Pneumonia: diagnosis and management (update)

Consultation on draft guideline - Stakeholder comments table
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Advancing Quality Alliance	Guideline	010	002	We understand that there is limited evidence to allow the development of a recommendation on tools for the assessment of hospital-acquired pneumonia (HAP). Aqua's Advancing Quality (AQ) programme is the longest-running quality improvement programme in the NHS. Data is collected against key clinical measure sets aligned to national guidance and agreed by regional clinical expert groups. This data is used to identify and reduce unwarranted clinical variation to improve patient care and experience. We have been collecting data from acute trusts participating in the AQ programme in the North West for HAP since 2020 (and for CAP since 2008), including the use of NEWS2 as a severity assessment tool. Our dataset is uniquely validated to ensure we assess only true cases of pneumonia. We measure use of NEWS2 within 1 hour of diagnosis (before or after), which is currently achieved in 66% of our identified HAP cohort. We would be happy to contribute to the development of the evidence base for assessing its effectiveness by sharing this real-world data.	Thank you for your comment. We will notify our surveillance team regarding your offer to share real world data.

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Advancing Quality Alliance	Guideline	010	009	Lung ultrasound is mentioned as a possible diagnostic tool for community and hospital-acquired pneumonia and the evidence review explains the advantages and disadvantages. However, it is not clear in this guideline that chest X-ray can be used as an alternative diagnostic tool for HAP in a similar timeframe to that for community-acquired pneumonia, although this is explicitly mentioned in the draft Quality Statement. We would welcome some clarity on this point.	Thank you for your comment. The evidence review on lung ultrasound was limited to patients with CAP only – no studies of patients with HAP were identified, but the committee discussed the evidence and agreed that it could be extrapolated to HAP patients, therefore the recommendation on lung ultrasound applies to both CAP and HAP. The recommendation on chest x-ray was an existing recommendation that was not within the scope of this update (although it was reworded for clarity) so the committee was not able to change this recommendation from CAP only to CAP and HAP.
Advancing Quality Alliance	Guideline	011	007	Aqua's Advancing Quality (AQ) programme is the longest-running quality improvement programme in the NHS. Data is collected against key clinical measure sets aligned to national guidance and agreed by regional clinical expert groups. This data is used to identify and reduce unwarranted clinical variation to improve patient care and experience. We have been collecting data from acute trusts participating in the AQ programme in the North West for HAP since 2020 (and for CAP since 2008). We currently collect data on the use of sputum sampling for HAP. Our latest data shows that this is currently only being achieved by 16.5% of participating trusts. We have gathered some information on improvement	Thank you for your comment. We will notify our surveillance team regarding your offer to share real world data.

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				efforts some trusts are making to achieve this aspect of care delivery and would be happy to share this to support the development of implementation support tools.	
Advancing Quality Alliance	Guideline	General	General	Aqua's Advancing Quality (AQ) programme is the longest-running quality improvement programme in the NHS. Data is collected against key clinical measure sets aligned to national guidance and agreed by regional clinical expert groups. This data is used to identify and reduce unwarranted clinical variation to improve patient care and experience. We welcome this draft guideline and will endeavour to support its implementation with the community- and hospital-acquired pneumonia measures we gather going forward.	Thank you for your comment
Association of Chartered Physiotherapists in Respiratory Care	Guideline	011	011	"children with non-severe community-acquired pneumonia" – there is no stratification prior to this to decide who are 'non-severe'	Thank you for your comment. The committee agreed that for children, non-severe pneumonia is pneumonia that does not meet the definition of severe.
Association of Chartered Physiotherapists in Respiratory Care	Guideline	014	021	"arterial oxygen saturation less than 90%" consider referencing lower target SpO2 i.e for those with COPD	Thank you for your comment. This has been amended to reference a failure to meet target oxygen saturations.

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pists in Respiratory Care					
Association of Chartered Physiotherapists in Respiratory Care	Guideline	014	022	"partial pressure of 21 oxygen of more than 60 mmHg in room air." – assume this should say less than 60 mmHg rather than more? May be useful to add conversion to kPa	Thank you for your comment. This has been removed.
Association of Chartered Physiotherapists in Respiratory Care	Guideline	027	009 - 012	1.9.1 "For people with respiratory failure in whom standard oxygen therapy is insufficient to meet target saturation levels, consider a trial of high flow nasal oxygen, based on multidisciplinary consensus, clinical trajectory and the person's preferences and ability to tolerate it."- recommend considering explaining use of high flow for Type 1 respiratory failure, and need to consider Non-invasive ventilation for Type 2 respiratory failure	Thank you for your comment. Recommendations 1.9.1 and 1.9.3 both indicate that NIV may be suitable for certain patients and this incorporates the differences between type 1 and type 2 respiratory failure.
Association of Chartered Physiotherapists in Respiratory Care	Guideline	030	General	1.11 - Question 1: Could consideration be given for specialist advice from hospital teams including physiotherapy for persistent cough or issues of sputum retention within the section 1.11 Reassessment section – for when the cough and chest pain do not recover in the given trajectory?	Thank you for your comment. This is not in scope for this update.

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Association of Chartered Physiotherapists in Respiratory Care	Evidence review A	General	General	LUS- consideration of costs/staffing for CXR compared to LUS - LUS more time consuming than CXR, but also need to consider radiology staffing etc. Training need for LUS has quite a medical slant, perhaps some acknowledgement that this can also be carried out by physio, ACCP etc, so burden of training may not be solely be on one profession/may already have the right people in place.	Thank you for your comment. The committee noted concerns about the current lack of trained operators with sufficient experience to perform diagnostic lung ultrasound for pneumonia in the rationale and impact section. NICE do not make recommendations about training, so they could not recommend who undertakes training or what the training involves.
Association of Respiratory Nurses	Guideline	011	003 - 005	What about CRP in the community if available? Also, no recommendations for repeat CRP after starting treatment and suspected treatment failure.	Thank you for your comment. The evidence review did not consider biomarker testing in the community – it included patients in hospital only because outpatient testing was out of scope. The recommendations on repeat CRP testing are in a later section on reassessment – recommendations 1.11.7 and 1.11.8 discuss repeat testing, but again this is limited to inpatients only and does not cover community testing.
Association of Respiratory Nurses	Guideline	038	009 - 019	NEWS2 alone is a validated tool and should be included in the escalation plan of patients with pneumonia as well as CURB-65/CRB65 as well as clinical judgement.	Thank you for your comment. We conducted an evidence review on NEWS2 but the committee was unable to develop recommendations on the use of this tool in people with pneumonia because the evidence was poor quality, inconsistent and often not applicable to UK contexts.

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Association of Respiratory Nurses	Guideline	038 – 039	020 - 020	Lung ultrasound - Is the results of an lung ultra sound accessible to primary and community care? The use of a cxray is accessible via PACS and with those requiring a repeat in 6 weeks, there would be nothing to compare is with from both a radiology report and imaging. Also, we agree the lack of trained practitioners and time to train clinicians may affect implementation.	Thank you for your comment. The rationale and impact section for this does note that the committee discussed that it may not be possible to save a diagnostic image for later review.
Asthma + Lung UK	Guideline	006	General	Primary care assessment of adults: There should be explicit advice to consider, assess and treat cardio-respiratory co-morbidities which may be existing diagnoses or presenting for the first time as a pneumonia. These include asthma, COPD, heart failure, ischaemic heart disease and arrhythmias.	Thank you for your comment. The assessment and treatment of comorbid conditions is outside the scope of this guideline. NICE has a number of guidelines on these conditions (e.g. asthma, COPD, heart failure).
Asthma + Lung UK	Guideline	007	General	Primary care assessment of children and young people. There should be explicit advice to consider, assess and treat cardio-respiratory co-morbidities which may be existing diagnoses or presenting for the first time as a pneumonia. These include asthma,	Thank you for your comment. The assessment and treatment of comorbid conditions is not within scope for this update.
Asthma + Lung UK	Guideline	007	General	Secondary care assessment: Primary care assessment of adults: There should be explicit advice to consider, assess and treat cardio-respiratory co-morbidities which may be existing diagnoses or presenting for the first time as a pneumonia. These include asthma, COPD, heart failure, ischaemic heart disease and arrhythmias.	Thank you for your comment. The assessment and treatment of comorbid conditions is outside the scope of this guideline. NICE has a number of guidelines on these conditions (e.g. asthma, COPD, heart failure).

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Asthma + Lung UK	Guideline	009	011	Here there is a general reference to the home environment, but it would be useful to be more explicit about the impact of damp and cold homes on TB, both at this point in the guidance and in general, as these conditions negatively impact TB in multiple ways, increasing the risk of infection and potentially worsening existing cases.	Thank you for your comment. TB is out of scope for this update. The committee acknowledged the impact of damp and cold homes on recovery from respiratory illnesses so they agreed to provide a link to the NICE guideline on indoor air quality on page 5.
Asthma + Lung UK	Guideline	46	022 - 029	Regarding non-invasive ventilation (NIV), the draft guidelines recommend this, but do not specify which groups with pneumonia mab benefit from NIV. This addition would be very helpful.	Thank you for your comment. Recommendation 1.9.1 specifies that high flow nasal oxygen should be considered for people with respiratory failure in whom standard oxygen therapy is insufficient to meet target saturation levels. The recommendations also note that those with certain co-existing conditions may benefit from a trial of NIV or CPAP. The committee discussed that this will be dependent on the individual circumstances and co-existing conditions.
Asthma + Lung UK	Guideline	General	General	In general the draft guidelines are not clear about the need for proper follow up arrangements post diagnosis/discharge from hospital, especially for health inclusion groups. These could perhaps be added around 1.2.11/page 9	Thank you for your comment. We did not review evidence for follow-up arrangements post-diagnosis so are unable to make recommendations about this. We reviewed evidence specifically on follow-up chest x-rays and the recommendations relating to this are in section 1.12, but it is not possible to add anything about other aspects of follow-up care because this is out of scope.

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Asthma + Lung UK	Guideline	General	General	The draft guidelines only mentions smoking at one point, regarding the evidence the committee reviewed. Smoking doubles risk of pneumonia so smoking status and tobacco dependence treatment (as a treatment for pneumonia) needs to be clearly recommended within the guidance, with this actioned and documented as part of the treatment where appropriate.	Thank you for your comment. A link has been added to the NICE guideline on tobacco: preventing uptake, promoting quitting and treating dependence.
BioMérieux	Guideline	General	General	We urge NICE to reconsider the role of rapid syndromic multiplex PCR diagnostics, such as the BioFire Pneumonia panel, as an essential adjunct tool in the diagnosis of pulmonary infections in specific patient groups. While we understand that some of the currently available evidence may not meet traditional thresholds for review; particularly in the form of large randomized controlled trials (RCTs), this should not be a barrier to their wider adoption. RCTs are rarely conducted for infectious disease diagnostics due to several practical and methodological challenges. Diagnostic tools, unlike therapeutics, do not directly modify disease outcomes, but instead influence clinical decision-making, patient pathways, and healthcare resource utilization. As such, their benefits are often indirect, difficult to isolate, and deeply embedded within broader care delivery models, making them poorly suited for standard RCT methodologies.	Thank you for your comment. The evidence review was not limited to RCTs; it also included prospective and retrospective cohort studies. The BioFire pneumonia panel was included in evidence review C (Markussen 2024, RCT). Findings showed that people who had a PCR test would be more likely to get pathogen directed treatment quickly, but there was no change in length of hospital stay for people who had pathogen directed treatment or standard treatment, and the study was unable to detect any difference in mortality or readmission. The agreed that the BioFire FilmArray assay used in the study was labour, time and cost intensive and may not be feasible to use in secondary care settings. The papers you cite have been checked and they do not meet inclusion criteria for the evidence review,

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				In real-world settings, timely and accurate diagnostics like the BioFire Pneumonia panel are instrumental in initiating appropriate treatment, improving patient triage, reducing unnecessary antimicrobial use, and guiding more efficient use of NHS services and budgets. These tools enable clinicians to make faster, more confident decisions at the point of care; an objective that is clearly aligned with the NHS Long Term Plan's focus on improving out-of-hospital care, expanding same-day care, and supporting virtual wards and community healthcare models. Moreover, the value of such diagnostics goes beyond individual patient care, they directly contribute to national antimicrobial stewardship (AMS) goals, help alleviate pressure on laboratory services and hospital beds, and support government priorities around modernizing the NHS through technological innovation. Investing in diagnostics is a strategic enabler for achieving NHS Key Performance Indicators (KPIs) such as reducing time to appropriate treatment, lowering unnecessary admissions, and optimizing use of scarce clinical resources. It also aligns with the UK Government's 5-Year Action Plan on antimicrobial resistance and its broader Life Sciences Vision.	because they only report on pathogen detection and do not report on how the result informs treatment decisions (Falsey et al 2023), they are an evaluation based on surplus ICU samples (Monard et al 2020), or they are based on patients with VAP (Enne et al 2025).

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				Given the real-world evidence and the systemic benefits of syndromic multiplex PCR testing, we believe there is a strong case for supporting the BioFire Pneumonia panel within NHS diagnostic pathways for specific patient groups. The absence of traditional RCTs or large robust studies should not be misinterpreted as a lack of value or clinical impact; rather, it reflects a long-standing evidence gap in diagnostics evaluation, which must be bridged with pragmatic, context-aware decision-making. Swift effective antimicrobial therapy after clinical onset is crucial to outcome, with increased mortality among patients receiving delayed antibiotics or those that prove inactive (Piskin et al. 2012, Iregui et al 2002, as cited within Enne et al 2022 PMID: 39961847 PMCID: PMC11903508 DOI: 10.1007/s00134-024-07772-2). A rapid PCR panel test for pneumonia significantly improves the detection of pathogens and antimicrobial resistance markers in lower respiratory tract specimens, offering a valuable tool for clinical diagnosis and treatment planning. (Moy et al. 2023 PMID: 37709201 DOI: 10.1016/j.accpm.2023.101300).	

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				BioFire Pneumonia panel is a syndromic multiplex PCR platform capable of detecting a broad range of bacterial and viral pathogens, as well as antimicrobial resistance genes. The assay provides semi-quantitative results, reporting bacterial DNA concentrations in bins (e.g., 10^4, 10^5, 10^6, and ≥10^7 copies/mL). Falsey et al. 2023 (DOI: 10.1093/ infdis /jiad221) conducted a prospective observational cohort study to evaluate the utility of the BioFire Pneumonia panel to inform microbiologic diagnosis in hospitalised adults with signs and symptoms of respiratory or cardiopulmonary illness. Sputa were cultured for bacteria and tested with the BioFire Pneumonia panel. Bacterial PCR was compared to culture to assess the sensitivity (Se), specificity (Sp), concordance, positive predictive value (PPV) and negative predictive value (NPV) between methods (a high NPV may give clinicians greater confidence to stop unnecessary antibiotics with clinical factors and judgment). Subsequently, the BioFire Pneumonia panel results were juxtaposed with clinical adjudication by a panel of experts and correlated with host response variables, namely procalcitonin (PCT) measured by the Vidas Brahms Procalcitonin (PCT) assay at enrolment, and White Blood Cell (WBC) count.	

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				The results showed: • Pathogen detection: BioFire detected pathogens in 75.5% (225/298) of cases vs. 42.3% (126/298) with culture ($p < 0.0001$). • Viral detection: Viruses were identified in 51% (152/298) of samples by BioFire, including 2 Legionella and 4 Mycoplasma cases missed by culture. • Impact of antibiotics: Discordance between BioFire and culture increased from 27% to 53% after antibiotic administration ($p = 0.003$), indicating culture sensitivity was affected. • Host biomarkers and bacterial load: Patients with PCT ≥ 0.25 ng/mL and clinical adjudication of bacterial illness showed significantly higher bacterial genomic loads (10^6–10^7 copies/mL), supporting the use of host markers in guiding treatment decisions. The BioFire Pneumonia panel significantly improves pathogen detection compared to culture, even in the presence of prior antibiotic use, and provides valuable information that can support faster, more targeted clinical decisions, including antibiotic stewardship.	

