Response to "Treatment guidelines for nosocomial pneumonia: Agreeing to disagree"

In the November/December 1993 issue of The Canadian Journal of Infectious Diseases, a conference report dealing with the initial antimicrobial treatment of hospital acquired pneumonia was published (1). An editorial by Dr Bruce Light accompanied the article and it is to this editorial which we are now responding (2).

Dr Light points out a number of issues that we certainly agree with. He states that, ideally, for guidelines to be meaningful, the following conditions should be met: first, a clearly defined diagnosis; second, knowledge of the usual microbial etiology and uniformity of pathogens in different places and at different times; and third, good comparative data regarding efficacy and cost of potential treatments.

However, the editorial then points out that these conditions are not met for nosocomial pneumonia, and that in the published literature a number of these issues are still hotly debated by clinicians and investigators alike.

Are these reasons not to attempt to develop appropriate treatment guidelines? One could argue that it is exactly such difficult diagnostic and therapeutic problems for which the practising physician requires some assistance and for which guidelines are most appropriate. If, in fact, clear case definitions exist, the pathogens are known and treatment is obvious, what is the need for guidelines?

We strongly support the concept of editorials and feel that they play an important role in informing the readership of a journal about a specific issue. However, one should expect factually correct information. We are concerned that the editorial, in trying to outline the "difficulties faced by the conference participants" has misinterpreted and misrepresented the information in the tables provided in the guidelines. For example, the description of the treatment options for patients with pneumonia following thoracoabdominal surgery is wrong. Also, the attempt to draw a parallel between the pneumonia guidelines and the Canadian guidelines for sexually transmitted diseases (3) is inappropriate. Pneumonia and sexually transmitted diseases have little in common, particularly when it comes to diagnosis. The former is exceedingly difficult to diagnose accurately, whereas the latter are much more easily dealt with.

Hospital acquired pneumonia is a very common and very serious illness. The fact that we do not have definitive criteria for diagnosis does not mean we should not have treatment guidelines. Physicians must contend with this disease on a daily basis and formulate therapeutic regimens as best they can. The editorial missed the point that the guidelines are not meant to provide a complete management or treatment course for a patient with pneumonia. As clearly stated in the guidelines, "The purpose of these guidelines is to help the practising physician in the choice of initial antimicrobial management of patients with hospital acquired pneumonia". The physician is certainly free to modify initial treatment once additional information becomes available.

The editorial expresses concern that multiple treatment options are provided, then states, "... for a disease like nosocomial pneumonia, it is not possible to make a specific recommendation that will be valid for all hospitals at all times." It is for precisely this reason that several treatment options are suggested. When treating any infectious disease, there are several variables that must be considered by the physician. These include: the in vitro susceptibility of the pathogen(s); the pharmacokinetics of the drug as well as its efficacy, toxicity and cost; and its potential for interactions with other drugs that the patient may be taking. By providing the physician with a choice of possible drugs, he or she can then consider the variables as they pertain to a particular patient and select the most appropriate therapy.

The need for guidelines for difficult and hard to
diagnose entities such as nosocomial pneumonia is apparent, and inappropriate therapy of nosocomial pneumonia adds to mortality (4). In developing these guidelines, we were fully aware of the dilemmas facing physicians who must deal with this problem. It is precisely because of the variation in institution-specific microbial epidemiology, bacterial resistance patterns and the presence or absence of risk factors in patients that the guidelines were developed in their present format.

We believe that these guidelines provide an organized approach to a difficult clinical problem and will promote the use of appropriate therapy in a larger percentage of patients than is currently the case. The guidelines are intended as an aid to the physician and not as a substitute for clinical decision making and independent objective thought on the part of clinicians. We feel that these guidelines represent an organized and logical approach to a complex and difficult problem and have faith in the ability of physicians to think critically and to use such guidelines appropriately.

REFERENCES
1. Mandell LA, Marrie TJ, Niederman MS. The Canadian Hospital Acquired Pneumonia Consensus Conference Group. Initial antimicrobial treatment of hospital acquired pneumonia in adults: a conference report. Can J Infect Dis 1993;4:317-21.
2. Light RB. Treatment guidelines for nosocomial pneumonia: agreeing to disagree. Can J Infect Dis 1993;4:305-6.
3. Health and Welfare Canada. Canadian guidelines for the prevention, diagnosis, management and treatment of sexually transmitted diseases in neonates, children, adolescents and adults. Can Common Dis Rep 1992;18:S1.1-213.
4. Hilt M, Yu VL, Sharp J, Zurvleff JJ, Korvick JA, Muder RR. Antibiotic therapy for Pseudomonas aeruginosa bacteremia: outcome correlations in a prospective study of 200 patients. Am J Med 1989;87:540-6.

Lionel A Mandell MD,
McMaster University,
Thomas J Marrie MD,
Dalhousie University,
Michael S Niederman MD
State University of New York at Stony Brook
