

Pneumonia in adults: diagnosis and management

Clinical guideline

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[nice.org.uk/guidance/cg191](https://www.nice.org.uk/guidance/cg191)

Your responsibility

The recommendations in this guideline represent the view of NICE, arrived at after careful consideration of the evidence available. When exercising their judgement, professionals and practitioners are expected to take this guideline fully into account, alongside the individual needs, preferences and values of their patients or the people using their service. It is not mandatory to apply the recommendations, and the guideline does not override the responsibility to make decisions appropriate to the circumstances of the individual, in consultation with them and their families and carers or guardian.

Local commissioners and providers of healthcare have a responsibility to enable the guideline to be applied when individual professionals and people using services wish to use it. They should do so in the context of local and national priorities for funding and developing services, and in light of their duties to have due regard to the need to eliminate unlawful discrimination, to advance equality of opportunity and to reduce health inequalities. Nothing in this guideline should be interpreted in a way that would be inconsistent with complying with those duties.

Commissioners and providers have a responsibility to promote an environmentally sustainable health and care system and should assess and reduce the environmental impact of implementing NICE recommendations wherever possible.

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This guideline is the basis of QS110.

Introduction

Pneumonia is an infection of the lung tissue. When a person has pneumonia the air sacs in their lungs become filled with microorganisms, fluid and inflammatory cells and their lungs are not able to work properly. Diagnosis of pneumonia is based on symptoms and signs of an acute lower respiratory tract infection, and can be confirmed by a chest X-ray showing new shadowing that is not due to any other cause (such as pulmonary oedema or infarction). In this guideline pneumonia is classified as community-acquired or hospital-acquired, based on different microbial causes and patient factors, which need different management strategies.

Every year between 0.5% and 1% of adults in the UK will have community-acquired pneumonia. It is diagnosed in 5–12% of adults who present to GPs with symptoms of lower respiratory tract infection, and 22–42% of these are admitted to hospital, where the mortality rate is between 5% and 14%. Between 1.2% and 10% of adults admitted to hospital with community-acquired pneumonia are managed in an intensive care unit, and for these patients the risk of dying is more than 30%. More than half of pneumonia-related deaths occur in people older than 84 years.

At any time 1.5% of hospital inpatients in England have a hospital-acquired respiratory infection, more than half of which are hospital-acquired pneumonia and are not associated with intubation. Hospital-acquired pneumonia is estimated to increase hospital stay by about 8 days and has a reported mortality rate that ranges from 30–70%. Variations in clinical management and outcome occur across the UK.

The guideline is needed because pneumonia is common and has a high mortality rate. The British Thoracic Society (2009) has published guidance on the [management of community-acquired pneumonia in adults](#), but there is a lack of evidence-based guidance on the management of hospital-acquired pneumonia. For both types of pneumonia there is variation in care and areas of uncertainty for best practice, and these are the main focus of this guideline.

This guideline provides recommendations for the management of suspected and confirmed community- and hospital-acquired pneumonia in adults. However, it does not provide recommendations on areas of care where best practice is already established, such as diagnosis using chest X-ray. This guideline does not cover bronchiectasis complicated by pneumonia, people younger than 18 years, or patients who acquire pneumonia while intubated or in an intensive care

unit, who are immunocompromised, or in whom management of pneumonia is an expected part of end-of-life care.

Medicines recommendations

The guideline will assume that prescribers will use a medicine's summary of product characteristics to inform decisions made with individual patients.

Key priorities for implementation

The following recommendations have been identified as priorities for implementation. The full list of recommendations is in [section 1](#).

Presentation with lower respiratory tract infection

- For people presenting with symptoms of lower respiratory tract infection in primary care, consider a point of care C-reactive protein test if after clinical assessment a diagnosis of pneumonia has not been made and it is not clear whether antibiotics should be prescribed. Use the results of the C-reactive protein test to guide antibiotic prescribing in people without a clinical diagnosis of pneumonia as follows:
 - Do not routinely offer antibiotic therapy if the C-reactive protein concentration is less than 20 mg/litre.
 - Consider a delayed antibiotic prescription (a prescription for use at a later date if symptoms worsen) if the C-reactive protein concentration is between 20 mg/litre and 100 mg/litre.
 - Offer antibiotic therapy if the C-reactive protein concentration is greater than 100 mg/litre.

