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Community-acquired pneumonia

FACTORS ASSOCIATED WITH PROLONGED TIME TO CLINICAL STABILITY IN HOSPITALISED ADULTS WITH COMMUNITY-ACQUIRED PNEUMONIA

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Objectives: Time to clinical stability is a key point in the management of community acquired pneumonia (CAP). It influences decision-making concerning hospital discharge and treatment length. The aim of our study was to identify the factors related to prolonged time to clinical stability in CAP.

Methods: Observational analysis of a prospective cohort of nonseverely immunosuppressed hospitalised adults with CAP (2002-2012). Clinical stability was defined as a temperature of ≤37.2C, heart rate ≤100 beats/min, respiratory rate ≤24 breaths/min, systolic blood pressure ≥90 mm Hg, oxygen saturation ≥90%, normal mental status and adequate oral intake. Patients with prolonged time to clinical stability (above the median) were compared with the remaining patients. A logistic regression analysis was performed to identify independent predictors associated with prolonged time to clinical stability.

Results: A total of 1751 hospitalised patients with CAP were studied. The median time from hospital admission to clinical stability was 3 days (interquartile range 2-5 days). Seven hundred sixty-one (43.5%) patients had prolonged time to clinical stability (above the median of 3 days). Patients with prolonged time to clinical stability were older (P=.001) and had more frequently comorbidities (P=.01). No significant differences in sex, current smokers, alcohol abuse and prior pneumococcal and influenza vaccination were documented between study groups. Altered mental status (P=.003), pleural effusion (P=.002), respiratory failure (P<.001) and multilobar pneumonia (P<.001) were more commonly documented in patients with prolonged time to clinical stability. Conversely, the frequency of causative pathogens and bacteraemia were similar in both groups. Similarly, empiric antibiotic timing and the frequency of adequate empiric antibiotic therapy and antibiotic monotherapy were comparable between study groups. Patients with prolonged time to clinical stability had more commonly acute cardiac events (P=.002) and adverse drug reactions, mainly phlebitis (P<.001). After adjustment in a multivariate analysis, independent factors associated with prolonged time to clinical stability were altered mental status (OR 1.38 95% CI 1.03-1.85), pleural effusion (OR 1.61 95% CI 1.61-2.17), multilobar pneumonia (OR 1.39 95% CI 1.12-1.73), acute cardiac events (OR 1.68 95% CI 1.12-2.53) and phlebitis (OR 2.07 95% CI 1.5-2.85).

Conclusions: Time to clinical stability in hospitalized patients with CAP is mainly determined by the severity of the illness at hospital admission. Potential preventable factors, such as acute cardiac events and phlebitis, also delay time to reach clinical stability in CAP patients.