Health Care Associated Pneumonia

Respiratory Block

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Objectives

- Define the terms, pneumonia, community acquired pneumonia, health care associated pneumonia
- (HCAP) and ventilator associated pneumonia (VAP).
- Describe the pathogenesis of the health care associated pneumonia (hospital associated pneumonia) and VAP.
- Classify HCAP according to the time of onset .

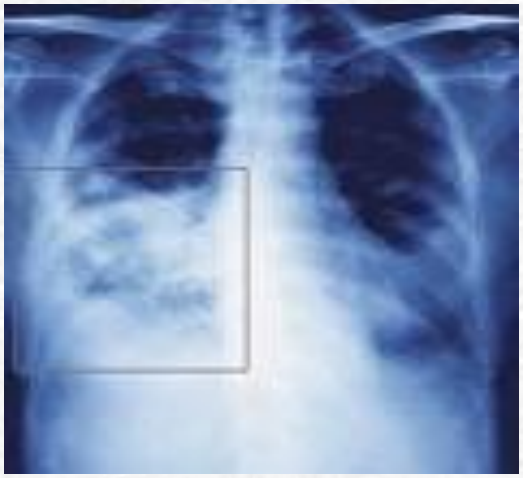
Objectives

- Name the different causative bacterial agents .
- Classify and describe types of VAP.
- Recognize the ways by which VAP is prevented.
- Describe the different chemotherapeutic anti microbial agents used for the treatment of health care associated pneumonia.
- Evaluate response to treatment and recognize reasons for failure of treatment.

Health Care Associated Pneumonia

- Definition of Pneumonia:

Infection of the pulmonary Parenchyma



PNEUMONIA can be :

- **A-Community acquired Pneumonia** acquired in the community, by community acquired organism, eg. *Streptococcus pneumoniae* usually susceptible to antibiotic.

- **B-Health care associated pneumonia** acquired **48-72 hours** after admission to health care institutions eg. pneumonia caused by organisms in hospital which are usually resistant to antibiotics-eg. *Pseudomonas aeruginosa*

Definition

- **Nosocomial pneumonia**: is defined as hospital associated pneumonia (HAP) or health care associated pneumonia (HCAP).
- Occurring at least **48 hours** after admission and not incubating at the time of hospitalization.

