP, Almela M, Marco F, Soriano A, Garcia E *et al.* Addition of a macrolide to a beta-lactam-based empirical antibiotic regimen is associated with lower in-hospital mortality for patients with bacteremic pneumococcal pneumonia. *Clin Infect.Dis.* 2003;**36**:389-95.
108. Menendez R, Ferrando D, Valles JM, Vallterra J. Influence of deviation from guidelines on the outcome of community-acquired pneumonia. *Chest* 2002;**122**:612-7.
109. Stahl JE, Barza M, DesJardin J, Martin R, Eckman MH. Effect of macrolides as part of initial empiric therapy on length of stay in patients hospitalized with community-acquired pneumonia. *Arch Intern Med* 1999;**159**:2576-80.
110. Waterer GW, Somes GW, Wunderink RG. Monotherapy may be suboptimal for severe bacteremic pneumococcal pneumonia. *Arch Intern Med* 2001;**161**:1837-42.
111. Lim WS, van der Eerden MM, Laing R, Boersma WG, Karalus N, Town GI *et al.* Defining community acquired pneumonia severity on presentation to hospital: an international derivation and validation study. *Thorax* 2003;**58**:377-82.
112. Fine MJ, Auble TE, Yealy DM, Hanusa BH, Weissfeld LA, Singer DE *et al.* A prediction rule to identify low-risk patients with community-acquired pneumonia. *N.Engl.J Med* 1997;**336**:243-50.
113. Kamath A, Pasteur MC, Slade MG, Harrison BD. Recognising severe pneumonia with simple clinical and biochemical measurements. *Clin Med* 2003;**3**:54-6.
114. Aujesky D, Auble TE, Yealy DM, Stone RA, Obrosky DS, Meehan TP *et al.* Prospective comparison of three validated prediction rules for prognosis in community-acquired pneumonia. *Am.J Med.* 2005;**118**:384-92.
115. Dudas V, Hopefl A, Jacobs R, Guglielmo BJ. Antimicrobial selection for hospitalized patients with presumed community-acquired pneumonia: a survey of nonteaching US community hospitals. *Ann.Pharmacother.* 2000;**34**:446-52.

116. Houck PM, MacLehose RF, Niederman MS, Lowery JK. Empiric antibiotic therapy and mortality among medicare pneumonia inpatients in 10 western states : 1993, 1995, and 1997. *Chest* 2001;**119**:1420-6.
117. Mufson MA, Stanek RJ. Bacteremic pneumococcal pneumonia in one American City: a 20-year longitudinal study, 1978-1997. *Am J Med* 1999;**107**:34S-43S.
118. Waterer GW. Combination antibiotic therapy with macrolides in community-acquired pneumonia: more smoke but is there any fire? *Chest* 2003;**123**:1328-9.
119. Baddour LM, YU VL, Klugman KP, Feldman C, Ortqvist A, Rello J *et al.* Combination antibiotic therapy lowers mortality among severely ill patients with pneumococcal bacteremia. *Am.J Respir. Crit Care Med.* 2004;**170**:440-4.
120. Oosterheert JJ, Bonten MJ, Hak E, Schneider MM, Hoepelman IM. How good is the evidence for the recommended empirical antimicrobial treatment of patients hospitalized because of community-acquired pneumonia? A systematic review. *J.Antimicrob.Chemother.* 2003;**52**:555-63.
121. File TM, Jr., Segreti J, Dunbar L, Player R, Kohler R, Williams RR *et al.* A multicenter, randomized study comparing the efficacy and safety of intravenous and/or oral levofloxacin versus ceftriaxone and/or cefuroxime axetil in treatment of adults with community-acquired pneumonia. *Antimicrob.Agents Chemother.* 1997;**41**:1965-72.
122. Finch R, Schurmann D, Collins O, Kubin R, McGivern J, Bobbaers H *et al.* Randomized controlled trial of sequential intravenous (i.v.) and oral moxifloxacin compared with sequential i.v. and oral co-amoxiclav with or without clarithromycin in patients with community-acquired pneumonia requiring initial parenteral treatment. *Antimicrob.Agents Chemother.* 2002;**46**:1746-54.
