Summary

Wah Kit Lam, *Symposium Chairperson*

Division of Respiratory and Critical Care Medicine, The University of Hong Kong,
Queen Mary Hospital, Hong Kong, China

The exciting and educational symposium, 'Advanced Strategies for Evaluation and Medical Management of Lower Respiratory Tract Infections' focused on community-acquired pneumonia (CAP) and exacerbations of chronic obstructive pulmonary disease (COPD). It was a highly informative symposium, with many technical tips from the speakers on the diagnosis and management of different subgroups of patients with these two common forms of lower respiratory tract infection (LRTI). The presentations were evidence-based, with the major points of each presentation clearly illustrated by a variety of cases.

We have learned that for CAP, accurate diagnosis and quantitative assessment of severity are important for optimal management. By classifying the patient into grades of severity, the physician is able to make optimal decisions regarding the required intensity of microbiological evaluation, selection of initial empirical antibiotic therapy and whether the patient should be treated as an outpatient or admitted to hospital. For those patients that do not respond to initial empirical therapy it

is necessary to follow a structured management plan. This includes considering whether an incorrect diagnosis was made initially, and determining that the patient does not have CAP. This requires the physician to look at all alternative options on the differential diagnosis list, including both non-infectious diseases like heart failure and pulmonary emboli, as well as other infectious possibilities. In Hong Kong, a physician investigating a patient with signs and symptoms of CAP must always consider tuberculosis, and in Southeast Asia, it is important to include melioidosis in the differential diagnosis.

If the correct diagnosis was made but the patient failed to respond to therapy, then the clinical failure may be due to host factors or issues related to either the drug or the pathogen. Host factors include the presence of an overwhelming infection or a suppurative complication such as empyema. Drug-related problems include inappropriate dosing and administration schedules, as well as poor compliance. Pathogen issues involve the presence of an unusual organism or more commonly, a pathogen that is resistant to the ini-

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Wah Kit Lam, MD

Professor and Chief of Division of Respiratory & Critical Care Medicine
Chairman of Department of Medicine, University of Hong Kong
Queen Mary Hospital, Pokfulam Road, Hong Kong (China)
Tel. +852 2855 4334, Fax +852 2855 1143, E-Mail lamwk@hkucc.hku.hk

tial therapy given. In fact, the rate of resistance among *Streptococcus pneumoniae* in Hong Kong is now more than 60% in many hospitals. In terms of unusual pathogens, it is important when assessing high-risk patients such as the elderly and those with significant comorbidity, to consider the possibility of a Gram-negative bacilli infection, Legionellosis, or even an infection by *Staphylococcus aureus*. In these situations, fluoroquinolones such as levofloxacin, which can be given intravenously or orally, may be very appropriate.

With regard to optimal management of patients with acute exacerbations of chronic bronchitis (AECB), we have learned that diagnostic difficulties may also arise. It is important for the physician to consider the full differential diagnosis, which includes asthma, bronchiectasis, diffuse panbronchiolitis, lung cancer, and tuberculosis, as well as complications of COPD such as cor pulmonale, aspiration pneumonia, and pneumothorax. All of these can mimic the clinical features of AECB.

Clinical failure after management of AECB can occur in up to 10–25% of all cases. When this occurs, it may be beneficial to increase the dosage of systemic steroids taken by the patient, or to intensify therapies such as nebuliser treatment, oxygen therapy, and physiotherapy. Many high-risk patients have an alternative diagnosis such as bronchiectasis, and these need to be considered. Sputum and blood cultures can be useful, especially

for those with very high fever. If positive identification of a pathogen occurs, the antimicrobial agents prescribed should be changed according to culture results. It is also important to consider a possible viral cause for the illness or the presence of resistant organisms. The choice of antibiotic depends to a large extent on local susceptibility patterns, and it is now well recognised that many countries and regions, including Hong Kong, have a major problem with resistance to penicillin, cephalosporins, and macrolides. This has resulted in the rise of fluoroquinolones as recommended agents for treatment of these infections. The fluoroquinolones are effective against all of the major pathogens, have excellent bioavailability and proven clinical efficacy. Of particular note is levofloxacin, which is not only extremely effective, but also well tolerated.

The issues discussed in this symposium are real, practical issues that will be faced very often by respiratory physicians as well as primary care practitioners. It is therefore of great benefit to have had such a wealth of clinical experience brought to the session, with presentations from experts recognised for their contributions to respiratory tract medicine around the world. I am certain that all participants at this meeting will have gained a clear insight into the optimal strategies for use in the management of these patients, and I hope they are able to use them in their own clinical practice.