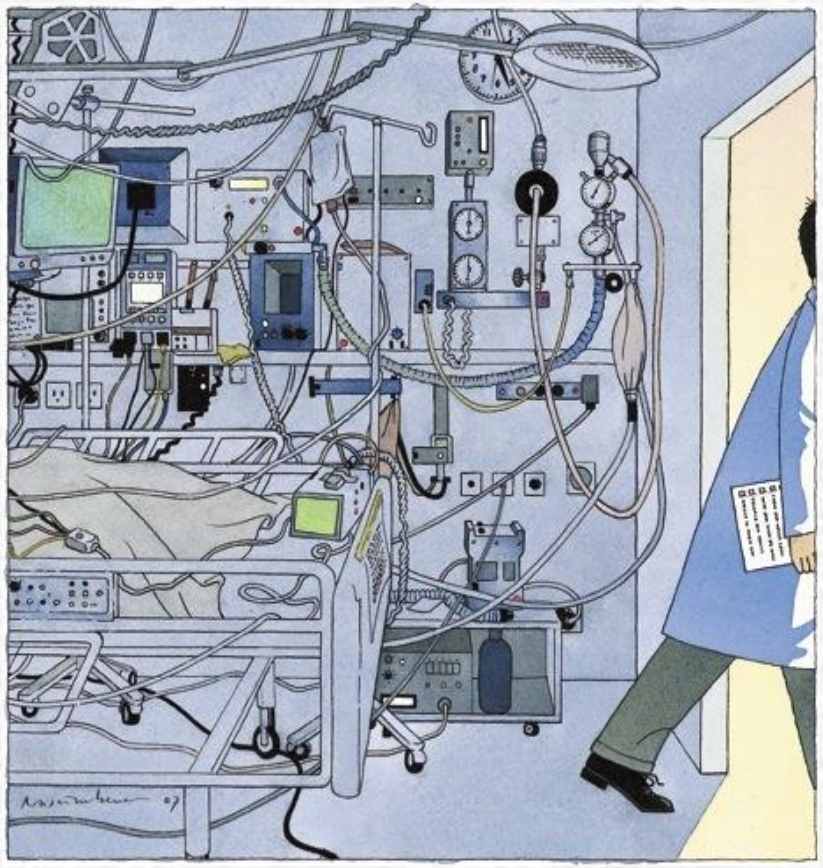
Health care associated Pneumonia

- **A**- Hospital Acquired Pneumonia(**HAP**)
- **B-** Ventilator Associated Pneumonia (**VAP**) in patients with assisted respiration for a period of 48 hours.

Introduction

- Nosocomial pneumonia is the 2nd most common hospital-acquired infections after urinary tract infection. Accounting for 31 % of all nosocomial infections
- Nosocomial pneumonia is the leading cause of death from hospital-acquired infections.
- The incidence of nosocomial pneumonia is highest in **ICU** (intensive care unit) patients.

ICU



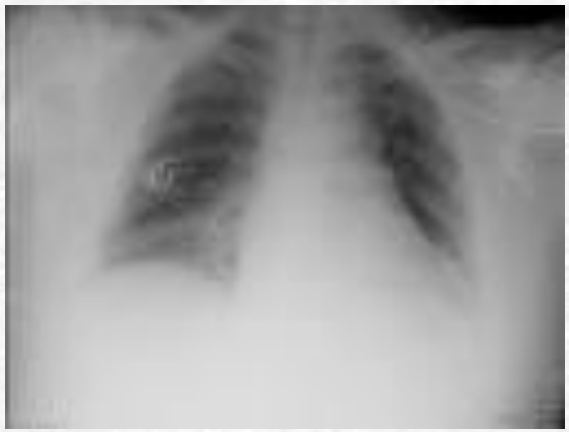
Introduction

- The incidence of nosocomial pneumonia in ventilated patients was **10-fold higher** than non-ventilated patients

- The reported crude **mortality** for HAP is 30% to greater than 70%.

--- Medical Clinics of North America
Therapy of Nosocomial pneumonia 2001 vol.85 1583-94