123. Norrby SR, Petermann W, Willcox PA, Vetter N, Salewski E. A comparative study of levofloxacin and ceftriaxone in the treatment of hospitalized patients with pneumonia. *Scand.J Infect.Dis.* 1998;**30**:397-404.
124. Petitpretz P, Arvis P, Marel M, Moita J, Urueta J. Oral moxifloxacin vs high-dosage amoxicillin in the treatment of mild-to-moderate, community-acquired, suspected pneumococcal pneumonia in adults. *Chest* 2001;**119**:185-95.
125. Aubier M, Verster R, Regamey C, Geslin P, Vercken JB. Once-daily sparfloxacin versus high-dosage amoxicillin in the treatment of community-acquired, suspected pneumococcal pneumonia in adults. Sparfloxacin European Study Group. *Clin Infect.Dis.* 1998;**26**:1312-20.
126. Frank E, Liu J, Kinasewitz G, Moran GJ, Oross MP, Olson WH *et al.* A multicenter, open-label, randomized comparison of levofloxacin and azithromycin plus ceftriaxone in hospitalized adults with moderate to severe community-acquired pneumonia. *Clin Ther.* 2002;**24**:1292-308.
127. Mills GD, Oehley MR, Arrol B. Effectiveness of beta lactam antibiotics compared with antibiotics active against atypical pathogens in non-severe community acquired pneumonia: meta-analysis. *BMJ* 2005;**330**:456.

128. Shefet D, Robenshtock E, Paul M, Leibovici L. Empiric antibiotic coverage of atypical pathogens for community acquired pneumonia in hospitalized adults. *Cochrane.Database.Syst.Rev.* 2005;CD004418.
129. Bohte R, van't Wout JW, Lobatto S, Blusse van Oud AA, Boekhout M, Nauta EH *et al.* Efficacy and safety of azithromycin versus benzylpenicillin or erythromycin in community-acquired pneumonia. *Eur.J Clin Microbiol.Infect.Dis.* 1995;**14**:182-7.
130. Ailani RK, Agastya G, Ailani RK, Mukunda BN, Shekar R. Doxycycline is a cost-effective therapy for hospitalized patients with community-acquired pneumonia. *Arch Intern Med* 1999;**159**:266-70.
131. Ragnar NS. Atypical pneumonia in the Nordic countries: aetiology and clinical results of a trial comparing fleroxacin and doxycycline. Nordic Atypical Pneumonia Study Group. *J Antimicrob.Chemother.* 1997;**39**:499-508.
132. Rello J, Catalan M, Diaz E, Bodi M, Alvarez B. Associations between empirical antimicrobial therapy at the hospital and mortality in patients with severe community-acquired pneumonia. *Intensive Care Med* 2002;**28**:1030-5.
133. Lode H, File TM, Jr., Mandell L, Ball P, Pypstra R, Thomas M. Oral gemifloxacin versus sequential therapy with intravenous ceftriaxone/oral cefuroxime with or without a macrolide in the treatment of patients hospitalized with community-acquired pneumonia: a randomized, open-label, multicenter study of clinical efficacy and tolerability. *Clin Ther.* 2002;**24**:1915-36.
134. Gaillat J, Bru JP, Sedallian A. Penicillin G/ofloxacin versus erythromycin/amoxicillin-clavulanate in the treatment of severe community-acquired pneumonia. *Eur.J Clin Microbiol.Infect.Dis.* 1994;**13**:639-44.
135. Chen DK, McGeer A, de Azavedo JC, Low DE. Decreased susceptibility of *Streptococcus pneumoniae* to fluoroquinolones in Canada. Canadian Bacterial Surveillance Network. *N.Engl.J Med* 1999;**341**:233-9.
136. Davidson R, Cavalcanti R, Brunton JL, Bast DJ, de Azavedo JC, Kibsey P *et al.* Resistance to levofloxacin and failure of treatment of pneumococcal pneumonia. *N.Engl.J Med* 2002;**346**:747-50.
