IS THE CURB-65 SCORE A RELIABLE TOOL FOR GUIDING INITIAL ANTIBIOTIC THERAPY IN ACUTELY UNWELL PATIENTS WITH COMMUNITY ACQUIRED PNEUMONIA?

A Hadjimichalis, C Coulter, D Jeyaratnam. King’s College Hospital, London, UK

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Introduction Prompt appropriate antibiotics for community acquired pneumonia (CAP) reduces mortality, length of stay and adverse events. Antibiotic choice is directed by the CURB-65 score and clinical judgement. Admission is recommended for most CURB-65 ≥2. Recent national data showed an unexplained non-compliance of 40% (>2000 patients) with CAP antibiotic guidelines using CURB-65 scores alone. Antimicrobial misuse and resistance are a global concern. We investigated compliance with our Trust CAP guidelines and used an early warning score (EWS) to quantify clinical judgement.

Methods Data were collected retrospectively for adults attending the emergency department with CAP over 4 months. The POTTS score of 2 triggers escalation of care. Prescriptions were compliant when the initial antibiotic concurred with the POTTS score and clinical judgement. POTTS were calculated at presentation. POTTS scores of 2 triggers escalation of care. Prescriptions were compliant when the initial antibiotic concurred with the Trust guideline. Patients receiving broader spectrum agents than recommended were ‘over-treated’. Admission was noted.

Results (Table 1) Of 77 patients with CAP, 11 (14%) received ‘compliant’ antibiotics (Table 1). 38 (49%) patients were over-treated, 25 (66%) of whom had POTTS ≥2, though 15 (60%) of these patients had low severity CURB-65 of 0–1. Of 49 patients with POTTS ≥2, 27 (55%) had a CURB-65 of 0–1, 26% a CURB-65 of 2. 44% and 68% of those with a CURB-65 of 0 or 1 were admitted, with higher average POTTS than those discharged.

Conclusion The majority of patients incorrectly prescribed broad spectrum antibiotics had a CURB-65 score that failed to categorise them as sick enough to warrant them despite an EWS ≥2. Hospital admission demonstrated similar findings. Over half of those with an elevated EWS had a low severity CURB-65. We did not collect outcome data but the ‘over-treatment’ and admission appear appropriate. Prompt, effective and empiric antimicrobials for septic patients give better clinical outcomes. Seemingly non-compliant antimicrobial prescriptions may have punitive implications for Trusts. We suggest that CURB-65 under-recognises sepsis syndrome and thus the EWS should be included and further validated in CAP guidelines and audits.

REFERENCE
1 BTS CAP guidelines

HIV-RELATED ACUTE RESPIRATORY ADMISSIONS – GOOD OUTCOMES AND AN OPPORTUNITY FOR TESTING

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P Howlett, D Lux, R Kulasegaram, RAM Breen. Guys and St Thomas; NHS Foundation Trust, London, UK

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DO WE NEED A SPECIFIC GUIDELINE FOR THE MANAGEMENT OF ASPIRATION PNEUMONIA (AP)?

S Cormack. James Cook University Hospital, Middlesbrough, UK

Introduction and objectives Aspiration-related pneumonia accounts for 10–15% of cases hospitalised with community acquired pneumonia. Guideline-directed pathways for the diagnosis and management of AP are lacking in detail (BTS/ATS/IDSA). The local practice of assessing patients admitted with primary diagnosis of AP and outcome was evaluated in a large tertiary hospital in the UK.

Methods A retrospective cohort study that reviewed the case notes of 34 consecutive patients admitted to hospital with a high likelihood for a diagnosis of community acquired aspiration pneumonia (CAAP). Aspiration risk assessment on admission, appropriate antimicrobial therapy, dietetic and Speech and Language Therapy (SALT) team input, airway assessment, length of hospital stay and mortality were included in the data analysis.

Results A crude risk assessment for aspiration was performed in all patients on admission. An aspiration event was witnessed in 35% of cases. Pre-existing neurological pathology was the predominant risk factor (70%). Appropriate antimicrobial therapy was commenced within 4 h of admission in 14 (58%) cases.