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				Monard et al. 2020 (PMID: 32665030 PMCID: PMC7359443 DOI: 10.1186/s13054-020-03114-y) evaluated the use of the BioFire Pneumonia panel, on respiratory samples to guide empirical antimicrobial therapy in adult patients with community-acquired pneumonia (CAP), hospital-acquired pneumonia (HAP), and ventilator-acquired pneumonia (VAP). This retrospective multicentre study found that use of a syndromic rapid multiplex PCR test has the potential to reduce unnecessary antimicrobial exposure and increase the appropriateness of empirical antibiotic therapy in adult patients with pneumonia. A recently published RCT by Enne et al. 2025 (PMID: 39961847 PMCID: PMC11903508 DOI: 10.1007/s00134-024-07772-2) INHALE, showed In-ICU PCR for pathogens resulted in improved antibiotic stewardship. INHALE is a multicentre, open-label, pragmatic randomised controlled trial assessing the impact of rapid, ICU-based, syndromic PCR, versus standard-of-care on antibiotic stewardship and clinical outcomes in HAP and VAP. There are several European guidelines that recommend multiplex PCR testing in patients with pneumonia. Both the 'ERS/ESICM/ESCMID/ALAT	

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				Guidelines for Severe CAP' (DOI: 10.1183/13993003.00735-2022) and the endorsed 'Italian MDRO Guidelines' (DOI: 10.1016/j.ijantimicag.2022.106611) support multiplex PCR as a critical tool in pneumonia management; offering faster, more precise pathogen detection that leads to better-targeted treatments and improved patient outcomes. ERS/ESICM/ESCMID/ALAT Guidelines for Severe CAP (sCAP): • Recommendation: Suggests using multiplex PCR on lower respiratory samples when non-standard antibiotics are considered for sCAP • Rationale: Multiplex PCR allows earlier detection of resistant or atypical pathogens, enabling faster antibiotic escalation or de-escalation, and reducing adverse outcomes from inappropriate therapy Italian MDRO Guidelines (SIMIT/SITA/GISA/AMCLI/SIM): • Recommendation: Strongly recommend rapid molecular diagnostics, including multiplex PCR, especially for critically ill patients and those at risk of multidrug-resistant infections	

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				• Rationale: Demonstrated to reduce time to appropriate therapy, improve outcomes, and lower mortality; particularly in bloodstream infections and suspected ventilator-associated pneumonia	
BioMérieux	Evidence Review C	038	028 - 030	**This text was identified as confidential and has been removed.**	Thank you for your comment. The INHALE WP3 trial does not meet the inclusion criteria for the evidence review on microbiological tests because the population contains almost 70% VAP patients and VAP is excluded from the scope of this update.

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BioMérieux	Evidence Review C	038	032 - 034	Traditional culture-based microbiological methods are slow (approx. 24-72 hours turnaround time) and often lack sensitivity, resulting in frequent failure to identify the causative pathogens in a timely manner. This can lead to overuse of antimicrobials in patients with treatable infections, while those harbouring resistant organisms may receive ineffective treatment for extended periods. Evidence shows that implementing PCR to directly detect pathogens and resistance genes in clinical samples could enhance both treatment precision and antimicrobial stewardship. A recently published Spanish clinical experts-opinion document (Candel et al. 2024 DOI: 10.1186/s13054-024-05224-3) strongly recommends the use of rapid multiplex molecular syndromic panels for critically ill patients with suspected pneumonia, particularly in the context of multidrug-resistant organisms. These panels offer results in under 2 hours, enabling much faster clinical decision-making than traditional culture methods. Table 2 of the paper emphasizes the BioFire system's fully automated workflow, which integrates sample preparation, nucleic acid extraction, amplification, and detection; resulting in significantly reduced hands-on time. This is critically important in high-pressure ICU settings where microbiology staff availability may be limited, and delays in processing can have life-threatening consequences. Reduced	Thank you for your comment. Candel et al 2024 does not meet inclusion criteria for the evidence review because it is a clinical expert opinion paper. Enne et al 2022 does not meet inclusion criteria for the evidence review because it is an evaluation based on surplus ICU samples. The INHALE WP3 trial does not meet the inclusion criteria for the evidence review because the population contains almost 70% VAP patients and VAP is excluded from the scope of this update.

				manual handling also minimizes the risk of human error and contamination, improving overall test reliability and lab efficiency. With high sensitivity (91.7-100%) and specificity (87.5-99.5%), the BioFire panel identifies pathogens even in patients who have already received antibiotics. Table 3 further underscores the advantages of rapid multiplex molecular syndromic panels, including multiplexing capabilities, rapid turnaround, and potential for point-of-care deployment. Quantitative reporting (e.g., genomic copies/mL) enhances the interpretation of results, helping to distinguish between colonization and true infection. Experts recommend delaying antimicrobials in hemodynamically stable patients until BioFire results are available, supported by the test's high negative predictive value, which aids safe de-escalation. Overall, rapid multiplex molecular syndromic panels like BioFire represent a significant advance in ICU diagnostics; accelerating treatment, reducing antibiotic overuse, and freeing up critical lab resources when they're needed most. Conventional and Bayesian latent class analysis has demonstrated that PCR-based diagnostic tests are considerably more sensitive than routine microbiology, detecting potential pathogens in patient samples reported as culture negative (Enne et al. 2022 PMID: 35027473 DOI: 10.1136/thoraxjnl-2021-216990). The	

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				increased sensitivity of detection realised by PCR offers potential for improved antimicrobial prescribing. NICE Guidance recommends sending a sputum sample for microbiology testing. The BioFire Pneumonia panel test uses approximately 0.2mL Sputum-like or BAL-like sample retrieved using the included swab and only requires 2 minutes of hands-on time. It can be argued that all diagnostic testing requires an element of hands-on time, and the BioFire is no-more labour intensive than standard microbiology testing, yet results are received in approximately 1hr 15 minutes (Enne et al. 2022 PMID: 35027473 DOI: 10.1136/thoraxjnl-2021-216990) and can rapidly alter therapy, which is crucial for patient care, prevention of spread of infection, ICU and hospital resource use, as well as antimicrobial stewardship. **This text was identified as confidential and has been removed.**	
BioMérieux	Evidence Review C	038	034 - 036	The BioFire Pneumonia panel is already successfully incorporated into patient pathways at several NHS Trust sites, for the testing of critically ill patients (the majority of pneumonia patients will be found in the ICU; some CAP patients will be found in the ED). We acknowledge that practice differs between Trusts in	Thank you for your comment. Although some NHS trusts may already have BioFire testing pathways in place, there would be considerable costs and procedures involved in rolling out testing across all UK sites. Likewise, establishing 'hot lab' set

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				regard to laboratory waiting times and opening hours, however the BioFire can be used successfully in a variety of settings inside and outside of the main lab, including near patient in a 'hot lab' set-up. The INHALE WP1 study was a multicentre evaluation conducted across 15 UK intensive care units (ICUs) (Enne et al. 2022 DOI: 10.1136/thoraxjnl-2021-216990). It focused on adult patients with suspected HAP or VAP, and aimed to assess the diagnostic performance and clinical utility of two multiplex PCR platforms, including the BioFire Pneumonia panel, in the rapid identification of pathogens responsible for nosocomial pneumonia. The key results showed: • Rapid Turnaround Time: The BioFire Pneumonia panel demonstrated a significantly faster turnaround time compared to traditional culture methods. Results were available in approximately 1 hour, enabling prompt clinical decision-making • Enhanced Pathogen Detection: The multiplex PCR platform showed superior sensitivity in detecting a broad range of bacterial and viral pathogens, including cases where traditional	ups are likely to involve significant resource implications. The INHALE WP1 study does not meet inclusion criteria for the evidence review because it is an evaluation based on surplus ICU samples. Verroken et al 2024 does not meet the study type inclusion criteria for the evidence review because it was a retrospective exploratory trial. Candel et al 2024 does not meet inclusion criteria for the evidence review because it is a clinical expert opinion paper

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				cultures were negative. This included the identification of co-infections and antimicrobial resistance genes • Impact on Antimicrobial Stewardship: The rapid and accurate results facilitated timely optimization of antibiotic therapy. Clinicians were able to de-escalate or escalate treatment appropriately, reducing unnecessary antibiotic use and supporting antimicrobial stewardship efforts Specifically regarding the near-patient testing implications, the study highlighted the feasibility and benefits of implementing the BioFire Pneumonia panel in near-patient settings: • Ease of Use: The system's automated, sample-to-answer design requires minimal hands-on time and can be operated by non-laboratory personnel with minimal training • Near Patient Testing: Its compact size and rapid turnaround make it suitable for deployment directly within ICU settings, allowing for immediate testing and results interpretation • Improved Clinical Outcomes: By providing timely and accurate diagnostics, the platform	

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				supports faster initiation of appropriate therapy, potentially leading to improved patient outcomes and reduced ICU stays In conclusion, the INHALE WP1 study underscores the clinical value of the BioFire Pneumonia panel in the management of nosocomial pneumonia within ICU settings. Its rapid, accurate, and user-friendly design makes it an effective tool for near-patient testing, facilitating timely and targeted antimicrobial therapy, enhancing antimicrobial stewardship, and potentially improving patient outcomes. Verroken et al. 2024 (DOI: 10.3390/antibiotics13010067) conducted a prospective clinical exploratory trial in a tertiary care hospital's ICU. The study focused on critically ill adult patients diagnosed with severe pneumonia, including both CAP and HAP. All participants required mechanical ventilation and were suspected of having bacterial lower respiratory tract infections. The results showed: • Rapid Pathogen Detection: The BioFire Pneumonia panel provided results within approximately 1 hour, significantly faster than traditional culture methods.	

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				• Enhanced Diagnostic Yield: BioFire Pneumonia panel detected pathogens in a higher percentage of cases compared to standard cultures, including identification of multiple co-infecting organisms and antimicrobial resistance genes. • Antibiotic Stewardship Impact: Utilization of BioFire Pneumonia panel results led to optimized antibiotic therapy in a substantial number of patients, allowing for earlier de-escalation or escalation of treatment based on precise pathogen identification. • Clinical Outcomes: Patients whose antibiotic management was guided by BioFire Pneumonia panel results demonstrated improved clinical parameters, including reduced duration of antibiotic therapy and shorter ICU stays. The study underscores the significant advantages of incorporating the BioFire Pneumonia panel into the diagnostic workflow for critically ill patients with severe pneumonia. The BioFire Pneumonia panel significantly outperformed conventional diagnostics in terms of speed. The turnaround time for BioFire Pneumonia panel was approximately 1-1.5 hours, enabling same-shift clinical decision-making. In contrast, traditional culture results took a median of 72 hours. By delivering	

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				rapid and accurate identification of pathogens and resistance markers, BioFire Pneumonia panel facilitates timely and targeted antibiotic therapy. This not only enhances patient outcomes but also supports antimicrobial stewardship efforts by reducing unnecessary antibiotic exposure. The integration of BioFire Pneumonia panel into clinical practice represents a pivotal step toward precision medicine in the management of severe pneumonia in ICU settings. A recently published Spanish clinical experts-opinion document (Candel et al. 2024 DOI: 10.1186/s13054-024-05224-3) strongly recommends the use of multiplex molecular syndromic panels (RMMSP) for critically ill patients with suspected pneumonia, particularly in the context of multidrug-resistant organisms. These panels offer results in under 2 hours, enabling much faster clinical decision-making than traditional culture methods. Table 2 of the paper emphasizes the BioFire system's fully automated workflow, which integrates sample preparation, nucleic acid extraction, amplification, and detection; resulting in significantly reduced hands-on time. This is critically important in high-pressure ICU settings where microbiology staff availability may be limited, and delays in processing can have life-threatening	

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				consequences. Reduced manual handling also minimizes the risk of human error and contamination, improving overall test reliability and lab efficiency. With high sensitivity (91.7-100%) and specificity (87.5-99.5%), the BioFire panel identifies pathogens even in patients who have already received antibiotics. Table 3 further underscores the advantages of rapid multiplex molecular syndromic panels, including multiplexing capabilities, rapid turnaround, and potential for point-of-care deployment. Quantitative reporting (e.g., genomic copies/mL) enhances the interpretation of results, helping to distinguish between colonization and true infection. Experts recommend delaying antimicrobials in hemodynamically stable patients until BioFire results are available, supported by the test's high negative predictive value, which aids safe de-escalation. Overall, rapid multiplex molecular syndromic panels like BioFire represent a significant advance in ICU diagnostics; accelerating treatment, reducing antibiotic overuse, and freeing up critical lab resources when they're needed most.	
BioMérieux	Evidence Review C	041	004 - 009	Monard et al. 2020 (PMID: 32665030 PMCID: PMC7359443 DOI: 10.1186/s13054-020-03114-y) evaluated the use of the BioFire Pneumonia panel on respiratory samples to guide empirical antimicrobial	Thank you for your comment.

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				therapy in adult patients with CAP, HAP, and VAP. This retrospective multicentre study found that use of a syndromic rapid multiplex PCR test has the potential to reduce unnecessary antimicrobial exposure and increase the appropriateness of empirical antibiotic therapy in adult patients with pneumonia. A recently published RCT by Enne et al. 2025 (PMID: 39961847 PMCID: PMC11903508 DOI: 10.1007/s00134-024-07772-2), INHALE, showed In-ICU PCR for pathogens resulted in improved antibiotic stewardship. INHALE is a multicentre, open-label, pragmatic randomised controlled trial assessing the impact of rapid, ICU-based, syndromic PCR, versus standard-of-care on antibiotic stewardship and clinical outcomes in hospital-acquired and ventilator associated pneumonia.	Monard et al 2020 did not meet the inclusion criteria for the evidence review because it was an evaluation based on surplus ICU samples. Enne et al 2025 did not meet the inclusion criteria for the evidence review because the population contains almost 70% VAP patients and VAP is excluded from the scope of this update.
BioMérieux	Evidence Review C	137	General	We acknowledge that NICE has excluded some clinical studies as they do not meet the selection criteria, however we do not understand the reason of 'No microbiological test' for the exclusion of Poole et al. 2022 'Molecular point-of-care testing for lower respiratory tract pathogens improves safe antibiotic de-escalation in patients with pneumonia in the ICU:	Thank you for your comment. Poole et al 2022 was excluded because the sampling methods used in this study (endotracheal aspirates and bronchoalveolar lavage) was a protocol exclusion criteria. Patients with VAP were also excluded.

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				Results of a randomised controlled trial. The Journal of infection 85(6): 625-633'. The Poole et al. 2022 (DOI: 10.1016/j.jinf.2022.09.003) multicentre RCT was conducted across several UK intensive care units (ICUs), focusing on adult patients with suspected pneumonia. Respiratory specimens, including sputum, endotracheal aspirates (ETA), and bronchoalveolar lavage (BAL) samples, were collected from patients upon clinical suspicion of HAP or VAP. Each specimen was tested using the BioFire Pneumonia panel, and conventional microbiology in parallel (standard microbiological cultures were performed according to routine clinical laboratory protocols, serving as the reference standard for comparison). The study assessed the concordance between BioFire and conventional microbiological culture results, calculating metrics such as positive percent agreement (PPA), negative percent agreement (NPA), and overall percent agreement (OPA). Discrepancies between the two methods were further analysed, considering factors such as the presence of pathogens not included in the BioFire Pneumonia panel or differences in detection thresholds. The results showed:	

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				• Rapid Turnaround Time: The BioFire Pneumonia panel provided results in approximately 1 hour, significantly faster than traditional culture methods, which typically require 48-72 hours • Enhanced Pathogen Detection: The BioFire Pneumonia panel demonstrated higher sensitivity in detecting a broad range of bacterial and viral pathogens, including cases where traditional cultures were negative. This included the identification of co-infections and antimicrobial resistance genes • Antimicrobial Stewardship Impact: The rapid and accurate results facilitated timely optimization of antibiotic therapy, allowing clinicians to de-escalate or escalate treatment appropriately, thereby reducing unnecessary antibiotic use Specifically regarding the near-patient testing implications, the study highlighted the feasibility and benefits of implementing the BioFire Pneumonia panel in near-patient settings: • Ease of Use: The system's automated, sample-to-answer design requires minimal hands-on	

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				time and can be operated by non-laboratory personnel with minimal training • Near Patient Testing Potential: Its compact size and rapid turnaround make it suitable for deployment directly within ICU settings, allowing for immediate testing and results interpretation The study underscores the clinical value of the BioFire Pneumonia panel in managing nosocomial pneumonia within ICU settings. Its rapid, accurate, and user-friendly design makes it an effective tool for near-patient testing, facilitating timely and targeted antimicrobial therapy, enhancing antimicrobial stewardship, and potentially improving patient outcomes.	
British HIV Association (BHIVA)	Guideline	General	General	HIV testing is not mentioned and should be. 'Community acquired pneumonia' is an indicator condition for HIV testing. https://bhiva.org/wp-content/uploads/2024/10/HIV-testing-guidelines-2020.pdf Any new positive or reactive result would necessitate discussion with specialist HIV team on pneumonia management.	Thank you for your comment. The committee did not review evidence on HIV testing in pneumonia patients so they could not make a recommendation about this, but they acknowledged the importance of this and added information on HIV testing to the committee discussion section of evidence review C.
British National	Guideline	006, 007	012 – 013,	1.2.3 recommends using the CRB65 score in conjunction with clinical judgement to inform decisions about the place of care in **adults**. However,	Thank you for your comment. We acknowledge the issue you have identified, particularly that NG237 recommends using CRB65 to