Community-acquired pneumonia

Microbiological tests

- For patients with moderate- or high-severity community-acquired pneumonia:
 - take blood and sputum cultures **and**
 - consider pneumococcal and legionella urinary antigen tests.

Timely diagnosis and treatment

- Put in place processes to allow diagnosis (including X-rays) and treatment of community-acquired pneumonia within 4 hours of presentation to hospital.

Antibiotic therapy

Low-severity community-acquired pneumonia

- Offer a 5-day course of a single antibiotic to patients with low-severity community-acquired pneumonia.
- Do not routinely offer patients with low-severity community-acquired pneumonia:
 - a fluoroquinolone
 - dual antibiotic therapy.

Patient information

- Explain to patients with community-acquired pneumonia that after starting treatment their symptoms should steadily improve, although the rate of improvement will vary with the severity of the pneumonia, and most people can expect that by:
 - 1 week: fever should have resolved
 - 4 weeks: chest pain and sputum production should have substantially reduced
 - 6 weeks: cough and breathlessness should have substantially reduced
 - 3 months: most symptoms should have resolved but fatigue may still be present
 - 6 months: most people will feel back to normal.

1 Recommendations

The following guidance is based on the best available evidence. The [full guideline](#) gives details of the methods and the evidence used to develop the guidance.

People have the right to be involved in discussions and make informed decisions about their care, as described in [your care](#).

[Making decisions using NICE guidelines](#) explains how we use words to show the strength (or certainty) of our recommendations, and has information about prescribing medicines (including off-label use), professional guidelines, standards and laws (including on consent and mental capacity), and safeguarding.

Terms used in this guideline

Clinical diagnosis of community-acquired pneumonia

Diagnosis based on symptoms and signs of lower respiratory tract infection in a patient who, in the opinion of the GP and in the absence of a chest X-ray, is likely to have community-acquired pneumonia. This might be because of the presence of focal chest signs, illness severity or other features.

Community-acquired pneumonia

Pneumonia that is acquired outside hospital. Pneumonia that develops in a nursing home resident is included in this definition. When managed in hospital the diagnosis is usually confirmed by chest X-ray.

Dual antibiotic therapy

Treatment with 2 different antibiotics at the same time.

Hospital-acquired pneumonia

Pneumonia that develops 48 hours or more after hospital admission and that was not incubating at hospital admission. When managed in hospital the diagnosis is usually confirmed by chest X-ray. For the purpose of this guideline, pneumonia that develops in hospital after intubation (ventilator-associated pneumonia) is excluded from this definition.

Lower respiratory tract infection

An acute illness (present for 21 days or less), usually with cough as the main symptom, and with at least 1 other lower respiratory tract symptom (such as fever, sputum production, breathlessness, wheeze or chest discomfort or pain) and no alternative explanation (such as sinusitis or asthma). Pneumonia, acute bronchitis and exacerbation of chronic obstructive airways disease are included in this definition.

Mortality risk

The percentage likelihood of death occurring in a patient in the next 30 days.

Severity assessment

A judgement by the managing clinician as to the likelihood of adverse outcomes in a patient. This is based on a combination of clinical understanding and knowledge in addition to a mortality risk score. The difference between categories of severity and mortality risk can be important. Typically the mortality risk score will match the severity assessment. However, there may be situations where the mortality score does not accurately predict mortality risk and clinical judgement is needed. An example might be a patient with a low mortality risk score who has an unusually low oxygen level, who would be considered to have a severe illness.