137. Pestova E, Millichap JJ, Noskin GA, Peterson LR. Intracellular targets of moxifloxacin: a comparison with other fluoroquinolones. *J Antimicrob.Chemother.* 2000;**45**:583-90.
138. Thomas JK, Forrest A, Bhavnani SM, Hyatt JM, Cheng A, Ballow CH *et al.* Pharmacodynamic evaluation of factors associated with the development of bacterial resistance in acutely ill patients during therapy. *Antimicrob.Agents Chemother.* 1998;**42**:521-7.
139. Blondeau JM, Zhao X, Hansen G, Drlica K. Mutant prevention concentrations of fluoroquinolones for clinical isolates of *Streptococcus pneumoniae*. *Antimicrob.Agents Chemother.* 2001;**45**:433-8.
140. Soman A, Honeybourne D, Andrews J, Jevons G, Wise R. Concentrations of moxifloxacin in serum and pulmonary compartments following a single 400 mg oral dose in patients undergoing fibre-optic bronchoscopy. *J Antimicrob.Chemother.* 1999;**44**:835-8.

141. Florea NR, Tessier PR, Zhang C, Nightingale CH, Nicolau DP. Pharmacodynamics of moxifloxacin and levofloxacin at simulated epithelial lining fluid drug concentrations against *Streptococcus pneumoniae*. *Antimicrob. Agents Chemother.* 2004;**48**:1215-21.
142. Capitano B, Mattoes HM, Shore E, O'Brien A, Braman S, Sutherland C *et al.* Steady-state intrapulmonary concentrations of moxifloxacin, levofloxacin, and azithromycin in older adults. *Chest* 2004;**125**:965-73.
143. Carbon C. Comparison of side effects of levofloxacin versus other fluoroquinolones. *Chemotherapy* 2001;**47 Suppl 3**:9-14.
144. Musher DM, Montoya R, Wanahita A. Diagnostic value of microscopic examination of Gram-stained sputum and sputum cultures in patients with bacteremic pneumococcal pneumonia. *Clin. Infect. Dis.* 2004;**39**:165-9.
145. Kazandjian D, Chiew R, Gilbert GL. Rapid diagnosis of *Legionella pneumophila* serogroup 1 infection with the Binax enzyme immunoassay urinary antigen test. *J. Clin. Microbiol.* 1997;**35**:954-6.
146. Dominguez JA, Gali N, Pedroso P, Fargas A, Padilla E, Manterola JM *et al.* Comparison of the Binax *Legionella* urinary antigen enzyme immunoassay (EIA) with the Biotest *Legionella* Urin antigen EIA for detection of *Legionella* antigen in both concentrated and nonconcentrated urine samples. *J. Clin. Microbiol.* 1998;**36**:2718-22.
147. Yzerman EP, Den Boer JW, Lettinga KD, Schellekens J, Dankert J, Peeters M. Sensitivity of three urinary antigen tests associated with clinical severity in a large outbreak of Legionnaires' disease in The Netherlands. *J. Clin. Microbiol.* 2002;**40**:3232-6.
148. Roig J, Rello J. Legionnaires' disease: a rational approach to therapy. *J. Antimicrob. Chemother.* 2003;**51**:1119-29.
149. Murdoch DR, Laing RT, Mills GD, Karalus NC, Town GI, Mirrett S *et al.* Evaluation of a rapid immunochromatographic test for detection of *Streptococcus pneumoniae* antigen in urine samples from adults with community-acquired pneumonia. *J Clin. Microbiol.* 2001;**39**:3495-8.
150. Farina C, Arosio M, Vailati F, Muioli F, Goglio A. Urinary detection of *Streptococcus pneumoniae* antigen for diagnosis of pneumonia. *New Microbiol.* 2002;**25**:259-63.
151. Dominguez J, Gali N, Blanco S, Pedroso P, Prat C, Matas L *et al.* Detection of *Streptococcus pneumoniae* antigen by a rapid immunochromatographic assay in urine samples. *Chest* 2001;**119**:243-9.