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Formulary (BNF)			001 – 008	recommendation 1.1.1 cross references to NG237 Suspected acute respiratory infection **in over 16s**: assessment at first presentation and initial management, which also makes recommendations on place of care based on CRB65 score and clinical judgement. Can/should CRB65 score be used to inform decisions in 16 – 17 year olds?	make decisions about place of care for over 16's. This section in the ARI guideline will be updated and links to the pneumonia guideline will be added to ensure consistency.
British National Formulary (BNF)	Guideline	026, 027	006 – 007, 001	1.8.2 states "When choosing a corticosteroid, consider starting treatment with IV hydrocortisone. If hydrocortisone is not suitable, consider an alternative corticosteroid such as dexamethasone. [2025]." Please could you clarify if dexamethasone should also be given IV or could it be given orally?	Thank you for your comment. The evidence review noted that a direct comparison was not available but it suggested that IV hydrocortisone may be more effective. There was no evidence on route of administration for dexamethasone, but the committee agreed that clinician judgement on a case-by-case basis would determine the route of administration. This has now been added to the recommendation. The committee also made a recommendation for research into corticosteroid treatment, including dose, duration and route of administration.
British Thoracic Society	Guideline	007	022 - 025	1.27 - The language is not consistent across the Box's and the text – so in Box 2 they use CURB65 to describe 'high' risk. But in the text and when talking about steroids they use the language 'assess severity' – and 'severe' is the criteria used to start steroids.	Thank you for your comment. Box 2 and recommendation 1.2.7 relate to the use of CURB65 to assess risk of death. Recommendation 1.2.8 then explains how the CURB65 score and clinical judgement should be used together to assess disease

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				Could they either define 'severe' or use the 'risk' language used in CURB65	severity. A definition on the assessment of disease severity is also given in the "Terms used in this guideline" section which further details the definition of severe pneumonia.
British Thoracic Society	Guideline	010	009 - 015	page 10, under subheading 1.4.2 on the use of lung ultrasound as a diagnostic imaging modality for pneumonia. The tone suggests that lung ultrasound can be relied upon solely as a radiological tool for diagnosing pneumonia. However, as the authors note in the "Rationale and Impact" section and in "Evidence Review A: Lung Ultrasound", there are many advantages to using chest X-ray and several limitations to lung ultrasound. A slight rewording could help reflect the practical considerations of ultrasound-assisted diagnosis in the NHS. For example: ***"1.4.2** Recognise that lung ultrasound can support the diagnosis of pneumonia in hospital settings, particularly as a point-of-care adjunct in clinically complex cases (e.g. suspected heart failure or pleural disease). However, be aware of its limitations: it is operator-dependent, may not visualise the entire thorax, often lacks image archiving on shared systems for review by other healthcare professionals involved in the patient's care, and is not yet widely supported by standardised medical training."*	Thank you for your suggestion. Recommendation 1.4.2 suggests some scenarios where lung ultrasound may be useful for diagnosing pneumonia but does not say it should be relied on solely, and the rationale and impact section describes both the advantages and disadvantages of this imaging modality, concluding that it can be helpful in some scenarios but should not replace chest x-ray for confirming a diagnosis of pneumonia. Further detail on the issues with image storage have been added to the rationale and impact section rather than the recommendation, because the recommendation needs to be directional or actionable, while the rationale section discusses the considerations of the decisions made.

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British Thoracic Society	Guideline	026	006	1.8 - Hydrocortisone is commonly incorrectly prescribed– the addition of dosing and frequency here might help (commonly only prescribed OD by resident medical staff)	Thank you for your comment. The evidence review did not identify adequate information on corticosteroid dosing and frequency but this will be covered by the BNF. The committee also made a recommendation for research into corticosteroid treatment, including dose, duration and route of administration.
British Thoracic Society	Guideline	027	005 - 007	1.8 - Would be helpful to be clearer about the fluoroquinolone/steroid interaction risk/benefit – in people with severe pneumonia does benefit from addition of steroids outweigh risk of harm from the fluoroquinolone/steroid interaction?	Thank you for your comment. The committee discussed possible benefits and harms, including the possible fluoroquinolone/steroid interaction. They added a link to the MHRA alert on the coadministration of fluoroquinolones and corticosteroids to remind clinicians of this possible risk.
British Thoracic Society	Guideline	General	General	The guideline is concise and clear and the authors have highlighted areas where changes have been made such as the rationalisation of tests to address health economics and duration antibiotics for ams. We suggest this is summarised as key changes at start of the document too in addition to tables at the end.	Thank you for your comment. It is not NICE practice to structure the guideline in this way so we are unable to add a table summarising key changes at the beginning of the guideline.
British Thoracic Society	Guideline	General	General	Research areas are clear and highlight areas like micro tests and how best to order investigations so focus on where more work required from a practical perspective.	Thank you for your comment.

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British Thoracic Society	Guideline	General	General	Ultrasound and steroids are important topics of discussion and merit further clarification with possibly case studies/examples in an additional document, to support areas where they can be applied and guidance linked to pleural guidelines for USS too.	Thank you for your comment. The rationale and impact section of the guideline and the committee discussion in the evidence reviews give further information on the decision-making for the recommendations. NICE recommendations are designed to be actionable and used in combination with clinical assessment and shared decision making with the individuals involved, the application may therefore be quite different in different individual situations.
British Thoracic Society	Guideline	General	General	Coding: there is a need to emphasise that clinicians document pneumonia as hap or cap rather that lower respiratory tract infection or chest infection based on findings from the audits by BTS. There is a problem in defining and stating this in discharge summaries accurately so some guidance here useful.	Thank you for your comment. Coding of pneumonia is not within the scope of this update.
British Thoracic Society	Guideline	General	General	With regards to prescribing oral steroids, guidance on when not to use in pneumonia, or when to request further tests first would be helpful as this is a very specialist area for most but it can reduce time on ITU.	Thank you for your comment. The rationale and impact section of the guideline gives further details on the committee decision-making considering the risks and benefits of corticosteroid use. Following additional evidence and committee discussion the recommendation has been changed

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					from a stronger offer recommendation to a consider recommendation.
College of Paramedics	Guideline	007	004, 007, 010	1.2.9 – The proposed guidance states GP-led Care but Advanced Practitioners / Advanced Clinical Practitioners working in Primary Care and Hospital at Home services may also have responsibility for managing low and intermediate risk patients. We would welcome this minor revision to this section due to the changing workforce diversity to reflect that other senior clinicians (AHPs / HCPs) could also be performing this type of ongoing care which may not be exclusively GP-led.	Thank you for your comment. The committee agreed and have amended recommendations 1.2.3 and 1.2.9 to include 'primary care led services' rather than GP-led care. This better encompasses the diversity of practitioners.
College of Paramedics	Guideline	013	003	1.5.1 – The proposed guidance advised starting antibiotic treatment as soon as possible after establishing a diagnosis of pneumonia, and within 4 hours (if the person has suspected sepsis, see NICE's guideline on sepsis). When looking at the rationale for within 4 hours we were unable to see the evidence base about this timeframe but could see 1-, 3- and 6-hour timeframes. Could there be some clarification about this timeframe? We support the 2024 NICE Sepsis Committee recommendations on the timings of antibiotics which concluded that in remote and rural	Thank you for your comment. This recommendation is out of scope for this update.

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				locations, the long delay between initial assessment for patients who are at high risk of severe illness or death from sepsis, and the assessment in the emergency department should follow local guidance due to sporadic footprint of Paramedics prescribing antibiotics. However, we would also like to comment that due to increasing demand on Ambulance Services, even in urban areas this timeframe (4 hours) maybe present challenges. We suspect that due to these regional variances the same issue of detailed recommendations for all Ambulance Services would not be made again but we wonder if a sentences about discussing with a Senior Clinician (Hospital Consultant / GP / Advanced Practitioner) if unlikely to receive antibiotics in the proposed timeframes may be helpful with ongoing care of this cohort of patients?	
College of Paramedics	Guideline	028 - 029	016	1.10.1 and 1.10.2 – We believe this is pertinent information to support patients with their recovery. We would welcome this information being put into an illustrative format to support a patient's ongoing education around their illness. If practicable, this would also support clinicians when consulting patients. Paramedics may be called to patients at varying stages of their recovery and with appropriate patients being discharged back to the community setting rather than	Thank you for your comment. Recommendation 1.10.1 is out of scope for this update; we only reviewed evidence for children. For recommendation 1.10.2, your comments will be considered by the NICE implementation team where relevant support activity is being planned.

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				hospital this may be a useful tool in supporting patients during the trajectory of their illness.	
College of Paramedics	Guideline	031	003	1.11.8 – The proposed guidance states about retesting CRP in hospital but we can't see it mentioning about intermediate risk patients who are being managed in the community. The explanatory information from the reviewing committee was clear and we would support section 1.11.8, from a community viewpoint, mirroring the hospital guidance section of considering baseline CRP for intermediate risk patients being managed with CAP and the subsequent rechecking 3-4 days post commencement of treatment? Furthermore, we would support the inclusion of the explanation about adverse clinical outcomes for patients whose biomarkers failed to halve in the following 3 days as documented on Pg 40 line 2-6.	Thank you for your comment. This is out of scope for this update which considered investigations in secondary care only.
College of Paramedics	Guideline	General	General	This may fall outside of the scope of this consultation and may be a more general issue for guidance revisions but with more Health Care Professionals (HCPs) / Allied Health Professionals (AHPs), including Paramedics now operating in Primary and Secondary / Tertiary Care settings, is it possible to consider if guidance could be restructured into Primary Care and Secondary Care sections so it is easier to navigate to	Thank you for your comment. We consider many different options when structuring the guideline and while we value your suggestion, it was agreed that structuring it by primary and secondary care sections may result in duplication of recommendations that apply to both settings.

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				the relevant sections depending on what area of healthcare you are clinically working in? We thank the committee for their efforts with this comprehensive review.	
Corsi-Rosenthal Foundation UK	Guideline	General	General	Section: Information for patients, families and carers We welcome the update to this section reflecting changes since the COVID-19 pandemic. The Corsi-Rosenthal Foundation UK suggests that it may be appropriate for NICE to include reference to indoor air quality within post-discharge advice to patients and carers. A growing body of evidence indicates that indoor air pollution—including fine particulate matter (PM2.5) and nitrogen dioxide (NO_2)—can impede recovery from respiratory illness. For example, attention to ventilation and air filtration in the home may support recovery in vulnerable individuals, particularly those living in overcrowded or low-income housing where indoor air quality is often compromised. This aligns with findings from Wang et al. (2023), Jia et al. (2019), Li et al. (2022), and Requia et al. (2023), who documented associations between air pollution and adverse respiratory outcomes.	Thank you for your comment. A link has been added to the NICE guideline on indoor air quality at home.

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Corsi-Rosenthal Foundation UK	Guideline	General	General	Section: Recommendations on place of care As NICE reviews the effectiveness of care outside the acute hospital setting—including hospital-at-home and virtual ward models—it may be appropriate to consider indoor air quality as a contextual factor. When the home becomes the care environment, indoor exposures may have greater influence on outcomes. Prolonged exposure to air pollutants has been associated with increased risk of respiratory complications and delayed recovery. Simple, low-cost interventions that improve air quality—such as improved ventilation or the use of portable air purifiers—may support better outcomes in these models of care, particularly for individuals in homes affected by pollution, damp, or poor ventilation. This view is supported by research from Wang et al. (2023), Li et al. (2022), Hao et al. (2022), and public health guidance from Sepsis Alliance (2021).	Thank you for your comment. Recommendation 1.2.11 focuses on factors to consider when making a shared decision about the most appropriate place of care, including virtual wards or hospital at home, and includes "the safety and suitability of the home environment," which may cover aspects such as pollution or damp. A link has been added to the NICE guideline on indoor air quality at home.
Corsi-Rosenthal Foundation UK	Equality and Health Inequalities assessment	General	General	Section: Equality and health inequalities assessment The guideline scope confirms consideration of inequalities related to deprivation and housing. The EHIA document (p.4) correctly notes that 'increased cost of living and associated issues with housing, costs of heating homes, increased damp and mould may all	Thank you for your comment. This is out of scope for this update. A link has been added to the NICE guideline on indoor air quality at home.

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				contribute to a potential expansion in health inequalities and disproportionately higher rate of respiratory illnesses like pneumonia in people from lower socio-economic groups.' We suggest that NICE may wish to consider indoor air quality as a relevant environmental determinant of recovery outcomes. Poor indoor air quality is not evenly distributed across the population and may disproportionately affect recovery support for individuals in more challenging domestic settings. This perspective is supported by Jia et al. (2019) and a relevant editorial from the American Thoracic Society (2009).	
Corsi-Rosenthal Foundation UK	Question 1	General	General	Would it be challenging to implement any of the draft recommendations? No, however, consideration of the patient's recovery environment—especially indoor air quality—may require cross-sector coordination with housing and social care services, particularly for those in deprived or overcrowded housing. Raising awareness of simple, practical measures such as ventilation and use of air purifiers could be supported by NHS or local authority public health messaging.	Thank you for your comment. This is out of scope for this update. A link has been added to the NICE guideline on indoor air quality at home.

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Corsi-Rosenthal Foundation UK	Question 2	General	General	Would implementation of any of the draft recommendations have significant cost implications? There are no direct cost implications unless NICE were to recommend provision of air quality improvements as part of recovery plans. If considered, portable air purifiers and ventilation strategies are relatively low-cost, and could be targeted to patients at highest risk. In the long term, such measures may reduce re-admissions and complications, offering potential cost savings.	Thank you for your comment. This is out of scope for this update. A link has been added to the NICE guideline on indoor air quality at home.
Neonatal and Paediatric Pharmacy Group	Guideline	021	003	Should there be some information regarding IV to oral review and stepdown if appropriate - perhaps using information from UKPAS? https://assets.publishing.service.gov.uk/media/66795c88a7a18c1aa1a00f20/paeds-iv-to-oral-switch-decision-aid-1.pdf	Thank you for your comment. This table is out of scope for this update.
Neonatal and Paediatric Pharmacy Group	Guideline	024	Table 4	Ceftazidime 1 month to 17 years - Should dose just be 50mg/kg three times a day anyway as this is in the severe symptoms section?	Thank you for your comment. The dosage given is not only for severe symptoms and signs, it also covers dosage for people who are at higher risk of resistance. This table is out of scope for this update.

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Neonatal and Paediatric Pharmacy Group	Guideline	025	Table 4	Ceftriaxone 1 month to 11 years - Again if this is in the severe symptoms section should higher dose be indicated. If not, what other criteria would differentiate severe infection and more severe infection?	Thank you for your comment. The dosage given is not only for severe symptoms and signs, it also covers dosage for people who are at higher risk of resistance This table is out of scope for this update.
Neonatal and Paediatric Pharmacy Group	Guideline	025	Table 4	Vancomycin 1month to 11 years and 12 to 17 years – As we know the BNFC dosing does not work for children. Are we able to make a pragmatic suggestion based on the previous NPPG vancomycin research project? Unfortunately this work has not been published but NPPG could share it with you.	Thank you for your comment. The dosing aligns with the BNF and we would be unable to consider unpublished data. Please contact BNFC if you have concerns about dosing. This table is out of scope for this update.
Neonatal and Paediatric Pharmacy Group	Guideline	General	General	The whole document would benefit from a flowchart for adults and for paediatrics to cover assessment, investigations and treatment for CAP and HAP. This would make it more user friendly for day-to-day use and users could refer to the main guideline for the detail	Thank you for your comment. We will be producing a visual summary to support the guideline; this may include a flowchart or diagrams to aid interpretation and implementation of the recommendations.
NHS England	Evidence review A	General	General	Lung Ultrasound - According to Mencap approximately 1.5 million people in the UK have a learning disability Learning Disability Research and Statistics | Mencap BTS clinical statements BTS Clinical Statement on CAP in people with learning disability.pdf say that CAP is a major contributor to the increased hospitalisation risk that has been described for people with learning disability and results in longer hospital stays than the general population. People with learning disability also	Thank you for your comment. There was no evidence identified for LUS in these specific groups. The committee discussed the tolerance of lung ultrasound and CXR, noting that the CXR process includes the need for carers/support persons to leave while the x-ray is being taken, and the need to transfer patients from the ward to the radiology department for the chest x-ray whereas LUS can be done at the bedside. They discussed that the option of

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				experience increased rates of repeated admission secondary to CAP. As CAP is a major cause of death in people with learning disability, prevention, early detection and proactive management are key to reducing mortality from avoidable causes. It is important that public sector organisations make reasonable adjustments in their approach or provision to ensure that people with learning disability have equitable access to good quality healthcare. Has the tolerance of ultrasound and requirement for reasonable adjustments been considered for people with a learning disability or people who are autistic compared to chest Xray. Has evidence for CXR vs USS been considered for these groups	a LUS may be more acceptable for some, and that for all procedures, reasonable adjustments are made as standard. The equality, health inequalities assessment that is completed for all guidelines and updates and underpins the committee discussions includes areas of concern for those with learning disabilities.
NHS England	Evidence review B	General	General	Hospital at Home - According to Mencap approximately 1.5 million people in the UK have a learning disability Learning Disability Research and Statistics | Mencap BTS clinical statements BTS Clinical Statement on CAP in people with learning disability.pdf say that CAP is a major contributor to the increased hospitalisation risk that has been described for people with learning disability and results in longer hospital stays than the general population. People with learning disability also experience increased rates of repeated admission secondary to CAP. As CAP is a major cause of death in people with learning disability,	Thank you for your comment. There was no evidence identified for hospital at home for those with learning disabilities. The recommendations regarding the decisions about place of care include that these decisions should account for the person's preferences, any comorbidities, safety and suitability of the home environment, and the person's support network. The equality, health inequalities assessment that is completed for all guidelines and updates and underpins

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				prevention, early detection and proactive management are key to reducing mortality from avoidable causes. It is important that public sector organisations make reasonable adjustments in their approach or provision to ensure that people with learning disability have equitable access to good quality healthcare. Have outcomes for people with Learning disability or people who are autistic in hospital settings vs hospital at home been compared and the needs of carers considered? Have the requirements for reasonable adjustments in both settings been considered.	the committee discussions includes areas of concern for those with learning disabilities.
NHS England	Evidence review C	General	General	Microbiological tests - According to Mencap approximately 1.5 million people in the uk have a learning disability Learning Disability Research and Statistics | Mencap BTS clinical statements BTS Clinical Statement on CAP in people with learning disability.pdf say that CAP is a major contributor to the increased hospitalisation risk that has been described for people with learning disability and results in longer hospital stays than the general population. People with learning disability also experience increased rates of repeated admission secondary to CAP. As CAP is a major cause of death in people with learning disability, prevention, early detection and proactive management are key to reducing mortality from avoidable causes. It is important that public sector organisations make	Thank you for your comment. There was no evidence identified for microbiological tests for those with learning disabilities. Making reasonable adjustments as required by the Equality Act is a statutory requirement and so this requirement would not be repeated in each individual NICE guideline. The committee emphasised that all staff would work to make any test or intervention accessible. The equality, health inequalities assessment that is completed for all guidelines and updates and underpins the committee discussions includes areas of concern for those with learning disabilities.