1.1 *Presentation with lower respiratory tract infection*

1.1.1 For people presenting with symptoms of lower respiratory tract infection in primary care, consider a point of care C-reactive protein test if after clinical assessment a diagnosis of pneumonia has not been made and it is not clear whether antibiotics should be prescribed. Use the results of the C-reactive protein test to guide antibiotic prescribing in people without a clinical diagnosis of pneumonia as follows:

- Do not routinely offer antibiotic therapy if the C-reactive protein concentration is less than 20 mg/litre.
- Consider a delayed antibiotic prescription (a prescription for use at a later date if symptoms worsen) if the C-reactive protein concentration is between 20 mg/litre and 100 mg/litre.
- Offer antibiotic therapy if the C-reactive protein concentration is greater than 100 mg/litre.

1.2 Community-acquired pneumonia

Severity assessment in primary care

- 1.2.1 When a [clinical diagnosis of community-acquired pneumonia](#) is made in primary care, determine whether patients are at low, intermediate or high risk of death using the CRB65 score (see box 1).

Box 1 CRB65 score for mortality risk assessment in primary care^[a]

CRB65 score is calculated by giving 1 point for each of the following prognostic features:

- confusion (abbreviated Mental Test score 8 or less, or new disorientation in person, place or time)^[b]
- raised respiratory rate (30 breaths per minute or more)
- low blood pressure (diastolic 60 mmHg or less, or systolic less than 90 mmHg)
- age 65 years or more.

Patients are stratified for risk of death as follows:

- 0: low risk (less than 1% mortality risk)
- 1 or 2: intermediate risk (1-10% mortality risk)
- 3 or 4: high risk (more than 10% mortality risk).

^[a] Lim WS, van der Eerden MM, Laing R, et al. (2003) Defining community-acquired pneumonia severity on presentation to hospital: an international derivation and validation study. *Thorax* 58: 377–82

^[b] For guidance on delirium, see the NICE guideline on [delirium](#).

- 1.2.2 Use clinical judgement in conjunction with the CRB65 score to inform decisions about whether patients need hospital assessment as follows:

- consider home-based care for patients with a CRB65 score of 0
- consider hospital assessment for all other patients, particularly those with a CRB65 score of 2 or more.

Severity assessment in hospital

- 1.2.3 When a diagnosis of community-acquired pneumonia is made at presentation to hospital, determine whether patients are at low, intermediate or high risk of death using the CURB65 score (see box 2).

Box 2 CURB65 score for mortality risk assessment in hospital^[a]

CURB65 score is calculated by giving 1 point for each of the following prognostic features:

- confusion (abbreviated Mental Test score 8 or less, or new disorientation in person, place or time)^[b]
- raised blood urea nitrogen (over 7 mmol/litre)
- raised respiratory rate (30 breaths per minute or more)
- low blood pressure (diastolic 60 mmHg or less, or systolic less than 90 mmHg)
- age 65 years or more.

Patients are stratified for risk of death as follows:

- 0 or 1: low risk (less than 3% mortality risk)
- 2: intermediate risk (3-15% mortality risk)
- 3 to 5: high risk (more than 15% mortality risk).

^[a] Lim WS, van der Eerden MM, Laing R, et al. (2003) Defining community-acquired pneumonia severity on presentation to hospital: an international derivation and validation study. *Thorax* 58: 377–82

^[b] For guidance on delirium, see the NICE guideline on [delirium](#).

- 1.2.4 Use clinical judgement in conjunction with the CURB65 score to guide the management of community-acquired pneumonia, as follows:

- consider home-based care for patients with a CURB65 score of 0 or 1
- consider hospital-based care for patients with a CURB65 score of 2 or more

- consider intensive care assessment for patients with a CURB65 score of 3 or more.

1.2.5 Stratify patients presenting with community-acquired pneumonia into those with low-, moderate- or high-severity disease. The grade of severity will usually correspond to the risk of death.

Microbiological tests

1.2.6 Do not routinely offer microbiological tests to patients with low-severity community-acquired pneumonia.

1.2.7 For patients with moderate- or high-severity community-acquired pneumonia:

- take blood and sputum cultures and
- consider pneumococcal and legionella urinary antigen tests.