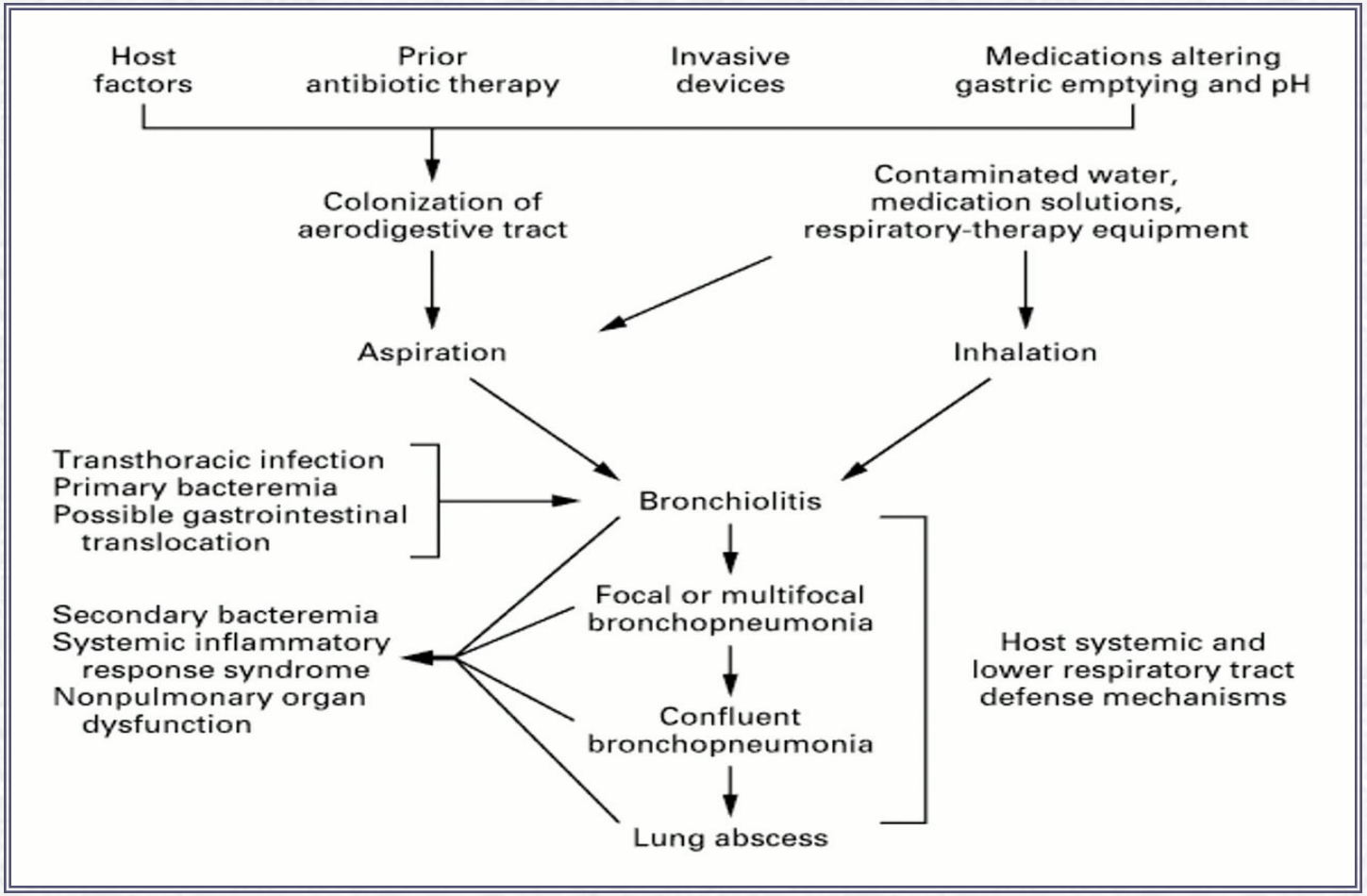
Pathogenesis



Pathogenesis

- For pneumonia to occur, at least one of the following **three conditions** must occur:
  1. Significant impairment of host defenses
  2. Introduction of a sufficient-size inoculum to overwhelm the host's lower respiratory tract defenses
  3. The introduction of highly virulent organisms into the lower respiratory tract
- Most common is microaspiration of oropharyngeal secretions colonized with pathogenic bacteria.

Pathogenesis



--- The Prevention of Ventilator-Associated Pneumonia Vol.340 Feb 25, 1999 NEJM

Classification

- Early-onset nosocomial pneumonia:

  Occurs during the **first 4 days** of admission.

  Usually is due to *S. pneumoniae*, MSSA (Methicillin sensitive *S.aureus*), *H. Influenza*, or anaerobes.

- Late-onset nosocomial pneumonia:

  occurs **more than 4 days** of admission.

  More commonly by Gram negative organisms, especially: *P. aeruginosa, Acinetobacter, Enterobacteriaceae* (*Klebsiella*, *Enterobacter, Serratia*) or MRSA.

Causative Agent

- **Enteric Gram negative bacilli** are isolated most frequently particularly in patients with late-onset disease and in patients with serious underlying disease often already on broad-spectrum antibiotics.
- Prior use of broad-spectrum antibiotics and an immunocompromised state make resistant Gram-negative organisms more likely.

Causative Agents

- ***P. aeruginosa*** and ***Acinetobacter*** are common causes of late-onset pneumonia, particularly in the ventilated patients.

Causative Agents

- ***S. aureus*** is isolated in about 20~40% of cases and is particularly common in :

1. Ventilated patients after head trauma, neurosurgery, and wound infection
2. In patients who had received prior antibiotics or Prolonged care in ICU

- **MRSA(methicillin resistant *S.aureus*)** is seen more commonly in patients who:

Received corticosteroids

Undergone mechanical ventilation >5 days

Presented with chronic lung disease

Had prior antibiotics therapy

Causative Agents

- **Anaerobes** are common in patients predisposed to aspiration .

- **Ventilator associated pneumonia (VAP)** with anaerobes occurred more often with oropharyngeal intubation than nasopharyngeal intubation.

