In the well-appearing patient, antibiotics are not the answer.

Community-Acquired Pneumonia (CAP) — Adults

Outpatient treatment of adults not HIV-infected or immunocompromised

Clinical Considerations

CAP should be suspected in patients with newly-acquired lower respiratory tract symptoms (cough, sputum production, or dyspnea) especially if accompanied by fever, altered breath sounds, and rales. A CXR is required to make the diagnosis.

The initial site of care is the single most important decision made by clinicians during an episode of CAP. This decision involves 3 steps: 1) assessment of any preexisting conditions that compromise the safety of home care; 2) calculation of the CURB-65 (see page 35); and 3) clinical judgement.

A significant number of treatment failures have been documented for *Streptococcus pneunomiae* resistant to macrolides.

Fluoroquinolones should be used for outpatients only when the patient has failed first-line therapy, has known allergy to first-line agents, or where highly resistant pneumococcus (penicillin MIC > 4 mcg/ml) is prevalent.

Management of Outpatients

Previously healthy, no recent (within 3 months) antibiotic therapy: 1) azithromycin, clarithromycin or doxycycline.

Antibiotics within past 3 months or comorbidities (COPD, diabetes, renal or congestive heart failure, malignancy): 1) azithromycin or clarithromycin, ***plus*** high dose amoxicillin, amoxicillin-clavulanate, cefdinir, cefpodoxime, cefprozil, or cefuroxime; 2) a respiratory fluoroquinolone alone.

Inpatients: 1) advanced macrolide plus a beta-lactam (cefotaxime, ceftriaxone, ampicillin, or ampicillin-sulbactam); 2) respiratory fluoroquinolone.

These guidelines were produced in collaboration with the Infectious Diseases Society of Oregon.

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