Timely diagnosis and treatment

1.2.8 Put in place processes to allow diagnosis (including X-rays) and treatment of community-acquired pneumonia within 4 hours of presentation to hospital.

1.2.9 Offer antibiotic therapy as soon as possible after diagnosis, and certainly within 4 hours to all patients with community-acquired pneumonia who are admitted to hospital.

Antibiotic therapy

Low-severity community-acquired pneumonia

1.2.10 Offer a 5-day course of a single antibiotic to patients with low-severity community-acquired pneumonia.

1.2.11 Consider amoxicillin in preference to a macrolide or a tetracycline for patients with low-severity community-acquired pneumonia. Consider a macrolide or a tetracycline for patients who are allergic to penicillin.

1.2.12 Consider extending the course of the antibiotic for longer than 5 days as a possible management strategy for patients with low-severity community-acquired pneumonia whose symptoms do not improve as expected

after 3 days.

- 1.2.13 Explain to patients with low-severity community-acquired pneumonia treated in the community, and when appropriate their families or carers, that they should seek further medical advice if their symptoms do not begin to improve within 3 days of starting the antibiotic, or earlier if their symptoms are worsening.
- 1.2.14 Do not routinely offer patients with low-severity community-acquired pneumonia:
- a fluoroquinolone
 - dual antibiotic therapy.

Moderate- and high-severity community-acquired pneumonia

- 1.2.15 Consider a 7- to 10-day course of antibiotic therapy for patients with moderate- or high-severity community-acquired pneumonia.
- 1.2.16 Consider dual antibiotic therapy with amoxicillin and a macrolide for patients with moderate-severity community-acquired pneumonia.
- 1.2.17 Consider dual antibiotic therapy with a beta-lactamase stable beta-lactam^[1] and a macrolide for patients with high-severity community-acquired pneumonia.

Glucocorticoid treatment

- 1.2.18 Do not routinely offer a glucocorticoid to patients with community-acquired pneumonia unless they have other conditions for which glucocorticoid treatment is indicated.

Monitoring in hospital

- 1.2.19 Consider measuring a baseline C-reactive protein concentration in patients with community-acquired pneumonia on admission to hospital, and repeat the test if clinical progress is uncertain after 48 to 72 hours.

Safe discharge from hospital

1.2.20 Do not routinely discharge patients with community-acquired pneumonia if in the past 24 hours they have had 2 or more of the following findings:

- temperature higher than 37.5°C
- respiratory rate 24 breaths per minute or more
- heart rate over 100 beats per minute
- systolic blood pressure 90 mmHg or less
- oxygen saturation under 90% on room air
- abnormal mental status
- inability to eat without assistance.

1.2.21 Consider delaying discharge for patients with community-acquired pneumonia if their temperature is higher than 37.5°C.

Patient information

1.2.22 Explain to patients with community-acquired pneumonia that after starting treatment their symptoms should steadily improve, although the rate of improvement will vary with the severity of the pneumonia, and most people can expect that by:

- 1 week: fever should have resolved
- 4 weeks: chest pain and sputum production should have substantially reduced
- 6 weeks: cough and breathlessness should have substantially reduced
- 3 months: most symptoms should have resolved but fatigue may still be present
- 6 months: most people will feel back to normal.

1.2.23 Advise patients with community-acquired pneumonia to consult their healthcare professional if they feel that their condition is deteriorating or not improving as expected.

1.3 *Hospital-acquired pneumonia*

Antibiotic therapy

- 1.3.1 Offer antibiotic therapy as soon as possible after diagnosis, and certainly within 4 hours, to patients with [hospital-acquired pneumonia](#).
- 1.3.2 Choose antibiotic therapy in accordance with local hospital policy (which should take into account knowledge of local microbial pathogens) and clinical circumstances for patients with hospital-acquired pneumonia.
- 1.3.3 Consider a 5- to 10-day course of antibiotic therapy for patients with hospital-acquired pneumonia.

