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Lung alert

A simplified tool for predicting mortality in ventilator-associated pneumonia

Ventilator-associated pneumonia (VAP) is associated with increased morbidity and mortality among critically ill patients. The Acute Physiology and Chronic Health Evaluation II (APACHE II) score is a validated tool for predicting mortality in critical care. However, the APACHE II score requires recording and input of multiple variables, which is time consuming and may lead to erroneous predictions if data are missing or inaccurately documented. The current study aimed to develop an uncomplicated tool that could be used by clinicians to predict mortality in VAP.

The authors identified patients diagnosed with VAP from four academic centres and performed univariate analysis of variables related to demographics, co-morbidities, physiological and laboratory parameters, and radiographs against mortality. Five variables associated with mortality, which could be obtained when VAP is diagnosed, were selected: Immunodeficiency, Blood pressure (<90 mm Hg systolic or 60 mm Hg diastolic), Multilobular infiltrates on the chest radiograph, Platelets $<100\times10^9$/l and hospitalisation >10 days before the onset of VAP. The IBMP-10 score (0–5) was derived by assigning one point for each variable, and had a higher sensitivity and specificity than APACHE II for predicting death.

The IBMP-10 score is the first tool to predict mortality specifically in patients with VAP and can undoubtedly be incorporated into daily clinical practice by physicians. However, as the same cohort of patients was used to both derive and evaluate IBMP-10, adoption of this score by clinicians cannot be recommended until it has been validated in a larger population of patients with VAP.

► Mirsaeidi M, Peyrani P, Ramirez JA, the Improving Medicine through Pathway Assessment of Critical Therapy of Hospital-Acquired Pneumonia (IMPACT-HAP) Investigators. Predicting mortality in patients with ventilator-associated pneumonia: the APACHE II score versus the new IBMP-10 score. *Clin Infect Dis* 2009;**49**:72–7.

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Thorax 2010;**65**:69. doi:10.1136/thx.2009.127423