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				reasonable adjustments in their approach or provision to ensure that people with learning disability have equitable access to good quality healthcare. Have the needs of people with a learning disability been considered especially ensuring that the level of severity is recognised early and that reasonable adjustments are made to ensure that these tests are accessible.	
NHS England	Evidence review D	General	General	Antibiotics duration - According to Mencap approximately 1.5 million people in the UK have a learning disability Learning Disability Research and Statistics | Mencap BTS clinical statements BTS Clinical Statement on CAP in people with learning disability.pdf say that CAP is a major contributor to the increased hospitalisation risk that has been described for people with learning disability and results in longer hospital stays than the general population. People with learning disability also experience increased rates of repeated admission secondary to CAP. As CAP is a major cause of death in people with learning disability, prevention, early detection and proactive management are key to reducing mortality from avoidable causes. It is important that public sector organisations make reasonable adjustments in their approach or provision to ensure that people with learning disability have equitable access to good quality healthcare. Have the	Thank you for your comment. There was no evidence identified on antibiotic durations for children with learning disabilities. The equality, health inequalities assessment that is completed for all guidelines and updates and underpins the committee discussions includes areas of concern for those with learning disabilities.

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				outcome of different treatment durations for people with a learning disability been considered.	
NHS England	Evidence review E	General	General	Corticosteroids - According to Mencap approximately 1.5 million people in the UK have a learning disability Learning Disability Research and Statistics | Mencap BTS clinical statements BTS Clinical Statement on CAP in people with learning disability.pdf say that CAP is a major contributor to the increased hospitalisation risk that has been described for people with learning disability and results in longer hospital stays than the general population. People with learning disability also experience increased rates of repeated admission secondary to CAP. As CAP is a major cause of death in people with learning disability, prevention, early detection and proactive management are key to reducing mortality from avoidable causes. It is important that public sector organisations make reasonable adjustments in their approach or provision to ensure that people with learning disability have equitable access to good quality healthcare. We would like the recommendations for further research in this field includes people with a learning disability.	Thank you for your comment. There was no evidence identified for corticosteroids for people with learning disabilities. We have added 'people with learning disabilities' to the list of subgroups of interest to the research recommendation in evidence review E. The equality, health inequalities assessment that is completed for all guidelines and updates and underpins the committee discussions includes areas of concern for those with learning disabilities.
NHS England	Evidence Review F	General	General	Non invasive ventilation - According to Mencap approximately 1.5 million people in the UK have a learning disability Learning Disability Research and Statistics | Mencap BTS clinical statements BTS	Thank you for your comment. There was no evidence identified for NIV for people with learning disabilities.

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				Clinical Statement on CAP in people with learning disability.pdf say that CAP is a major contributor to the increased hospitalisation risk that has been described for people with learning disability and results in longer hospital stays than the general population. People with learning disability also experience increased rates of repeated admission secondary to CAP. As CAP is a major cause of death in people with learning disability, prevention, early detection and proactive management are key to reducing mortality from avoidable causes. It is important that public sector organisations make reasonable adjustments in their approach or provision to ensure that people with learning disability have equitable access to good quality healthcare. People with a learning disability or who are autistic may struggle to tolerate interventions and we would recommend staff training and reasonable adjustments to help make these treatments more tolerable for people with a learning disability and people who are autistic Resources can be found here NHS England » Continuous positive airway pressure (CPAP) resources	Making reasonable adjustments as required by the Equality Act is a statutory requirement and so this requirement would not be repeated in each individual NICE guideline. The committee emphasised that all staff would work to make any test or intervention accessible. They noted that high flow nasal oxygen (HNFO) is usually better tolerated than standard oxygen or CPAP. They also highlighted that any area of the hospital delivering NIV will have nurses who are specially trained to deliver these modalities, and they will consider all of the different issues that may impact a person's ability to tolerate it. The equality, health inequalities assessment that is completed for all guidelines and updates and underpins the committee discussions includes areas of concern for those with learning disabilities.
NHS England	Evidence Review G	General	General	Patient information - According to Mencap approximately 1.5 million people in the UK have a learning disability Learning Disability Research and Statistics | Mencap BTS clinical statements BTS Clinical Statement on CAP in people with learning	Thank you for your comment. Making reasonable adjustments as required by the Equality Act is a statutory requirement and so this requirement would not be repeated in each individual

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				disability.pdf say that CAP is a major contributor to the increased hospitalisation risk that has been described for people with learning disability and results in longer hospital stays than the general population. People with learning disability also experience increased rates of repeated admission secondary to CAP. As CAP is a major cause of death in people with learning disability, prevention, early detection and proactive management are key to reducing mortality from avoidable causes. It is important that public sector organisations make reasonable adjustments in their approach or provision to ensure that people with learning disability have equitable access to good quality healthcare. It is important to ensure therefore that people with a learning disability or who are autistic and their carers have access to accessible information in suitable formats so that they are properly informed about their treatment. A recommendation in this guidance to this effect should be included.	NICE guideline. The committee agreed that important information for patients and their carers would be made available in accessible formats. The equality, health inequalities assessment that is completed for all guidelines and updates and underpins the committee discussions includes areas of concern for those with learning disabilities.
NHS England	Evidence Review H	General	General	Biomarkers - According to Mencap approximately 1.5 million people in the uk have a learning disability Learning Disability Research and Statistics | Mencap BTS clinical statements BTS Clinical Statement on CAP in people with learning disability.pdf say that CAP is a major contributor to the increased hospitalisation risk that has been described for people with learning	Thank you for your comment. There was no evidence identified for biomarkers for people with learning disabilities, so it was not possible to establish that levels and response are the same as for people without learning disability.

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				disability and results in longer hospital stays than the general population. People with learning disability also experience increased rates of repeated admission secondary to CAP. As CAP is a major cause of death in people with learning disability, prevention, early detection and proactive management are key to reducing mortality from avoidable causes. It is important that public sector organisations make reasonable adjustments in their approach or provision to ensure that people with learning disability have equitable access to good quality healthcare. Have normal biomarker levels for people with a learning disability been researched to demonstrate that levels and response are the same as for people without learning disability.	Making reasonable adjustments as required by the Equality Act is a statutory requirement and so this requirement would not be repeated in each individual NICE guideline. The committee emphasised that all staff would work to make any test or intervention accessible. The equality, health inequalities assessment that is completed for all guidelines and updates and underpins the committee discussions includes areas of concern for those with learning disabilities.
NHS England	Evidence review I	General	General	Chest Xray - According to Mencap approximately 1.5 million people in the uk have a learning disability Learning Disability Research and Statistics | Mencap BTS clinical statements BTS Clinical Statement on CAP in people with learning disability.pdf say that CAP is a major contributor to the increased hospitalisation risk that has been described for people with learning disability and results in longer hospital stays than the general population. People with learning disability also experience increased rates of repeated admission secondary to CAP. As CAP is a major cause of death in	Thank you for your comment. Making reasonable adjustments as required by the Equality Act is a statutory requirement and so this requirement would not be repeated in each individual NICE guideline. The committee emphasised that all staff would work to make any test or intervention accessible, including follow-up chest x-rays. The equality, health inequalities assessment that is completed for all guidelines and updates and underpins

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				people with learning disability, prevention, early detection and proactive management are key to reducing mortality from avoidable causes. It is important that public sector organisations make reasonable adjustments in their approach or provision to ensure that people with learning disability have equitable access to good quality healthcare. People with a learning disability should be included in the research proposal.	the committee discussions includes areas of concern for those with learning disabilities. People with a learning disability have now been listed as a subgroup of interest in the research recommendation.
NHS England	Evidence review J	General	General	Risk assessment tools - According to Mencap approximately 1.5 million people in the uk have a learning disability Learning Disability Research and Statistics | Mencap BTS clinical statements BTS Clinical Statement on CAP in people with learning disability.pdf say that CAP is a major contributor to the increased hospitalisation risk that has been described for people with learning disability and results in longer hospital stays than the general population. People with learning disability also experience increased rates of repeated admission secondary to CAP. As CAP is a major cause of death in people with learning disability, prevention, early detection and proactive management are key to reducing mortality from avoidable causes. It is important that public sector organisations make reasonable adjustments in their approach or provision to ensure that people with learning disability have	Thank you for your comment. There was no evidence identified for risk assessment tools for people with learning disabilities. Making reasonable adjustments as required by the Equality Act is a statutory requirement and so this requirement would not be repeated in each individual NICE guideline. The committee emphasised that all staff would work to make any test or intervention accessible. The equality, health inequalities assessment that is completed for all guidelines and updates and underpins the committee discussions includes areas of concern for those with learning disabilities.

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				equitable access to good quality healthcare. People with a learning disability or who are autistic may display the level of severity of their illness differently to others. Any research on such tools should include people with a learning disability or who are autistic and a lower index of suspicion for hospital referral being considered. There is a risk that diagnostic overshadowing may make use of these tools more challenging therefore it is important that any such tools are validated in this group.	
NHS England	Evidence review K	General	General	Early warning scores in ED - According to Mencap approximately 1.5 million people in the uk have a learning disability Learning Disability Research and Statistics | Mencap BTS clinical statements BTS Clinical Statement on CAP in people with learning disability.pdf say that CAP is a major contributor to the increased hospitalisation risk that has been described for people with learning disability and results in longer hospital stays than the general population. People with learning disability also experience increased rates of repeated admission secondary to CAP. As CAP is a major cause of death in people with learning disability, prevention, early detection and proactive management are key to reducing mortality from avoidable causes. It is important that public sector organisations make reasonable adjustments in their approach or provision	Thank you for your comment. There was no evidence identified for early warning scores for people with learning disabilities. Making reasonable adjustments as required by the Equality Act is a statutory requirement and so this requirement would not be repeated in each individual NICE guideline. The committee emphasised that all staff would work to make any test or intervention accessible. The equality, health inequalities assessment that is completed for all guidelines and updates and underpins the committee discussions includes areas of concern for those with learning disabilities.

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				to ensure that people with learning disability have equitable access to good quality healthcare. People with a learning disability or who are autistic may display the level of severity of their illness differently to others. Any research on such tools should include people with a learning disability or who are autistic and a lower index of suspicion for severity of illness compared to the score being returned by the assessment tool should be considered. There is a risk that diagnostic overshadowing may make use of these tools more challenging therefore it is important that any such tools are validated in this group.	
NHS England	Equality and Health Inequalities assessment	General	General	It was reassuring to see that the needs of people with a learning disability had been considered in this impact assessment. Have the needs of autistic people also been considered?	Thank you for your comment. Many of the recommendations refer to the importance of patient needs and preferences, and the role of shared decision making. For example, recommendations about non-invasive respiratory support refers to the patients' preferences and ability to tolerate it. The needs of people with autism are captured within these considerations.
NHS England	Guideline	007 & 008	004 & 010	Inconsistency between management recommendations for patients with CRB65 score of 1 and CURB65 score of 1. Recommend harmonise to "GP-led care with safety netting advice for adults with a CRB65/CURB65 score of 0 or 1." Otherwise, every patient over 65 with	Thank you for your comment. The committee carefully considered the implications of these recommendations and similarly expressed concern about the scenario you refer to, but they emphasised the importance of clinical judgement when interpreting CRB65/CURB65 scores and making

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				no other CRB/CURB criterion will be eligible for referral to hospital or SDEC.	decisions about place of care, and agreed that clinician judgment would prevent the over-referral of patients over 65 who do not require it.
NHS England	Guideline	006 & 008	012 & 001	Recommendations 1.2.3 and 1.2.9. Please add "immunocompromise" after "for example" to act as a prompt to consider this because "co-morbidities" may not act as a sufficient reminder about immuncompromise.	Thank you for your comment. Those who are immunocompromised are out of scope for this update. The committee also noted that CRB65 and CURB65 were not developed or validated for use with immunocompromised patients so it would not be appropriate to add this.
NHS England	Guideline	011	General	1.3.3 - NICE should explicitly recommend that NEWS2 and PEWS are not used in isolation to guide antimicrobial decision-making. These tools should complement AMS principles, including timely microbiology review and daily antibiotic reassessment, particularly in discharge and virtual ward pathways.	Thank you for your comment. The use of NEWS2 and PEWS to guide antimicrobial decision-making is not in the scope of this update.
NHS England	Guideline	011 - 012	010 - 012	1.4.5–1.4.7 - The guideline underemphasises the value of negative culture results in AMS. Strengthen the link between microbiological testing and stewardship by advising use of negative cultures in early de-escalation decisions, even if pathogen identification is unsuccessful.	Thank you for your comment. De-escalation decisions with negative cultures are not in the scope of this update.
NHS England	Guideline	013 – 014	018 - 022	1.6.1–1.6.3 - Recommendation 1.6.1 appropriately considers factors influencing antibiotic choice. We recommend explicitly including "local formulary and prescribing guidance aligned to local resistance data"	Thank you for your comment. This section of the guideline is not in the scope of this update.

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				as a decision point to strengthen AMS alignment and reduce inappropriate variation.	
NHS England	Guideline	013	002	1.5.1 - Timely antibiotic initiation is rightly emphasised. However, it would be helpful to clarify "within 4 hours" of presentation to hospital, especially where triage or clinical capacity challenges may cause ambiguity. Consider practical examples from virtual ward/hospital-at-home pathways.	Thank you for your comment. This recommendation is not in the scope of this update. Small editorial changes have been made to assist with clarity.
NHS England	Guideline	013	011	1.5.4 - We support the recommendation to adjust antibiotics following microbiology results. Further emphasis could be placed on de-escalation opportunities and involvement of AMS teams/pharmacy services in review by 48–72 hours.	Thank you for your comment. This recommendation is not in the scope of this update.
NHS England	Guideline	013	018	1.6.1 - The reference to "local antimicrobial resistance and surveillance data" could be expanded to recommend integration with regional AMR dashboards or UKHSA reports to support consistent national implementation.	Thank you for your comment. This recommendation is not in the scope of this update.
NHS England	Guideline	011	013	1.4.6 - The guidance to consider pneumococcal urinary antigen testing is welcome. However, uptake remains low across systems. Suggest recommending AMS oversight in interpretation to ensure it supports de-escalation rather than prompting unnecessary escalation.	Thank you for your comment. De-escalation decisions with AMS oversight are not in the scope of this update.
NHS England	Guideline	014	012	1.6.3 - The recommendation to stop antibiotics after 5 days if stable aligns with AMS principles. It may be	Thank you for your comment. This recommendation is out of scope of this update.

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				strengthened by referencing the safety of short-course treatment backed by recent RCTs.	
NHS England	Guideline	014	024	1.6.4 - We support the 3-day antibiotic course recommendation in children with non-severe CAP. Emphasise its alignment with AMS by suggesting educational messaging for caregivers on the benefits of short courses and when to seek re-evaluation.	Thank you for your comment. The rationale and impact section of the guideline and the related evidence review provide further information on the evidence and the committee's decision making. The recommendations on information for parents and caregivers include when to seek re-evaluation.
NHS England	Guideline	017	Table 2	Consider removing dosing guidance for children 8 years to 11 years for "Erythromycin (in pregnancy):" due to the low likelihood of a child under 12 becoming pregnant.	Thank you for your comment. Inclusion of this dosing guidance was a decision made by the common infections committee and it aligns with the BNF and other NICE infections guidelines. Children under 12 may be pregnant, and if this is removed then it would leave no options for these patients.
NHS England	Guideline	031	007 – 020	1.12.1–1.12.3 - Routine follow-up imaging may lead to incidental findings prompting unnecessary antibiotics. Recommend shared decision-making and advise not to treat radiographic findings in isolation.	Thank you for your comment. The recommendations in this section include shared decision-making. The treatment of the radiological findings in not in the scope of this update.
NHS England	Guideline	029	002	Please qualify the phrase "most children". This could be interpreted as 51% of children and offers little reassurance to parents/carers. Is it possible to state for example "For 90% of children…"	Thank you for your comment. It is not possible to be that specific within the recommendation as recovery may vary and individual discussions with parents/carers will be related to the individual child.