Ventilator-associated Pneumonia (VAP)

Ventilator-associated Pneumonia (VAP)

- Definition:

  Nosocomial pneumonia that has developed in patient who are receiving mechanical ventilation.

- Classification:

  Early-onset: within 48-72 hours after tracheal intubation, which complicates the intubation process

  Late-onset: after 72 hours

Pathogenesis

- Requires 2 important processes:
  1. Bacterial colonization of the aerodigestive tract
  2. Aspiration of contaminated secretion into the Lower airway
- Prevents mechanical clearance by cough and the mucociliary escalator.

Prevention for VAP

- The oral regimen (*topical Gentamicin, Colistin, Vancomycin cream given every 6h for 3 weeks*) treating oropharyngeal colonization could prevent VAP.

--- **Prevention of VAP by oral decontamination**

American journal of respiratory critical care medicine2001 164:382-8

Preventions for VAP

Non-pharmacologic strategies

- Effective hand washing and use of protective gowns and gloves
- Semirecumbent positioning
- Avoidance of large gastric volume
- Oral (non-nasal) intubation
- Continuous subglottic suctioning
- Humidification with heat and moisture exchanger
- Posture change

--- The Prevention of Ventilator-Associated Pneumonia Vol.340 Feb 25, 1999 NEJM

Preventions for VAP

Pharmacologic strategies

- Stress-ulcer prophylaxis
- Combination antibiotic therapy
- Prophylactic antibiotic therapy
- Chlorhexidine oral rinse
- Prophylactic treatment of neutropenic patients
- Vaccines

--- The Prevention of Ventilator-Associated Pneumonia Vol.340 Feb 25, 1999 NEJM

Treatment

- Most initial therapy is empiric because no pathogen is identified or results are not available when antimicrobial decisions are made in most patients.

Treatment

- Initially be treated with a broad-spectrum antibiotic regimen aimed at covering all likely bacterial pathogen
- This regimen should subsequently be narrowed, according to the result of culture

Treatment

- The pathogen may be influenced by coexisting illnesses, prior treatment, and length of hospitalization.

- The frequency of ICU-acquired *P. aeruginosa* carriage or colonization/infection was 23.4% at 7 days and 57.8% at 14 days.

---- Current opinion in infectious disease 2002, 15:387-94, copyright LWW

Treatment

- The mortality can be reduced with early appropriate empiric therapy.

(Form 30 % with appropriate therapy to more than 90 % with inappropriate therapy) .

Treatment

- Guidelines by American Thoracic Society has divided patients into three groups, each with a set of probable pathogens.

Group 1: mild to moderate HAP with no risk factor

Group 2: mild to moderate HAP with risk factor

Group 3a: severe HAP, early-onset with no risk factor

Group 3b: severe HAP, late-onset or with risk factor

Treatment

- For **mild-to-moderate** HAP, monotherapy has been shown to be effective.
- For **severe** HAP in which infection with resistant organisms is likely, combination therapy probably should be instituted until culture result are available.

Treatment

- Patients with *S. aureus* infection, agents against this organism are necessary, including **Vancomycin** if MRSA is suspected.

- **Linezolid** is comparable with Vancomycin.

  The advantage of Linezolid is less possible nephrotoxicity.

---- current opinion in infectious disease 2002, 15:387-94, copyright LWW

Treatment

- Combination of antipseudomonal drugs is controversial:

1. **Traditional:**

   antipseudomonal Beta-lactam with an Aminoglycoside.
   Synergy but potential nephrotoxicity.

2. **Another approach**:

   antipseudomonal Beta-lactam with a Fluoroquinolone.
   No benefit of synergy but reduce concern of nephrotoxicity, and quinolone gets into the lungs at higher concentrations.

Response to Therapy

- If no clinical response is noted or deterioration occurs, we need to consider:

1. **Infectious causes**:

   Resistant pathogen
   Superinfection
   Unusual pathogens
   Lung abscess
   Extrapulmonary infection

2. **Noninfectious events**:

   Heart: congestive heart failure (CHF)
   Lung: fibroproliferative acute respiratory distress syndrome (ARDS), pulmonary emboli, Atelectesis.