More information

You can also see this guideline in the NICE Pathway on [pneumonia](#).

To find out what NICE has said on topics related to this guideline, see our web page on [infections](#).

See also the guideline committee's discussion and the evidence reviews (in the [full guideline](#)), and information about [how the guideline was developed](#), including details of the committee.

^[1] Available beta-lactamase stable beta-lactams include: co-amoxiclav, cefotaxime, ceftazidime, ceftriaxone, cefuroxime and piperacillin with tazobactam.

2 Research recommendations

The Guideline Development Group has made the following recommendations for research, based on its review of evidence, to improve NICE guidance and patient care in the future.

2.1 *Urine antigen testing*

In moderate- to high-severity community-acquired pneumonia does using legionella and pneumococcal urinary antigen testing in addition to other routine tests improve outcomes?

Why this is important

Current practice and evidence suggest that giving a combination of antibiotics to patients with moderate- to high-severity community-acquired pneumonia reduces mortality. However, no randomised controlled trial has looked at using urinary antigen testing to target treatment. If effective, such targeted treatment could improve antibiotic stewardship, increase compliance and potentially reduce costs.

2.2 *C-reactive protein guided antibiotic duration*

In patients hospitalised with moderate- to high-severity community-acquired pneumonia, does using C-reactive protein monitoring in addition to clinical observation to guide antibiotic duration safely reduce the total duration of antibiotic therapy compared with a fixed empirical antibiotic course?

Why this is important

The recommended duration of antibiotic therapy for adults hospitalised with moderate- to high-severity community-acquired pneumonia is based on evidence of very low quality; no relevant clinical trials were identified by NICE. The burden of community-acquired pneumonia is large, and its treatment accounts for a high proportion of antibiotic use in hospitals. Overuse of antibiotics is associated with antimicrobial resistance, which is a national and global priority.

2.3 *Continuous positive pressure ventilation*

What is the clinical effectiveness of continuous positive pressure ventilation compared with usual care in patients with community-acquired pneumonia and type I respiratory failure without a history of chronic obstructive pulmonary disease?

Why this is important

Type I respiratory failure is a common feature of pneumonia. Mild type I respiratory failure is easily corrected with low levels of supplemental oxygen, whereas severe life-threatening hypoxemia needs immediate intubation and invasive ventilation. Research into whether continuous positive pressure ventilation improves gas exchange and subsequent outcomes, such as mortality, could help improve care for patients with respiratory failure between these extremes.

2.4 *Hospital-acquired pneumonia*

Can rapid microbiological diagnosis of hospital-acquired pneumonia reduce the use of extended-spectrum antibiotic therapy, without adversely affecting outcomes?

Why this is important

Data are limited on the microbiology of hospital-acquired pneumonia to guide antibiotic therapy. Hospital-acquired infections can be caused by highly resistant pathogens that need treatment with extended-spectrum antibiotics (for example, extended-spectrum penicillins, third-generation cephalosporins, aminoglycosides, carbapenems, linezolid, vancomycin, or teicoplanin), as recommended by British Society of Antimicrobial Chemotherapy guidance. Because routine microbial tests lack sensitivity and take 24–48 hours to identify a causative pathogen, patient characteristics are used to guide antibiotic choice. However, this may lead to unnecessary use of extended-spectrum antibiotics in patients infected with non-resistant organisms, and inappropriate use of first-line antibiotics (such as beta-lactam stable penicillins, macrolides or doxycycline) in patients infected with resistant organisms.

Rapid diagnostic tests to identify causative bacterial pathogens and determine whether they are resistant to antibiotics may have a role in guiding antibiotic choice for postoperative hospital-acquired pneumonia.

To limit population variability and include high-risk patients spending time in intensive care, studies should include postoperative patients from different surgical specialties.

Update information

Minor changes since publication

November 2018: The term glucocorticosteroids was updated to glucocorticoids throughout after a surveillance review.

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Accreditation