152. Burel E, Dufour P, Gauduchon V, Jarraud S, Etienne J. Evaluation of a rapid immunochromatographic assay for detection of *Streptococcus pneumoniae* antigen in urine samples. *Eur J Clin. Microbiol. Infect. Dis.* 2001;**20**:840-1.
153. Gutierrez F, Masia M, Rodriguez JC, Ayelo A, Soldan B, Cebrian L *et al.* Evaluation of the immunochromatographic Binax NOW assay for detection of *Streptococcus pneumoniae* urinary antigen in a prospective study of community-acquired pneumonia in Spain. *Clin. Infect. Dis.* 2003;**36**:286-92.

154. Ramirez JA, Vargas S, Ritter GW, Brier ME, Wright A, Smith S *et al.* Early switch from intravenous to oral antibiotics and early hospital discharge: a prospective observational study of 200 consecutive patients with community-acquired pneumonia. *Arch Intern Med* 1999;**159**:2449-54.
155. Rhew DC, Tu GS, Ofman J, Henning JM, Richards MS, Weingarten SR. Early switch and early discharge strategies in patients with community-acquired pneumonia: a meta-analysis. *Arch Intern Med* 2001;**161**:722-7.
156. Polk R. Optimal use of modern antibiotics: emerging trends. *Clin.Infect.Dis.* 1999;**29**:264-74.
157. Siegel RE, Alicea M, Lee A, Blaiklock R. Comparison of 7 versus 10 days of antibiotic therapy for hospitalized patients with uncomplicated community-acquired pneumonia: a prospective, randomized, double-blind study. *Am J Ther.* 1999;**6**:217-22.
158. Bauwens AM, de Graaff CS, Boersma WG. [Pleural effusion and empyema as complications of pneumonia]. *Ned.Tijdschr.Geneeskd.* 2002;**146**:464-9.
159. Garau J. Treatment of drug-resistant pneumococcal pneumonia. *Lancet Infect.Dis.* 2002;**2**:404-15.
160. Roson B, Carratala J, Tubau F, Dorca J, Linares J, Pallares R *et al.* Usefulness of betalactam therapy for community-acquired pneumonia in the era of drug-resistant *Streptococcus pneumoniae*: a randomized study of amoxicillin-clavulanate and ceftriaxone. *Microb.Drug Resist.* 2001;**7**:85-96.
161. Dedicoat M, Venkatesan P. The treatment of Legionnaires' disease. *J Antimicrob.Chemother.* 1999;**43**:747-52.
162. de Vries PA, van der Werf TS, Manson WL, Zijlstra JG. [Choice of antimicrobial therapy for Legionella infection]. *Ned.Tijdschr.Geneeskd.* 2005;**149**:452-7.
163. Bartlett JG, Dowell SF, Mandell LA, File Jr TM, Musher DM, Fine MJ. Practice guidelines for the management of community-acquired pneumonia in adults. Infectious Diseases Society of America. *Clin Infect.Dis.* 2000;**31**:347-82.
164. Lawrence M, Olesen F. Indicators of Quality in Health Care. *Eur J Gen Pract* 1997;103-8.
165. Cantrill JA, Sibbald B, Buetow S. Indicators of the appropriateness of long-term prescribing in general practice in the United Kingdom: consensus development, face and content validity, feasibility, and reliability. *Qual.Health Care* 1998;**7**:130-5.
166. Campbell SM, Braspenning J, Hutchinson A, Marshall MN. Research methods used in developing and applying quality indicators in primary care. *BMJ* 2003;**326**:816-9.
167. Grol R, Grimshaw J. From best evidence to best practice: effective implementation of change in patients' care. *Lancet* 2003;**362**:1225-30.
168. Schouten JA, Hulscher ME, Natsch S, Grol RP, van der Meer JW. Antibiotic control measures in Dutch secondary care hospitals. *Neth.J Med.* 2005;**63**:24-30.