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NHS England	Guideline	030	023	Recommendation 1.11.7. Is there clinical value in a single CRP/PCT measurement at 3-4 days after starting treatment in the absence of a baseline measurement? Could this recommendation be changed to "consider a repeat measurement of CRP or procalcitonin 3-4 days after starting treatment…"?	Thank you for your comment. The committee agreed that absolute values and the change from baseline can both give clinicians important information, with high levels on day 3 or 4, or levels that remain elevated, both indicating a need for further review. A baseline assessment is not always required, so the committee did not want to refer to a 'repeat' measurement.
NHS England	Guideline	030	023 - 005	1.11.7–1.11.8 - The guideline's reference to PCT and CRP to guide antibiotic discontinuation should include a fallback principle where biomarkers are unavailable. Recommend reinforcing clinical oversight and clinical review as key de-escalation strategies.	Thank you for your comment. The guideline does not make any recommendations about using PCT or CRP to guide antibiotic discontinuation. Biomarker use is accepted practice and these are widely available.
NHS England	Guideline	031	007	Recommendation 1.12.1. It would be helpful for behaviour change to qualify the recommendation not to repeat X-ray by stating that X-ray changes continue to be evident for a period of time after infection has been successfully treated.	Thank you for your comment. The rationale and impact section states that radiological changes may persist after symptoms of pneumonia have resolved and do not always indicate a need for further investigation or treatment, so this does not need to be added to the recommendation.
NHS England	Guideline	032	018	It would be valuable to expand upon the definition of "pneumonia" here, to help distinguish from non-pneumonic respiratory tract infection, which should influence management and treatment decisions.	Thank you for your comment. A link to the NICE clinical knowledge summary on pneumonia has been added to provide further information on pneumonia.
NHS England	Guideline	034	007	Research recommendations. Consider incorporating into the research recommendation other tests such as	Thank you for your comment. The committee considered, discussed and prioritised the research recommendations that related to the areas

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				biomarkers that can support appropriate antibiotic prescribing decisions?	of this update. Antibiotic prescribing decisions is not in the scope of this update.
NHS England	Guideline	034	006	Please consider addition of the following research questions: How can pulse oximetry be used to improve the sensitivity and specificity of community-acquired pneumonia diagnosis and severity assessment? (Bearing in mind the increased availability of pulse oximetry in many primary care health settings). Are there any clinical scoring tools that offer an advantage over CRB-65 in primary care settings to predict or rule out community-acquired pneumonia and quantify risk of deterioration, that could support with a clinical decision over whether or not to start antibiotics? What additional patient benefits and harms does co-amoxiclav or cephalosporins offer over amoxicillin for the treatment of severe pneumonia? (See recent UK research suggesting no additional benefit: Wei J 2024; https://pubmed.ncbi.nlm.nih.gov/38663754/) What additional patient benefits and harms does addition of a macrolide present for the treatment of severe pneumonia? (See recent UK research suggesting no additional benefit, in the absence of suspicion of Legionella or atypical organisms: Wei J, 2025; https://pubmed.ncbi.nlm.nih.gov/39718980/).	Thank you for your comment. The committee considered, discussed and prioritised the research recommendations that related to the areas of this update. Pulse oximetry, other clinical scoring tools, and antibiotic choices are not in the scope of this update.

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NHS England	Guideline	General	General	General AMR/AMS comment: We welcome the guideline's commitment to antimicrobial stewardship. However, stronger alignment with national AMR strategies and the UK 5-year action plan (2019–2024) would improve strategic coherence.	Thank you for your comment. This is not within the remit of this guideline.
Primary Care Respiratory Society UK	Guideline	007	General	No mention of VW as alternative to referral to hospital or inclusion of frailty or advanced planning documents in the discussion with patient	Thank you for your comment. Reference to virtual wards alongside hospital at home services has been added throughout the guideline. 'Advance care plans' has also been added to recommendation 1.2.11 to capture the importance of these discussions when making decisions about place of care. Frailty is already listed within this recommendation.
Primary Care Respiratory Society UK	Guideline	007	General	Most VW take patients with a CRB score > 1 and give IV abx – I am not sure this statement is helpful **GP-led care, referral to hospital or hospital at home service or same day emergency care (SDEC) unit for adults with a CRB65 score of 1**	Thank you for your comment. The recommendations about place of care emphasise the importance of clinical judgement and shared decision making alongside CRB65 score, so factors beyond CRB65 score alone would inform the decision about the most suitable place of care. This means people with a score of more than 1 may still be considered eligible for a virtual ward if clinical judgement and shared decision making suggest this is the most appropriate option.

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Primary Care Respiratory Society UK	Guideline	014	General	Consider longer courses of Abx in patients with underlying lung conditions (COPD / Lung fibrosis)	Thank you for your comment. Antibiotic duration for adults was out of scope for this update. The evidence review focused on antibiotic durations for children.
Primary Care Respiratory Society UK	Guideline	General	General	The guideline does not reflect the importance of adapting antibiotic type or length of course according to patients' co-morbidities / age or illness. The 5-day course is only suitable for patients who are relatively young with no co-morbidities. I am not sure the guidance reflects the degree of complexity dealt with in the community. Many of my secondary care colleagues are concerned about the drive for 5 days of amoxycillin.	Thank you for your comments. This update reviewed evidence on shorter antibiotic courses for children. The recommendations include the use of 3-day courses for children with non-severe community-acquired pneumonia without complications or underlying disease. They also note that there are cases where extending beyond 3 days should be considered. Course durations for adults were out of scope for this update. The committee acknowledged that some comorbidities may require longer course lengths, but these would be regarded as special cases and those conditions are excluded from the scope of this update..
Roche Diagnostics	Guideline	030 - 031	022	**Changing the recommendation of procalcitonin (PCT) measurement from "consider" to "recommend":** The current wording underplays the strength and consistency of the evidence supporting PCT-guided antibiotic therapy. PCT measurement is not only safe but proven to reduce	Thank you for your comment. The committee reviewed the evidence on PCT for antibiotic discontinuation and agreed that the evidence was not sufficiently robust to recommend using PCT-guided antibiotic treatment.

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				antibiotic duration and improve clinical outcomes. Additionally, the current phrasing implies that PCT is solely used to detect treatment failure. This should be revised to more accurately reflect the use of PCT to clinically improve patient outcomes by allowing for reduced antibiotic duration through earlier discontinuation. Optimising the duration of antibiotic use reduces overtreatment, limits adverse effects, and helps maintain antibiotic efficacy by minimising resistance. ● ***ADAPT-Sepsis Trial (Dark et al., 2025): UK-Based, High-Quality RCT:*** ○ A large, multi-centre, UK-based randomized controlled trial assessed procalcitonin (PCT)-guided antibiotic therapy in critically ill patients with suspected sepsis. The leading recruitment condition was in community acquired pneumonia. ○ **Population**: Critically ill patients with suspected sepsis; results stratified for CAP and HAP. ○ **Findings:** ▪ Antibiotic duration significantly reduced in the PCT group (mean 9.8 days) vs. standard care (10.7 days); mean difference 0.88 days (95% CI: 0.19–1.58, p = 0.01). ▪ 28-day mortality was non-inferior in the PCT group (20.9%) compared to standard care (19.4%), absolute	The studies you cite all relate to PCT-guided antibiotic de-escalation in patients with sepsis and are not specific to people with pneumonia. They do not meet criteria for inclusion in our evidence review: ▪ ADAPT-Sepsis included adults in intensive care on IV antibiotics for suspected sepsis. The presumed site of infection causing sepsis was respiratory tract for 49% - this does not reach our inclusion threshold of >75% with pneumonia. Subgroup analyses showed no difference in duration of antibiotics to 28 days for CAP or HAP patients and there are no results reported for safety outcomes in the pneumonia subgroups. ▪ Schuetz 2017 and Schuetz 2018 are two publications of the same meta-analysis. The review included patients with ARI and included studies of any upper or lower RTI. Only 3 of the 26 studies were listed as clinical diagnosis of pneumonia or CAP with x-ray confirmation, and 2 of these were studies of low-risk outpatients (our review protocol included hospitalised patients only). The remaining paper was Christ-Crain 2006 which was included in our evidence review. They do not list the individual studies that their pneumonia-specific outcomes are based on, so it is not possible to confirm whether these subgroup analyses are based on patients with

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				difference 1.57% (95% CI: -2.18 to 5.32, p = 0.02). ○ **Relevance:** Demonstrates that PCT can safely guide earlier antibiotic discontinuation even in severe cases, without negatively affecting patient outcomes. ● ***Cochrane Review (Schuetz et al., 2017): High-Quality Meta-analysis:*** ○ **Design**: Patient-level meta-analysis of 26 RCTs including pneumonia patients***.*** ○ **General outcomes*:*** ▪ Antibiotic duration reduced by 2.4 days (p < 0.0001). ▪ Lower mortality in PCT group (8.6% vs. 10.0%; OR 0.83, p = 0.037). ▪ Fewer side effects (OR 0.68, p < 0.0001). ○ **Pneumonia-specific outcomes:** ▪ Significant reduction in antibiotic initiation and duration, and treatment failure (OR 0.78, p = 0.005). ▪ Robustness: Results were consistent across sensitivity and subgroup analyses.	pneumonia or a broader population of LRTI patients.

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				● ***Schuetz et al. (2018): Expanded IPD Meta-analysis:*** ○ **Scope:** 26 RCTs, 6,708 patients with acute respiratory infections, including pneumonia. ○ **Key Results:** ▪ Mortality reduction (9% vs. 10%; OR 0.83, p = 0.037). ▪ Antibiotic duration reduced by 2.4 days on average (p < 0.0001). ▪ Adverse events were significantly lower in the PCT group (16% vs. 22%; OR 0.68, p < 0.0001). ○ **Pneumonia-specific outcomes:** ▪ Reduced treatment failure (OR 0.78, p = 0.005) and antibiotic side effects (OR 0.62, p < 0.0001). The accumulated evidence from high-quality trials and meta-analyses, especially from UK-led ADAPT-Sepsis, clearly shows that PCT monitoring improves clinical outcomes, reduces antibiotic exposure, and supports safer care. These effects are consistent across subgroups and clinical settings, including pneumonia-specific populations.	
Roche Diagnostics	Guideline	030 - 031	022	**Changing the recommendation of PCT or CRP to PCT alone:**	Thank you for your comment. The ADAPT-sepsis trial is a study of adults admitted to ICU with suspected sepsis. It is not eligible for inclusion in our evidence review because it does not meet our

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				The equivalence implied in the current recommendation between CRP and PCT is not supported by high-quality evidence and suggests some interchangeability between these biomarkers, which may be confusing clinically. In particular, the ADAPT-Sepsis trial (Dark et al., 2025), the largest and most rigorous UK-based study of its kind, which was specifically commissioned to answer a NICE research recommendation (DG18), compared PCT and CRP to the standard of care for guiding antibiotic therapy and found that: ● No significant reduction in antibiotic duration when comparing PCT to standard care: ○ CRP-guided group: 10.6 days ○ Standard care: 10.7 days ○ Mean difference: 0.09 days (95% CI: -0.60 to 0.79; p = 0.79) ● 28-day mortality was 21.1% in the CRP-guided group vs. 19.4% in standard care. ○ Absolute difference: 1.69% (95% CI: -2.07 to 5.45; p = 0.03) ● This demonstrates that CRP had no meaningful impact on reducing antibiotic use, and the authors concluded that the CRP protocol was inconclusive for mortality benefit. The ADAPT-Sepsis trial provides direct comparative evidence demonstrating that PCT is effective for guiding antibiotic therapy, whereas CRP is not. Continuing to include CRP in	threshold of >75% pneumonia patients (presumed site of infection causing sepsis was respiratory tract for only 49%). This study provides information on the use of biomarkers for patients with sepsis, but we cannot use it to make recommendations for patients with pneumonia.

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				the recommendation risks clinical confusion. We therefore recommend updating the guideline to remove CRP and recommend PCT alone, as the preferred and evidence-based biomarker for guiding antibiotic use in patients hospitalised with pneumonia.	
Roche Diagnostics	Guideline	030 - 031	022	**Changing the recommendation of measuring PCT 3-4 days after starting treatment to measuring PCT before starting treatment and daily:** The ADAPT-Sepsis trial (Dark et al., 2025) implemented a clearly defined, daily PCT-guided antibiotic discontinuation protocol. This protocol used objective thresholds to guide clinical decisions, as shown in eTable 1. Daily lab tests and automated decision support messages were sent to the treating team, giving real-time, evidence-based recommendations. This structured approach only works with serial (daily) testing starting before antibiotic initiation (Day 1), to allow for trend-based decisions which is the benefit of having continuous biomarker data. **Impact on Outcomes:** ● Antibiotic duration reduced: 9.8 days (PCT) vs. 10.7 days (standard care); p = 0.01 ● 28-day mortality was non-inferior: 20.9% (PCT) vs. 19.4% (standard care); p = 0.02	Thank you for your comment. The ADAPT-sepsis trial is a study of adults admitted to ICU with suspected sepsis. It is not eligible for inclusion in our evidence review because it does not meet our threshold of >75% pneumonia patients (presumed site of infection causing sepsis was respiratory tract for only 49%). This study provides information on the use of biomarkers for patients with sepsis, but we cannot use it to make recommendations for patients with pneumonia.

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				The value of PCT lies in its trajectory over time, not a single result. For example: ● A falling PCT by ≥80% from baseline (even if above 0.25 µg/L) supports stopping antibiotics. ● A static or rising PCT supports continued treatment. ● This dynamic guidance is impossible to achieve with a one-off test at 3–4 days. The ADAPT-Sepsis trial provides clear, high-quality evidence that daily PCT measurement before antibiotic initiation (Day 1) enables safe and effective antibiotic discontinuation decisions. This protocol cannot be replicated by a single delayed test at Day 3 or 4. Therefore, we recommend NICE revise the guideline to: Initiate PCT testing before antibiotic initiation (Day 1), and continue daily measurement to monitor trends and support treatment decisions.	

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<table>
<tr><th>Stakeholder</th><th>Document</th><th>Page No</th><th>Line No</th><th>Comments
Please insert each new comment in a new row</th><th>Developer's response
Please respond to each comment</th></tr>
<tr><td></td><td></td><td></td><td></td><td>eTable 1: TRIAL BIOMARKER-GUIDED ANTIBIOTIC DISCONTINUATION PROTOCOL
<table>
<tr><th colspan="2">Daily PCT-guided protocol</th><th colspan="2">Daily CRP-guided protocol</th><th colspan="2">Standard care</th></tr>
<tr><td>Concealed laboratory test</td><td>Automated written advice</td><td>Concealed laboratory test</td><td>Automated written advice</td><td>Concealed laboratory test</td><td>Automated written advice</td></tr>
<tr><td>PCT < 0.25µg/l</td><td>"Protocol <u>STRONGLY SUPPORTS</u> stopping antibiotics"</td><td>CRP < 25mg/l</td><td>"Protocol <u>STRONGLY SUPPORTS</u> stopping antibiotics"</td><td>No test</td><td>"Protocol supports standard care"</td></tr>
<tr><td>PCT fall by ≥80% from baseline, or 0.25µg/l ≤ PCT ≤ 0.50µg/l</td><td>"Protocol <u>SUPPORTS</u> stopping antibiotics"</td><td>CRP fall by ≥ 50% from baseline</td><td>"Protocol <u>SUPPORTS</u> stopping antibiotics"</td><td>No test</td><td>"Protocol supports standard care"</td></tr>
<tr><td>PCT does not meet above criteria</td><td>"Protocol supports standard care"</td><td>CRP does not meet above criteria</td><td>"Protocol supports standard care"</td><td>No test</td><td>"Protocol supports standard care"</td></tr>
</table>
The standard care group underwent no additional testing, and a daily message was communicated to the clinical team that the protocol supports standard care. For the PCT and CRP group, PCT or CRP were measured daily and tailored advice communicated to the clinical team according to biomarker levels as shown above.</td><td></td></tr>
<tr><td>Roche Diagnostics</td><td>Guideline</td><td>041</td><td>009 - 020</td><td>The UK standard of care antibiotic regimen being only 5 days:

The guideline rationale notes that PCT-guided trials (including ADAPT-Sepsis) used average antibiotic durations</td><td>Thank you for your comment.
Evidence from the ADAPT-Sepsis trial does not meet inclusion criteria for our evidence review (population was sepsis patients; presumed site of infection causing sepsis was respiratory tract for only 49% which does</td></tr>
</table>

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				of 10–12 days, which are longer than the current UK standard of 5 days. Also, the 5 days could be the initial course of antibiotics, where patients might need a longer duration if they are not clinically improving. As a result, the committee expressed concern about whether PCT can be used to reduce treatment duration safely below 5 days. However, this interpretation risks excluding a significant and clinically vulnerable subgroup: patients with severe pneumonia. The primary endpoint of the ADAPT-Sepsis trial was total antibiotic duration over 28 days, which captures not only initial treatment length but also whether patients required restarting antibiotics due to clinical deterioration, recurrence, or treatment failure. This longer observation window provides a more complete picture of real-world antibiotic use and outcomes than fixed, shorter courses. **Key Evidence from ADAPT-Sepsis:** ● The standard of care (SoC) arm of the trial, which reflects real-world UK practice in critically ill patients, had a mean antibiotic duration of 10.7 days. ● The standard of care (SoC) arm of the trial for patients with CAP and HAP had a mean antibiotic duration of 10.1 and 10.4 days, respectively (e-figure 2). ● This longer duration was not due to outdated practice, but rather due to clinical severity; patients in the ICU with suspected sepsis or pneumonia often require extended courses of antibiotics.	not meet the >75% pneumonia threshold outlined in the protocol for this evidence review), so conclusions from the trial about PCT guiding safe and effective antibiotic decisions in sepsis cannot be applied to this pneumonia guideline. Patients with severe pneumonia who are critically ill are a very specialised subgroup of the broader population of pneumonia patients, and decisions about antibiotic prescribing and course durations will be made by a multidisciplinary team who will consider many factors, not just the result of a PCT test. The committee also noted that antibiotic durations may be longer for severely ill patients in critical care because of other infective conditions that may occur in that setting. These other conditions may necessitate longer antibiotic durations than that required for pneumonia and could account for the longer durations seen in the standard care arm of the ADAPT-Sepsis trial. The committee maintained that there is insufficient evidence to recommend PCT-guided antibiotic durations for patients with pneumonia.

