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Role of the Stratification of Patients with Community-Acquired Pneumonia: the Importance of the Tools Adjusted to Local Reality

El papel de la estratificación de pacientes con neumonía adquirida en la comunidad: la importancia de las herramientas adecuadas a la realidad local

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Community-acquired pneumonia (CAP) is still an important cause of morbidity and mortality in the adult population[1]. One important aspect for the management of this disease is the decision-making process regarding the suggested antibiotic treatment, the choice between outpatient and inpatient treatment (both in general areas and intensive care units) and the assessment of the patient's prognosis.

Some currently validated tools for the assessment of patients with community-acquired pneumonia (CAP) are the CURB 65 score (confusion, urea, respiratory rate, blood pressure, and age ≥ 65 years)[2], which allows for risk estimation and choice between outpatient and inpatient management, and the Pneumonia Severity Index (PSI)[3].

Randomized, multicenter studies showed that the PSI is superior to CURB 65 in terms of deciding between hospitalization and outpatient management without affecting mortality[4]. However, the ATS/IDSA (American Thoracic Society/Infectious Diseases Society of America) Guidelines[5] emphasize that these indices must not be used separately when determining whether the patient is to be hospitalized or not; instead, they must be supplemented with the assessment of other clinical and psychosocial aspects, the possibility to receive outpatient drugs, etc. Given the fact that neither the CURB 65 nor the PSI were designed to define the hospitalization level of care, the same guidelines suggest admission to an intensive care unit in cases of hypotension requiring vasopressors or respiratory failure requiring mechanical respiratory assistance; and in cases under different conditions, the recommendation is to apply a series of minor criteria (breathing rate > 30/min, PaO_2/FiO_2 [arterial oxygen pressure/fraction of inspired oxygen] < 250, multilobar infiltrates, confusion, urea > 20 mg/dL, white blood count < 4000 cells/mL, platelets < 1000 000/mL, hypothermia and hypotension requiring fluid resuscitation) plus the clinical criterion regarding the need to increase treatment intensity.

In this RAMR issue, Corona Martínez et al report the use of an index for the stratification of patients with community-acquired pneumonia, as a consequence of an unfavorable experience with the use of another tool, the PSI. The authors emphasize its prognostic value but also indicate that the tool has been designed to guide the physician through the decision-making process related to the patient's management. We should emphasize it is a user-friendly tool, since it is based on clinical and radiological data.

This publication shows the importance of having tools for evaluating patients with community-acquired pneumonia that allow us to assess the patient's risk and simplify the decision-making process, and that can be adjusted to local needs.

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