

# Letters to the editor

## Re: “Community-acquired pneumonia”

Kudos to Drs. Lorber and Fekete for pointing out the inanity of the term CAP (Spring 2011, pp. 19–21). For years I have tried unsuccessfully to teach our residents not to use the term, but to think in terms of the etiology of the infection. However, given the endorsement of the term CAP by both the IDSA and the ATS we have little chance of eliminating it from the lexicon. In most cases they use the term CAP in place of pneumococcal pneumonia (the most common cause of pneumonia in adult civilians), because they never attempt to isolate a pathogen from the sputum. As the authors point out, clinical microbiology has been sadly devalued by hospital administrators, who outsource the work, and most physicians, who don't order the tests. One of the consequences of not making an etiologic diagnosis is the reliance on broad spectrum antibiotics, and this is one practice that drives the current epidemic of antibiotic resistance. It also contributes to the shockingly high incidence of nosocomial *Clostridium difficile* infections.

The authors also point out that there is an overuse of broad spectrum antibiotics for anyone admitted with a respiratory complaint. This is in response to the standard imposed by the Joint Commission, that “initial antibiotic be received within six hours of hospital arrival” (the previous standard was four hours). However, I disagree with the authors that there are studies that provide a rationale for this practice. In the article they cite,<sup>1</sup> the graph relating time of administration to outcome is very revealing; the

group with the highest mortality was the one that received antibiotics within one hour of arrival. The most likely explanation is that the sickest people got treated fastest, and of course were the most likely to die. Similar confounders are almost certainly at work for those whose therapy was delayed. Observational studies such as this one can never establish causality, only associations. This is a very weak reed to support a national health care policy with many unintended consequences.

I can only hope that in the future hospitals will be required to have microbiology laboratories as part of accreditation and that physicians will again learn to turn to the laboratory to them help to diagnose and treat this group of patients rationally. Laboratories really can diagnose pneumococcal pneumonia if they get sputum from the patient before antibiotics are started. That will not always be possible, but it is a goal.

### Reference

1. Meehan TP, Fine MJ, Krumholz HM, et al. Quality of care, process, and outcomes in elderly patients with pneumonia. *JAMA* 1997; 278: 2080–84.

Joshua Fierer, MD, FIDSA  
(AQA, *New York University*, 1963)  
*University of California, San Diego*,  
*School of Medicine*  
*VA Healthcare San Diego*  
*E-mail: jfierer@ucsd.edu*

.....

I understand and fully support the point made by Drs. Lorber and Fekete in their article on community-acquired pneumonia (Spring 2011, pp. 19–21), which suggests that the term is so broad and nonspecific that it under-

mines the thoughtful investigation of the individual patient. However, I would be remiss if I did not point out that the authors fall into exactly the same trap when they observe that the patient had a “left mid-lung infiltrate.” In fact, this patient has a cavitory lesion in the superior segment of the left lower lobe with an associated left pleural effusion. Those observations, had they been made, would have strongly suggested the correct diagnosis of *Mycobacterium tuberculosis* infection at the time of the initial X-ray examination. Failure to correctly characterize the “infiltrate” allowed the physicians caring for this patient to proceed down the wrong track. I would strongly suggest that, had the film been reviewed by a trained, experienced physician, the correct diagnosis would have been made at the outset and the patient's subsequent complicated course potentially avoided. Failure to appreciate the precise location of the abnormality (superior segment of the left lower lobe), the fact that it was cavitory with an air fluid level within it, and the presence of an associated left pleural effusion is almost unforgivable. Reliance on a generic description such as “left mid-lung infiltrate” is simply too imprecise and leads to the same kinds of errors as lumping all pneumonias into the “community-acquired pneumonia” category creates. As the authors point out, “language matters,” as does the need to fully appreciate the abnormalities so clearly demonstrated on the initial chest radiograph.

Carl E. Ravin, MD  
(AQA, *elected as faculty, Duke University*, 1986)  
*Duke University Medical Center*  
*Durham, North Carolina*  
*E-mail: carl.ravin@duke.edu*