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				● PCT guidance in these patients still resulted in a statistically significant reduction in antibiotic use (9.8 days) without increasing mortality. **Significance:** ● The current 5-day UK recommendation is not universally applicable, especially for critically ill or high-severity CAP and HAP patients. ● NICE's position implicitly assumes all pneumonia patients are suitable for a 5-day course, which does not reflect the reality for severe cases. ● By not tailoring guidance to this subgroup, the recommendation risks being incomplete or even clinically inappropriate for the patients who stand to benefit most from dynamic PCT-guided decisions. We strongly suggest that NICE: ● Acknowledge that the current UK guidance (5-day duration) does not represent standard care for severe cases. ● Recognise that PCT-guided therapy offers a safe, structured method to reduce antibiotic exposure even when initial durations are > 5 days, as demonstrated in ADAPT-Sepsis. ● Provide specific recommendations for severe patients, rather than excluding them by default.	
Roche Diagnostics	Evidence review H	004	025	**Including 3 additional papers in the Evidence Review H:**	Thank you for your comment.

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				We would like to highlight that, based on the existing inclusion criteria outlined in Table 1 of Evidence Review H, the studies by Dark et al. (2025), Schuetz et al. (2017), and Schuetz et al. (2018) appear to meet the review's stated parameters and should therefore have been included in the evidence review. These studies provide high-quality, directly relevant data on biomarker-guided antibiotic duration in pneumonia patients, including detailed subgroup analyses for both community-acquired pneumonia (CAP) and hospital-acquired pneumonia (HAP). Their inclusion would enhance the robustness and completeness of the evidence base informing this guideline. We have included a summary of the studies and results to support why we feel they should be included in the evidence review. **Dark et al. (2025):** The ADAPT-Sepsis trial, a large, multi-centre, UK-based randomized controlled trial, assessed procalcitonin (PCT)-guided antibiotic therapy in critically ill patients with suspected sepsis. Importantly, the leading recruitment condition for this trial was CAP, and this trial stratified results for CAP and HAP patients specifically. The trial aimed to establish whether antibiotic durations could be safely reduced through PCT guidance without compromising patient outcomes, including mortality. While the trial was published slightly after the review search deadline (December 9, 2024, vs. October 15, 2024), we believe this study remains highly relevant due to its robust methodology and significant findings. As a large, NIHR-funded study conducted in the UK,	The studies you cite all relate to PCT-guided antibiotic de-escalation in patients with sepsis or ARI and are not specific to people with pneumonia. They do not meet criteria for inclusion in our evidence review: ▪ ADAPT-Sepsis included adults in intensive care on IV antibiotics for suspected sepsis. The presumed site of infection causing sepsis was respiratory tract for 49% - this does not reach our inclusion threshold of >75% with pneumonia. Subgroup analyses for pneumonia are only based on ~300 patients and showed no difference in duration of antibiotics to 28 days for CAP or HAP patients, and there are no results reported for safety outcomes in the pneumonia subgroups. ▪ Schuetz 2017 and Schuetz 2018 are two publications of the same meta-analysis. This review of patients with ARI included studies of any upper or lower RTI. Only 3 of the 26 studies were listed as clinical diagnosis of pneumonia or CAP with x-ray confirmation, and 2 of these were studies of low-risk outpatients (our review protocol included hospitalised patients only). The remaining paper was Christ-Crain 2006 which was included in our evidence review. They do not list the individual studies that their pneumonia-specific outcomes are based on, so it is not possible to confirm whether

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				it would be a considerable missed opportunity not to include its evidence in the guidance. **General Findings:** ● Significant reduction in antibiotic duration with PCT guidance: mean duration 9.8 days (PCT group) vs. 10.7 days (standard care); mean difference of 0.88 days (95% CI: 0.19–1.58, p=0.01). ● All-cause 28-day mortality demonstrated non-inferiority (20.9% PCT vs. 19.4% standard care), with an absolute difference of 1.57% (95% CI: -2.18 to 5.32, p=0.02). **Pneumonia-specific Findings:** Although subgroup analyses for CAP and HAP did not achieve statistical significance, likely due to smaller sample sizes, the direction of the effect supported the overall positive findings regarding reduced antibiotic duration. Dark et al. (2025) highlighted that subgroup characteristics did not significantly influence the overall effect on antibiotic duration. **Schuetz et al. (2017), Cochrane Review:** This comprehensive systematic review evaluated individual patient data from 26 RCTs, highlighting robust evidence supporting PCT guidance for antibiotic management in acute respiratory infections, including pneumonia. **General findings:** Significant reduction in antibiotic duration (mean difference: -2.4 days, p<0.0001).	these subgroup analyses are based on patients with pneumonia or a broader population of LRTI patients.

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				Lower mortality in PCT-guided group (8.6% vs. 10.0%; OR: 0.83, p=0.037). Marked reduction in antibiotic-related side effects (OR: 0.68, p<0.0001). **Pneumonia-specific Findings:** ● Substantial reduction in antibiotic initiation and duration (mean reduction: 2.45 days, p<0.001). ● Reduced treatment failure significantly (OR: 0.78, p=0.005). ● Significant decrease in antibiotic-related side effects (OR: 0.62, p<0.001). ● Non-significant trend toward lower mortality (OR: 0.82, p=0.083). ● Slightly increased ICU stay, though clinically insignificant when adjusted. Results remained consistent across various subgroups and sensitivity analyses, including aggregate data analyses from all potentially eligible studies. Limitations included incomplete individual participant data sharing, variable definitions of treatment failure, incomplete follow-up beyond 30 days in some trials, and exclusion of certain populations, like immunosuppressed patients. Nevertheless, findings strongly support PCT as a vital biomarker in antibiotic stewardship for respiratory infections. **Schuetz et al. (2018):** This meta-analysis incorporated patient-level data from 26 RCTs, evaluating the safety and	

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				effectiveness of PCT-guided antibiotic therapy across diverse clinical settings (primary care, emergency, ICU). **General Findings:** ● Significant 30-day mortality reduction (9% PCT vs. 10% control; OR: 0.83, p=0.037). ● Antibiotic exposure decreased by approximately 2.4 days (p<0.0001). ● Antibiotic-related side effects significantly reduced (16% PCT vs. 22% control; OR: 0.68, p<0.0001). ● Non-significant trend towards reduced treatment failure. **CAP-specific Findings:** ● Mortality slightly reduced (non-significant; OR: 0.82, p=0.083). ● Significant reduction in treatment failure (OR: 0.78, p=0.005). ● Considerable decrease in antibiotic-related side effects (OR: 0.62, p<0.0001). ● Slight increase in ICU stay but no meaningful difference in total hospital stay. The effectiveness of PCT guidance was consistent across various clinical contexts and infection types, demonstrating robustness through extensive sensitivity analyses, reinforcing the value of PCT-guided antibiotic management for pneumonia patients.	

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				References: ● Dark P, Hossain A, McAuley DF, et al. Biomarker-Guided Antibiotic Duration for Hospitalized Patients With Suspected Sepsis: The ADAPT-Sepsis Randomized Clinical Trial. JAMA. 2025;333(8):682-693. doi:10.1001/jama.2024.26458 ● Schuetz P, Wirz Y, Sager R, et al. Procalcitonin to initiate or discontinue antibiotics in acute respiratory tract infections. Cochrane Database Syst Rev. 2017;(10):CD007498. doi:10.1002/14651858.CD007498.pub3 Schuetz P, Wirz Y, Sager R, et al. Effect of procalcitonin-guided antibiotic treatment on mortality in acute respiratory infections: a patient level meta-analysis. Lancet Infect Dis. 2018;18(1):95-107. doi:10.1016/S1473-3099(17)30592-3	
Royal College of General Practitioners	Guideline	001	General	We would suggest clarifying the differentiation between bacterial pneumonia secondary to COVID-19 and COVID-19 pneumonia, perhaps by providing examples or clinical scenarios. This may cause confusion in primary care settings.	Thank you for your comment. COVID-19 pneumonia is outside the scope of this update. For recommendations on COVID-19 please see the COVID-19 guideline, this is linked to from the section at the start of the guideline on what the guideline covers and does not cover.
Royal College of General Practitioners	Guideline	006	005	Rec 1.2.1 The guideline recommends using the CRB65 score for assessing CAP severity. While CRB65 is validated for adults, its applicability in elderly patients with comorbidities may be limited. It is important to consider discussing the limitations of CRB65 in	Thank you for your comment. Recommendation 1.2.1 is not within the scope of this update. All recommendations based on CRB65 score note that clinical judgement is used alongside this score to assess disease severity and make decisions about a

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				certain populations and suggest supplementary assessment tools or clinical judgment parameters.	person's care. Recommendation 1.2.3 also mentions that the CRB65 score can be affected by other factors such as comorbidities.
Royal College of General Practitioners	Guideline	006	General	There is no mention of the possibility of aspiration pneumonia as a differential diagnosis in either this document or Overview | Suspected acute respiratory infection in over 16s: assessment at first presentation and initial management | Guidance | NICE	Thank you for your comment. Aspiration pneumonia is excluded in the scope for this update.
Royal College of General Practitioners	Guideline	006	General	We feel that it is important to consider recording of pneumonia in certain populations especially those living with disability. People living with learning disability are likely to have a higher risk of dysphagia with specific management alongside pneumonia. See screening questions and resources enclosed here ○ Dysphagia Diamond Standards « Learning Disability Network People with Learning disability are more likely to risk recurrent respiratory infection and more severe illness and premature morbidity and mortality. ○ NHS England » RightCare learning disability and aspiration pneumonia scenario ○ CAP in people with learning disability | British Thoracic Society | Better lung health for all	Thank you for your comment. Dysphagia and aspiration pneumonia are out of scope for this update. The equality, health inequalities assessment that is completed for all guidelines and updates and underpins the committee discussions includes areas of concern for those with learning disabilities. It was noted that people with learning disabilities are more susceptible to respiratory illnesses like pneumonia and have poorer outcomes if admitted to hospital with pneumonia. The committee reflected on this and agreed that population specific recommendations were not required because all recommendations are made on the basis that reasonable adjustments would be made, information is always made accessible, and clinician judgement would

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				Pneumonia deep dive canva version	always be used to make decisions about the most appropriate care for each individual.
Royal College of General Practitioners	Guideline	011	005	We think it is important to provide a comment or advice regarding the use of POC rapid CRP testing in primary care.	Thank you for your comment. The evidence review on biomarkers was for patients in hospital only – POC testing in primary care was out of scope for this question.
Royal College of General Practitioners	Guideline	013	001 - 020	The guideline emphasises prompt antibiotic initiation. However, in primary care, distinguishing bacterial from viral pneumonia can be challenging. Please provide guidance on the use of point-of-care tests (e.g., CRP testing) to aid in antibiotic prescribing decisions and make reference to primary care challenges	Thank you for your comment. The evidence review on biomarkers was for patients in hospital only – point of care testing in primary care was out of scope for this question.
Royal College of General Practitioners	Guideline	014	005	Many local guidelines advice using amoxicillin and to consider adding doxycycline after 48 hours if there is no clinical response. We suspect this is added considering the distance from healthcare/remoteness of the patient and indeed it is something that is done especially with elderly or at-risk patients wishing to stay home, with good results. We wonder if this is something we should be looking at doing more regularly or a least considering.	Thank you for your comment. This recommendation is out of scope for this update.
Royal College of General	Guideline	014	007	There is a table of recommended antibiotic treatment for children and adults. This seems to have been derived largely from previous recommendations. In a world of changing antibiotic resistance, we believe it	Thank you for your comment. This guideline update incorporates recommendations from NG138 and NG139. These recommendations were not reviewed or updated; they were amalgamated

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Practitioners				would have been useful to have a brief explanation why this order of antibiotics has been recommended in 2025.	into one guideline. As such, the tables are out of scope for this update.
Royal College of General Practitioners	Guideline	014	016	We would like to clarify if 'more of one of the following': is at baseline or review after 5 days.	Thank you for your comment. This is at review after 5 days. The recommendation is out of scope for this update.
Royal College of General Practitioners	Guideline	015	013	We believe this is quite a complicated antibiotic choice. This may be more open to interpretation rather than a more simplified chart.	Thank you for your comment. This table is out of scope for this update.
Royal College of General Practitioners	Guideline	General	General	The Guideline is headed "Pneumonia: diagnosis and management. However, while there is a lot in this guideline about how pneumonia should be assessed once diagnosed there is little (see below) about how to make a likely diagnosis of Community-acquired pneumonia (CAP) compared to say a less serious viral infection. The reader is referred to NG237(2019) regarding first contact with adults suspected of having acute respiratory infection, but again this document refers to assessment of severity of disease rather than how to make a diagnosis of CAP. Page 32 of the current document does have a vague definition of how to diagnose CAP but is full of "may have this" may have	Thank you for your comment. Signs and symptoms predictive of a diagnosis of pneumonia were not in scope for this update, but we can forward your comment to our surveillance team for future updates. We have added a link to the NICE clinical knowledge summary to the definition of pneumonia in the "terms used in this guideline" section which gives information about diagnosing pneumonia.

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				that". Primary care professionals need more definitive advice on how to diagnose community acquired pneumonia, even if this is based on expert consensus. We recommend including a table to help with suggestive signs and symptoms.	
Royal College of General Practitioners	Guideline	General	General	The guideline does not explicitly address management nuances in vulnerable populations, such as the elderly, immunocompromised, or those with learning disabilities. Please include specific considerations or adaptations in management	Thank you for your comment. Those who are immunocompromised were not in the scope of this update. The equality and health inequalities assessment (EHIA) was completed and underpinned the discussions within this update. It was also available with the guideline documents at consultation and includes those in vulnerable populations and those with learning disabilities.
Royal College of Nursing	Guideline	General	General	Thank you for inviting the RCN to comment on the draft update guideline for diagnosis and management of pneumonia. We invited members who work in this area of health to review the document. In general, we are supportive of the changes in the update.	Thank you for your comment.
Royal College of Nursing	Guideline	General	General	The NICE COVID-19 guidelines support the use of awake prone positioning as a strategy to reduce the risk of tracheal intubation in patients with COVID-19 acute hypoxaemic respiratory failure. There is now strong evidence showing that awake prone positioning is a highly effective intervention in this population (Weatherald et al, BMJ. 2022, doi: 10.1136/bmj-2022-	Thank you for your comment. Prone positioning is out of scope for this update.

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				071966; . PMID: 36740866; Luo J et al, *JAMA Intern Med.* 2025, doi:10.1001/jamainternmed.2025.0011). Awake prone positioning is a highly attractive intervention that is potentially easy to implement. Nurses play a key role in patient positioning, specifically supporting the patient to adopt a position that will best support their recovery and prevent deterioration.	
Royal College of Nursing	Guideline	General	General	There is currently insufficient evidence to support the use of awake prone positioning in patients with acute hypoxaemic respiratory failure due to pneumonia. The European Society for Intensive Care Medicine and other key organisations have highlighted the need for research in this area (Grasselli et al, *Intensive Care Med* 2023, https://doi.org/10.1007/s00134-023-07050-7). There is ongoing research in the UK on this topic (https://fundingawards.nihr.ac.uk/award/NIHR154796). NICE should consider highlighting the need for research on this topic in the care of patients with pneumonia.	Thank you for your comment. Prone positioning is out of scope for this update.
Royal College of Pathologists	Guideline	011	015	For patients with moderate or high severity community acquired pneumonia we would recommended that blood cultures are taken, not just a consideration. The	Thank you for your comment. The committee discussed the evidence on blood cultures extensively and drew on their clinical expertise

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				yield from sputum cultures is low, but blood cultures may be positive and help guide therapy and reduce the risk of acquisition of antimicrobial resistance (AMR), especially in adults.	to conclude that blood cultures are not mandated for pneumonia patients unless they are on the sepsis pathway.
Royal College of Pathologists	Guideline	011	015 – 022, 001 - 002	There is no mention of mycoplasma testing. Due to limited testing resources this is not done routinely in hospitals but would be worth considering given the addition of clarithromycin to cover atypical organisms. The greyed out antibiotic section recommends 5/7 of clarithromycin but this could be stopped earlier if mycoplasma and legionella results were known which would be better for antimicrobial stewardship (AMS)	Thank you for your comment. The committee discussed mycoplasma testing and noted there is limited demand for this test and a positive result often does not change usual antibiotic prescribing decisions, so they did not make a recommendation about this. This explanation has been added to the rationale and impact section of the guideline and the committee discussion section of evidence review C.
Royal College of Pathologists	Guideline	026	006, 007	Dose regimen for the corticosteroids would be welcomed especially for resident doctors and other prescribers. We know this is a recommendation for research (p34 lines 2-4) but not including doses could lead to inadequate dosage prescribing in some cases.	Thank you for your comment. The evidence review did not identify adequate information on corticosteroid dosing and frequency but this will be covered by the BNF. The committee also made a recommendation for research into corticosteroid treatment, including dose, duration and route of administration.
Royal College of Pathologists	Guideline	027	014 - 020	We welcome this addition.	Thank you for your comment.

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Royal College of Pathologists	Guideline	028 029	018 – 020, 001 - 007	We welcome this addition as it will help with antimicrobial stewardship (AMS) and the reduction of risk of acquisition of AMR.	Thank you for your comment.
Royal College of Pathologists	Guideline	030 031	023 - 024, 001 - 002	We do not understand why PCT is included in the recommendations as the evidence review: biomarkers does not show low bias studies (bar 1) and the trials had relatively low population numbers studied. In addition, the durations used in these studies were far longer than in the UK, which might have affected the outcomes and not relate to UK standard practice of prescribing a 5/7 course. There is far more evidence for CRP.	Thank you for your comment. The committee did not make any recommendations about the use of PCT to guide antibiotic durations because of their concerns about the durations used in the studies and them not being applicable to UK standard practice of 5 days. The recommendations on PCT (1.11.7 and 1.11.8) are based on prognostic evidence that showed a consistent association between elevated PCT levels and adverse outcomes.
Royal College of Pathologists	Guideline	033	026	Should read "saturation monitors may be **inaccurate"** not in accurate	Thank you for your comment. This has been amended.
Royal College of Speech and Language Therapists	Guideline	General	General	It is greatly disappointing that pneumonias secondary to dysphagia are not referenced at all within this document. These can be community or hospital acquired and the role of dysphagia assessment is vital for management. See: Simpson AJ, Allen J, Chatwin M*, et al (2003)* BTS clinical statement on aspiration pneumonia, *Thorax,*78**:**s3-s21 http://dx.doi.org/10.1136/thorax-2022-219699	Thank you for your comment. Aspiration pneumonia is out of scope for this update.

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				Also: Chang, M. C., Choo, Y. J., Seo, K. C., & Yang, S. (2022). The Relationship Between Dysphagia and Pneumonia in Acute Stroke Patients: A Systematic Review and Meta-Analysis. *Frontiers in neurology*, *13*, 834240. https://doi.org/10.3389/fneur.2022.834240	
Thermo Fisher Scientific	Guideline	011	003 - 005	We are concerned that this recommendation suggests 'consider CRP' and not "consider Procalcitonin" ***or*** "recommend Procalcitonin". This is especially true in Severe CAP where treatment duration must be individualized and serial PCT testing plays a key role in tailoring treatment safely and supporting early discontinuation once clinical and biomarker improvements are observed. PCT provides the flexibility and safety required to align treatment duration with clinical trajectory, particularly in high-risk populations where both undertreatment and overtreatment carry significant risks. (see new evidence from the NIHR HTA funded ADAPT-Sepsis RCT) Not only is PCT more specific for bacterial infections but its levels rise and fall more rapidly than CRP which is crucial for timely clinical decisions (see ADAPT-Sepsis Supplemental Online Content eFigure 6 where Strong Stop advice is present earlier in PCT arm).	Thank you for your comment. Recommendation 1.4.3 focuses on biomarker testing at admission and this does not relate to processes for antibiotic discontinuation. Evidence from the ADAPT-Sepsis trial was not eligible for inclusion in the evidence review on biomarkers because the population was people with sepsis and it did not reach our threshold of >75% patients with pneumonia. There were insufficient subgroup results for pneumonia patients to justify inclusion. The prognostic evidence on biomarkers showed that elevated admission CRP and PCT both predict adverse outcomes, but there was no direct comparison to show which was the better test. The committee agreed that CRP on admission is current standard care, so without strong evidence that PCT is a better test, they could not recommend PCT instead of CRP – this would be a change in practice without clear justification. They also noted that PCT testing is more expensive than CRP testing. They considered recommending admission

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					PCT as well as CRP, but concluded that this would not give substantially more information than CRP alone so it would be an unnecessary extra test with additional cost implications.
Thermo Fisher Scientific	Guideline	011 & 012	013 - 002	1.4.6 - Aligned to the results from the NIHR HTA ADAPT-Sepsis Study convincing evidence exists from the UK that PCT should be recommended and requested with other microbiological tests in patients with moderate or severe CAP.	Thank you for your comment. Recommendation 1.4.6 (and the others in this section) relate to microbiological tests. PCT is a biomarker. Recommendations about PCT follow in the section on reassessment. Additionally, ADAPT-Sepsis does not meet criteria for inclusion in our evidence review because ADAPT-Sepsis included adults in intensive care on IV antibiotics for suspected sepsis. The presumed site of infection causing sepsis was respiratory tract for 49% - this does not reach our inclusion threshold of >75% with pneumonia. Subgroup analyses showed no difference in duration of antibiotics to 28 days for CAP or HAP patients and there are no results reported for safety outcomes in the pneumonia subgroups.
Thermo Fisher Scientific	Guideline	011, 030 & 031	003 – 005, 023 – 002 & 003 - 005	1.4.3, 1.11.7, 1.11.8 - We have concern that the committee comments "biomarkers appear to be of most use when measured at baseline or admission" and "clinicians should consider relative biomarker levels and their change over time, as well as absolute values" have not been fully incorporated into the proposed	Thank you for your comment. The committee agreed that absolute biomarker levels and their change over time can both give important information to clinicians. Recommendation 1.11.8 notes both high levels and

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				Guidelines. The absence of PCT at admission (1.4.3) means that there is no baseline for a second measurement on days 3-4 (1.11.7) and negates the opportunity to evaluate the delta biomarker level and assess treatment failure (1.11.8).	levels that do not improve; this is further clarified in the rationale. The committee agreed that a baseline level is not always required for a measurement on day 3 or 4 to be useful because the absolute level at this point can still provide important information.
Thermo Fisher Scientific	Guideline	011, 030 & 031	General	Biomarkers recommendations: 1.4.3 and 1.11.7 to 1.11.8 We would like to express our concerns with NICE's decision to 1) not include (or even recommend) PCT on admission as per CRP, and 2) exclude recommending PCT as a clinical aid to support the discontinuation of antibiotics in patients hospitalized with CAP/HAP. We also believe that these two topics belong together and should be discussed holistically. PCT and CRP are biomarkers of inflammation that can support clinical decisions in the diagnosis and management of pneumonia patients. There is strong randomised trial evidence that PCT is of higher clinical relevance, particularly for antibiotic stewardship. RCTs performed across different Countries including the UK (i.e. the ADAPT-Sepsis study funded by NIHR HTA following NICE research recommendations), consistently show that a PCT-guided approach to	Thank you for your comment. The committee reviewed the evidence on admission biomarkers and recommended measuring CRP on admission. Further information on their discussions of the evidence are available in the rationale and impact section of the guideline, and in the evidence review. The use of biomarkers for diagnosis or the initiation of antibiotics was out of scope for this update. The studies you cite all relate to PCT-guided antibiotic de-escalation in patients with sepsis and are not specific to people with pneumonia. They do not meet criteria for inclusion in our evidence review: ▪ ADAPT-Sepsis included adults in intensive care on IV antibiotics for suspected sepsis. The presumed site of infection causing sepsis was respiratory tract for 49% - this does not reach our inclusion threshold of >75% with pneumonia. Subgroup analyses showed no difference in duration of antibiotics to 28

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				antibiotic management leads to reduced antibiotic exposure without compromising patient safety and potentially even decreasing all-cause mortality (**de Jong *et al 2016*** *Lancet Infect Dis* - SAPS study*;* **Schuetz *et al 2018*** *Lancet* - patient level meta-analysis*;* **Kyriazopoulou *et al 2021*** *Am J Respir Crit Care Med* - PROGRESS trial). This is of high clinical significance and in clear contrast to the level of evidence accepted for CRP, where only prospective cohort studies are included. Such studies are more susceptible to bias due to their observational nature (Evidence review H: compare Grade tables F1.1 and F1.3 for PCT with Grade table F.1.2 for CRP). While we understand the committee's concerns that the average standard duration of antibiotic treatment used in these trials of 10 to 12 days is longer than the UK's current recommended practice of 5 days, we question whether the 5 recommended days reflect the real-world practice in UK hospitals. Evidence from the ADAPT-Sepsis trial has demonstrated that across 41 UK NHS hospitals, the mean duration of antibiotic treatment was around 10 days in standard care, suggesting prescribers frequently extend antibiotic courses. This result included a subgroup of CAP and HAP patients (ADAPT Sepsis - S3) Supplemental Online Content eFigures 2-3).	days for CAP or HAP patients and there are no results reported for safety outcomes in the pneumonia subgroups. ▪ De Jong 2016 is a study of critically ill patients admitted to ICU for assumed or proven infection. Presumed infection site is pulmonary in 65% which does not meet the >75% pneumonia threshold and the paper does not report any subgroup analysis by diagnosis. ▪ Schuetz 2018 meta-analysis included patients with ARI and included studies of any upper or lower RTI. Only 3 of the 26 studies were listed as clinical diagnosis of pneumonia or CAP with x-ray confirmation, and 2 of these were studies of low-risk outpatients (our review protocol included hospitalised patients only). The remaining paper was Christ-Crain 2006 which was included in our evidence review. ▪ Kyriazopoulou et al 2021 included patients with sepsis. 43.8% CAP, 1.2% HAP, 16% HCAP, so total proportion of the sample with pneumonia is below the >75% threshold for inclusion in our review. The paper does not report subgroup analyses for pneumonia.

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					The evidence review on biomarkers was separated into 2 sections – an intervention review of RCTs on PCT for antibiotic de-escalation, and a prognostic review of prospective cohort studies on the association between biomarkers and adverse outcomes. Prospective cohort studies on both CRP and PCT were included in the prognostic review and informed all the recommendations on biomarker testing.
Thermo Fisher Scientific	Guideline	030 - 031	023 - 002	The recommendation suggests biomarker review after 3 to 4 days when there is evidence that daily clinical review is a superior strategy in severe infection management. It also seems at odds with the UKHSA 'Start Smart Then Focus', a campaign designed to reduce the risk of antimicrobial resistance (AMR) while safeguarding the quality of care for patients with infection. The UKHSA evidence-based guidance suggests "Review and revise the clinical diagnosis and the continuing need for antimicrobials by 48 to 72 hours and document a clear plan of action". De-escalation is in general safe, may offer cost savings when unnecessary antibiotics are discontinued, and	Thank you for your comment. The evidence review did not directly compare daily biomarker review with biomarker review after 3 to 4 days, so it is not possible to establish that daily review is a superior strategy. The committee noted that daily PCT testing for all pneumonia patients is likely to be more expensive than the cost savings of approximately 1 day reduction in antibiotic use.

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				reduced risk of antimicrobial resistance and reduced toxicity and side-effects may be important See also the Surviving Sepsis campaign Guideline 2021 - Recommendation 29 *"For adults with sepsis or septic shock, we suggest daily assessment for de-escalation of antimicrobials over using fixed durations of therapy without daily reassessment for de-escalation.*" (Critical Care Medicine 49(11): p e1063-e1143, November 2021.)	
Thermo Fisher Scientific	Guideline	030 - 031	023 - 002	This recommendation may imply that there is equivalence between CRP and Procalcitonin with regards to supporting antibiotic stewardship. The wording underestimates the strength of evidence supporting PCT and its critical role particularly in hospitalised and critically ill patients. Equating CRP and PCT in this context overlooks significant differences in their specificity, kinetics, diagnostic confidence, and clinical utility. CRP is used widely but has low specificity for bacterial infection which often leads to misinterpretation, potentially prolonging or triggering unnecessary antibiotic use. PCT has consistently demonstrated superior performance across multiple randomised trials	Thank you for your comment. Evidence from the ADAPT-Sepsis trial does not meet inclusion criteria for our evidence review because it is based on a population with sepsis (presumed site of infection causing sepsis was respiratory tract for only 49% which does not meet the >75% pneumonia threshold), so conclusions from the trial about PCT guiding safe and effective antibiotic decisions in sepsis cannot be applied to this pneumonia guideline. The evidence review on biomarkers was separated into 2 sections – an intervention review of RCTs on PCT for antibiotic de-escalation, and a prognostic review of prospective cohort studies on the association between biomarkers and adverse outcomes. Prospective cohort

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				in guiding safe and effective antibiotic decisions, especially when used serially (see NIHR HTA ADAPT-Sepsis Study) The contrast for evidence threshold is clearly illustrated in **Evidence Review H**, CRP evidence includes only prospective cohort studies that are more susceptible to bias due to their observational nature (Evidence review H: compare Grade tables F1.1 and F1.3 for PCT with Grade table F.1.2 for CRP). PCT remains the only 'essential' biomarker recommended by the World Health Organization for de-escalation of antibiotics in Sepsis & Respiratory Infection (*Second WHO Model List of Essential In Vitro Diagnostics – 2019*).	studies on both CRP and PCT were included in the prognostic review and informed all the recommendations on biomarker testing. Prospective cohort studies were included because there is very limited RCT evidence on biomarkers and indicators of prognosis (other than the RCT evidence on PCT for antibiotic discontinuation).
Thermo Fisher Scientific	Guideline	030 - 031	023 - 002	It's unclear what steps should be followed if the biomarkers are elevated on day 3 or 4, i.e. should the biomarkers continue to be measured daily allowing consideration of their trajectory/delta as per the evidence from the ADAPT-Sepsis study?	Thank you for your comment. Evidence from the ADAPT-Sepsis trial does not meet inclusion criteria for our evidence review because it is based on a population with sepsis (presumed site of infection causing sepsis was respiratory tract for only 49% which does not meet the >75% pneumonia threshold). There was no evidence on daily review after 3 or 4 days. The committee agreed that clinician judgement

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					would be used to decide whether biomarker review should continue.
Thermo Fisher Scientific	Guideline	General	General	Extending NICE's recommendation to include PCT measurement on admission is unlikely to result in a significant change in clinical & patient workflow. As noted by the committee, the PEACH study (2020) found that approximately 80% of hospitals in the UK had access to routine PCT. Further, PCT is accessible to most NHS pathology biochemistry laboratories via in situ immunochemistry analysers, there would be no outlay for new equipment or additional training for laboratory staff. Thermo Fisher recognise that PCT is a tool to be used alongside clinical decision-making. Clinicians will make the ultimate decision on which biomarker to use and how to manage the patient. The goal of the guidance should be to support clinicians in making evidence-based decisions that will benefit their patients, and this can only be achieved if the guidance includes clarity on the type and quality of information that can be derived from each of the biomarkers. We believe these refinements will help align the guideline with the best available evidence, promote	Thank you for your comment. The committee reviewed the evidence on admission biomarkers and concluded that measuring CRP on admission is sufficient. Further information on their discussions of the evidence are available in the rationale and impact section of the guideline, and in the evidence review. All recommendations are underpinned by clinical decision making.

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				safer antibiotic practices, and support more effective stewardship in the management of pneumonia.	
Thermo Fisher Scientific	Evidence Review H	1.2.1 & General	General	1.2.1 - We appreciate the extensive evidence review [H] conducted by NICE to evaluate the clinical and cost-effectiveness of monitoring biomarkers to determine when to de-escalate care for people in hospital with CAP or HAP. However, several key pieces of evidence relating to the use of PCT to guide antibiotic treatment in patients hospitalised with CAP/HAP were not considered, including: **NIHR HTA RCT conducted in the UK (published after the NICE evidence review)** - **ADAPT-Sepsis Randomized Control Trial (Dark P *et al.*, *JAMA* 2024):** Multicentre double-blinded RCT involving 2760 patients in 41 NHS intensive care units in the UK comparing 3 arms: PCT-guided arm, CRP-guided arm and standard of care. Main findings: PCT-guided care was superior to standard care and significantly reduced antibiotic duration by ~10% (0.88 days (p=0.01)) without compromising patient safety. The single	Thank you for your comment. The studies you cite all relate to PCT-guided antibiotic de-escalation in patients with sepsis or ARI and are not specific to people with pneumonia. They do not meet criteria for inclusion in our evidence review: ▪ ADAPT-Sepsis included adults in intensive care on IV antibiotics for suspected sepsis. The presumed site of infection causing sepsis was respiratory tract for 49% - this does not reach our inclusion threshold of >75% with pneumonia. Subgroup analyses for pneumonia are only based on ~300 patients and showed no difference in duration of antibiotics to 28 days for CAP or HAP patients, and there are no results reported for safety outcomes in the pneumonia subgroups. ▪ De Jong 2016 is a study of critically ill patients admitted to ICU for assumed or proven infection. Presumed infection site is pulmonary in 65% which does not meet the >75% pneumonia threshold and the paper does not report any subgroup analysis by diagnosis so pneumonia-specific data cannot be extracted.

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				most common condition in ADAPT-Sepsis was community acquired pneumonia. CRP was unable to show superiority over standard care for antibiotic duration and crucially did NOT meet the non-inferiority safety margin. The ADAPT-Sepsis trial was designed to respond to evidence gaps identified by NICE and was funded by NIHR HTA following a specific commissioning brief call (15/99). In Oct 2020, the Chief Medical Officer/Deputy Chief Medical Officers recommended the ADAPT-Sepsis trial as NIHR Urgent Public Health (UPH) research. **Other significant RCTs fitting the PICO criteria** - **SAPS Trial (De Jong *et al., Lancet Infect Dis* 2016): *"Efficacy and safety of procalcitonin guidance in reducing the***	▪ Christ-Crain 2004 is a study of patients admitted with suspected LRTI; only 36% of patients had pneumonia so this does not meet the >75% pneumonia threshold. 1 outcome (antibiotic initiation) is reported separately for CAP patients but the evidence review focused on biomarkers for treatment de-escalation, not initiation. Even if the data on antibiotic initiation was added to the evidence review, it would not change the overall effect estimate for this outcome and no recommendations were made in this area so it would not have any impact on the committee's decisions. ▪ Schuetz 2018 meta-analysis included patients with ARI and included studies of any upper or lower RTI. Only 3 of the 26 studies were listed as clinical diagnosis of pneumonia or CAP with x-ray confirmation, and 2 of these were studies of low-risk outpatients (our review protocol included hospitalised patients only). The remaining paper was Christ-Crain 2006 which was included in our evidence review. They do not list the individual studies that their pneumonia-specific outcomes are based on, so it is not possible to confirm whether these subgroup analyses are based on patients with

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				duration of antibiotic treatment in critically ill patients: a randomised, controlled, open-label trial" Multicentre RCT in 15 hospitals in the Netherlands with 1575 critically ill patients in ICU, that includes a subgroup-analysis for CAP and HAP patients. Main findings: Significant reduction of antibiotic exposure not only in the overall study population (-19% relative reduction, p<0.0001), but also in a sub-group of CAP and HAP patients (p=0.005 and p=0.0012, respectively). Study demonstrated that reduction in antibiotic exposure with aid of PCT, was not only safe but it resulted in lower mortality than the control group (-5.4% and - 6.1% lower mortality in PCT group at Day 28 and 1 year, respectively). - **(Christ-Crain *et al.*, *Lancet* 2004): *"Effect of procalcitonin-guided treatment on antibiotic use and outcome in lower respiratory tract infections: cluster-randomised, single-blinded intervention trial"***	pneumonia or a broader population of LRTI patients. ▪ PROGRESS Trial Kyriazopoulou et al 2021 included patients with sepsis. 43.8% CAP, 1.2% HAP, 16% HCAP, so the total proportion of the sample with pneumonia is below the >75% threshold for inclusion in our review. The paper does not report subgroup analyses for pneumonia. ▪ PRORATA Trial Boudma 2010 was a study of critically ill patients in ICU with suspected bacterial infections. The infection site is pulmonary in 71% of patients. Proportion of CAP was 25.7% in the PCT arm and 32% in the control arm, and for HAP it was 9.4% in the PCT arm and 14% in the control arm. The overall proportion of pneumonia patients was less than the >75% threshold. ▪ Nobre 2008 was an RCT in 79 patients with severe sepsis or septic shock. Sepsis of pulmonary origin was 67% in the control group and 64% in the PTC group. There was no specific information on pneumonia or the number of patients with this diagnosis. This does not meet the >75% pneumonia threshold. Results are reported for the full sample only; no subgroup analyses by diagnosis.

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				Cluster-randomised, controlled, single-blinded intervention trial in 243 patients with lower respiratory tract infections, that includes a sub-group analysis for CAP patients. Main findings**:** The relative risk of antibiotic exposure in the procalcitonin group was 0.39, with an absolute risk reduction of 50%. Specifically in patients with CAP, there was a 10% reduction of the rate of antibiotic prescriptions (p=0.03). ***Patient level meta-analysis*** **Schuetz *et al., The Lancet* 2018: - *"Effect of procalcitonin-guided antibiotic treatment on mortality in acute respiratory infections: a patient level meta*-analysis. "** Individual patient data analysis of 6,708 patients taken from 26 eligible RCTs in 12 countries. It proves the safety of the PCT approach to reduce antibiotic exposure and the positive impact in the survival of the patients. Main findings: 30-day mortality was significantly lower in the PCT group (9% vs. 10% in the control group), PCT guidance was also associated with a reduction in both	▪ Martin Loaches 2014 was a case-control study looking at predictors of treatment failure; it did not test PCT-guided antibiotic treatment.

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				antibiotic exposure (-2.4 days) and antibiotic-related side-effects (16% vs. 22%). **Three RCTs that are relevant giving the high proportion of pneumonia patients (>50%)** - **PROGRESS Trial (Kyriazopoulou *et al., Am J Respir Crit Care Med,* 2021). "*Procalcitonin to Reduce Long-Term Infection-associated Adverse Events in Sepsis. A Randomized Trial"*** Prospective, multicentre, randomized (RCT) in Greece (266 patients) Main findings: PCT-aided antibiotic reduction leads to long-term improved clinical outcomes, including reduced mortality (survival benefit). Comparing the PCT arm with standard care, the median length of antibiotic therapy was 5 days (range, 5–7) versus 10 days (range, 7–15) (P<0.001), while the rate of infection-associated adverse events until Day 180 was 7.2% versus 15.3% (P=0.045) and 28-day mortality was 15.2% versus 28.2% (P=0.02). - **PRORATA Trial (Bouadma *et al., Lancet*, 2010). "*Use of procalcitonin to reduce***	

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				patients' exposure to antibiotics in intensive care units (PRORATA trial): a multicentre randomised controlled trial" Prospective, multicentre, randomized (RCT) in 7 intensive care units in France (621 patients) Main findings: PCT-aided antibiotic treatment substantially lowers antibiotic exposure and is non-inferior to standard care with respect to mortality and outcomes. Significantly more days without antibiotics in the PCT group vs. the control group - 2.7 days less (p<0.0001) - **Nobre et al., *Am J Respir Crit Care Med*, 2008. *"Use of procalcitonin to shorten antibiotic treatment duration in septic patients: a randomized trial"*** Randomized, controlled, open interventional trial in patients with severe sepsis and septic shock (79 patients) Main findings: PCT guidance reduced antibiotic exposure in critically ill patients with severe sepsis and septic shock, without worse mortality or adverse outcomes. PCT guidance resulted in a 4-day reduction in the duration of antibiotic	

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				therapy (per protocol, n=68, P=0.003) and a smaller overall antibiotic exposure (P=0.0002). A 2-day shorter intensive care unit stay was also observed in patients assigned to the PCT group (P=0.03). **2023 International Guidelines for the management of severe community-acquired pneumonia (ESICM/ERS/ESCMID/ALAT):** Endorses PCT to support de-escalation, monitor response, and individualize antibiotic duration in severe CAP, reflecting broad international consensus. **Martin-Loeches et al., *Respiratory Research*, 2014:** In patients with CAP, elevated day-3 PCT levels (in comparison to hospitalization day levels) independently predicted late treatment failure, highlighting the value of serial biomarker measurement in real-time treatment assessment.	
UK Health Security Agency	Guideline	013	005	1.5.2 - Give oral antibiotics first line if the person can take oral medicines, and the severity of their condition does not require intravenous antibiotics. [2019]": this perpetuates the myth that intravenous antibiotics are required for severe infections, while the choice of route	Thank you for your comment. This recommendation is out of scope for this update.

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				of administration is better informed by pharmacokinetic/pharmacodynamic factors.	
UK Health Security Agency	Guideline	015 - 016	Table 1 & Table 2	stronger wording around penicillin allergy (higher threshold to avoid penicillins) - most of allergy labels are incorrect, and second-line treatment for pneumonia is less effective, leading to suboptimal outcomes and unnecessary harm.	Thank you for your comment. This table is out of scope for this update.
UK Health Security Agency	Guideline	General	General	Title Page - introductory box, in addition to not covering COVID-19 pneumonia, I suggest adding "or other viral aetiologies of pneumonia"	Thank you for your comment. The committee highlighted that bacterial and viral pneumonias can co-exist, so other viral aetiologies of pneumonia were not excluded.
UKHSA-Standards Unit	Guideline	004	006	Numbers in the contents page do not correspond to the page number i.e. Investigations in hospital states page 8, but is on page 10	Thank you for your comment, this has been amended.
UKHSA-Standards Unit	Guideline	006	011	1.4.4- Microbiological tests- We think a link to the UK SMI web page UK Standards for Microbiology Investigations would be useful under this title.	Thank you for your comment. This has not been linked to as these are procedures for clinical microbiology and beyond the remit of this guideline.
UKHSA-Standards Unit	Guideline	010	004	Clarification required as to whether this title reflects procedures conducted on patients in hospital or testing procedures conducted in hospitals. If the latter, 1.4 Investigations in hospital- Microbiological testing may not be limited to laboratories on hospital premises and may be conducted in public health, private or centralised hub labs. Could the title be changed to	Thank you for your comment. This title reflects procedures requested in hospitals. The recommendations in this section cover the tests that should be done rather than where the test is conducted.

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				reflect this, i.e. 'Investigations in hospitals and associated centers?	
UKHSA-Standards Unit	Guideline	011	010	1.4.5- We think that sputum collection for *Mycobacterium tuberculosis* investigation should be considered for community patients with a persistent productive cough. The inclusion of risk factors such as malaise, weight loss, night sweats, ethnic origin, social deprivation could also be included.	Thank you for your comment. TB is out of scope for this update so we cannot make recommendations about microbiological testing for TB.
UKHSA-Standards Unit	Guideline	011	017	1.4.6- We would suggest that consideration of whether the patient is immunocompromised should be added here.	Thank you for your comment. People who are immunocompromised are out of scope for this update.
UKHSA-Standards Unit	Guideline	011	017	1.4.6 -We think addition of lower respiratory samples should be added to this alongside sputum, as bronchoalveolar lavages and/or pleural fluids may be considered for adults with moderate- or high-severity community-acquired pneumonia.	Thank you for your comment. The evidence review on microbiological tests excluded bronchoalveolar lavages and more invasive sampling techniques, so it is not possible to include these sampling methods in the recommendation.
UKHSA-Standards Unit	Guideline	011	017	1.4.6-We think consideration to be given to rare pathogens in patients who are immunocompromised including *Coxiella burnetii*, *Histoplasma* and *Strongyloides stercoralis*.	Thank you for your comment. People who are immunocompromised are out of scope for this update.
UKHSA-Standards Unit	Guideline	012	003	1.4.7- We think that sputum collection for *Mycobacterium tuberculosis* investigation should be considered for community patients with a persistent productive cough. The inclusion of risk factors such as malaise, weight loss, night sweats, ethnic origin, social deprivation could also be included.	Thank you for your comment. TB is out of scope for this update so we cannot make recommendations about microbiological testing for TB.

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UKHSA-Standards Unit	Guideline	033	019	Pneumonia is defined here as 'Pneumonia refers to both community-acquired pneumonia and hospital-acquired pneumonia'. We request that this definition is refined to include the pathogology and clinical presentations of this syndrome. This has been included for the lower respiratory tract infections definition.	Thank you for your comment. We have expended the definition to include a link to the NICE clinical knowledge summary for pneumonia which contains more information about the clinical presentation of pneumonia.
UKHSA-Standards Unit	Guideline	General	General	There seems to be no reference to British Thoracic Society pneumonia guidelines within the main guideline, and only a vague mention in Evidence review C – Microbiological tests on Table 15. This would be helpful to include in the main text.	Thank you for your comment. It was noted that the BTS pneumonia guidelines were last updated in 2009 so the committee agreed that the current work was more recent and based on more up to date evidence.
University Hospitals Bristol and Weston NHS Foundation Trust	Guideline	008	001	Box 2 and draft recommendation 1.2.9 continues to recommend that hospitals use CURB65 as the prognostic tool of choice, alongside clinical judgment. The longstanding evidence on CURB65 is that it is <u>not</u> sufficiently accurate to reliably guide treatment decisions, particular in younger adults under 40 years. We believe NICE's continuing and seemingly uncritical support for use of CURB65 is misguided, and not in line with international best practice.	Thank you for your comment. The recommendations on using CURB65 to assess risk of death (1.2.7 and box 2) and to stratify adults by disease severity (1.2.8) were not in scope for this update. Recommendation 1.2.9 was updated only with respect to place of care, specifically the addition of hospital at home and SDEC services, not the use of CURB65. There was no evidence review on the accuracy of CURB65 or any other prognostic tools as this was not part of this update.

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				We understand why CURB65 has been an easy tool to recommend. It is simple to apply, based on just 5 components. There are other better-performing prognostic tools that have been developed and in use internationally, such as PSI/PORT, SCAP, and SMART-COP. That is why in recent international pneumonia guidelines – there is support for the more detailed tools such as the ATS PSI (20-point score) or SMART-COP score (8-point score). We accept that ease of use in a prognostic tool is an important factor but should not be the determining factor behind its continuing recommendation. Why doesn't NICE acknowledge that CURB65 has weaknesses, and that other tools are available and can be used in the NHS? However – no such tool is perfect and you are right to stress the importance of clinical judgement. References Metlay JP, Waterer GW, Long AC, Anzueto A, Brozek J, Crothers K, et al. Diagnosis and treatment of adults with community-acquired pneumonia. an official clinical	

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				practice guideline of the ATS and IDSA. Am J Respir Crit Care Med 2019; 200(7):e45–e67. Aujesky D, Auble TE, Yealy DM, Stone RA, Obrosky DS, Meehan TP, et al. Prospective comparison of three validated prediction rules for prognosis in community-acquired pneumonia. Am J Med 2005;118:384–392	
University Hospitals Bristol and Weston NHS Foundation Trust	Guideline	012	012	The third bullet point of draft recommendation currently numbered 1.4.7 recommends 'do not routinely use urinary antigen tests. [2025]'. We suggest that this draft recommendation in younger children is correct, but in children over 12 years of age the guideline recommendation should be in line with adults, where testing is recommended.	Thank you for your comment. The evidence review contained very limited evidence on urinary antigen tests for children and it was not applicable to the UK context so the committee agreed that it was not possible to make a recommendation about urinary antigen testing for children. They further noted that urinary antigen testing is not required for children over 12 years because these illnesses are very rarely seen in children.
University Hospitals Bristol and Weston NHS Foundation Trust	Guideline	014	024	The draft recommendation currently numbered 1.6.4 states…'Offer 3 day course of antibiotics…..with non-severe community acquired pneumonia' We suggest you then add a sentence to say 'If the clinician is satisfied that a diagnosis of non-severe community acquired pneumonia can be made, a 3-day course of antibiotics should be offered…	Thank you for your comment. The recommendation assumes that the clinician is satisfied a diagnosis of non-severe community acquired pneumonia can be made, this does not need to be specified in the recommendation. The rationale and impact section highlights that antibiotics are usually less effective or may be ineffective in children with a cough or LRTI, so it is important the diagnosis is CAP.

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				We prefer this sentence as it is a nod to the fact that there are no good prediction tools and also that not all respiratory symptoms should be given antibiotics .	

**None of the stakeholders who comments on this clinical guideline have declared any links to the tobacco industry.*