

Adherence to guidelines for hospitalized community-acquired pneumonia over time and its impact on health outcomes and mortality

Running Head:

Adherence and impact of clinical guidelines for hospitalized CAP.

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Abstract

Background. Adherence to validated guidelines is crucial to guide management of patients hospitalized with community-acquired pneumonia (CAP). Data describing real-life management and treatment of CAP are limited.

Objective. We aimed to evaluate the adherence to guidelines over time, and to assess its impact on all-cause mortality and clinical outcomes.

Methods. We retrospectively compared two cohorts of patients admitted to hospital, throughout 2005, just after implementation of a local clinical pathway based on CAP international guidelines, and 7 years later over 2012. We included all patients with a diagnosis of pneumonia and/or related complications.

Results. 564 patients were included. Pneumonia Severity Index calculation was better documented in 2012 (25.23%) compared to 2005 (17.70%; $p=0.032$), but adherence to guideline empirical antibiotic therapy was lower in 2012 (56.70%) than in 2005 (68.75%; $p=0.004$). Performance of guideline recommended urinary antigen tests was higher in 2012 and associated with 57.3% lower odds of in-hospital mortality (95%CI 15.0% to 78.5%) and with 65.9% lower odds of 30-day mortality (95%CI 31.5% to 83.0%). Adherence to empirical antibiotic therapy was associated with 2.9 days lower mean length of hospital stay (95%CI -4.2 to -1.6 days) and with 2.0 days lower mean duration of antibiotic therapy (95%CI -3.3 to -0.7 days).

Conclusions. Adherence to guidelines changed over time, with some effects on mortality and with an apparent reduction in length of hospital stay and duration of antibiotic therapy. Specific clinical training and hospital control policies could achieve greater adherence to guidelines and thus reduce burden on hospital services.

INTRODUCTION

Community-acquired pneumonia (CAP) is the leading cause of death for infectious disease worldwide, representing a considerable cause of morbidity and mortality, especially among hospitalized patients. [1, 2] Both prevalence and hospitalization rates are particularly high in elderly and comorbid patients; [3, 4] for people over 65 years early readmission to hospital has also been increasing. [5] Today, if recurrences are excluded, the mean European length of hospital stay is 9.0 days and in-hospital mortality rates vary from 0% to 17.5% across countries. [6]

Given the high burden of disease and the wide spectrum of clinical severity, use of validated guidelines is crucial in guiding diagnostic and therapeutic approaches. Adherence to guidelines has been found to improve clinical outcomes, independently on contextual and patient-specific variables (such as the decision to hospitalize and the rapidity of administration of the first antibiotic dose), [6] and to reduce unnecessary hospitalizations and readmissions, length of hospital stay, costs, and mortality. [7-19]

Although adherence to guidelines varies among clinicians and is conditioned by various factors, [20] site of care, i.e. management outside or inside hospital, and correct timing of antibiotic therapy are vital factors in reducing risk of complications and mortality from CAP. [21] These aspects, as well as choice of empirical antibiotic therapy, are most critical when applying guideline indications. [6]

To comply with international guidelines, in 2005 we implemented a CAP clinical pathway (CP) based on American Thoracic Society and British Thoracic Society guidelines, and which is still largely compatible with the most updated guidelines available in 2015. [22, 23]

Objectives

We aimed to evaluate to what extent adherence to the local CAP CP in our hospital changed over time from 2005 to 2012. We also aimed to evaluate the impact of hospital-wide adherence to the local CAP CP over time on (i) in-hospital all-cause mortality, (ii) 30-day all-cause mortality, (iii) length of hospital stay, and (iv) length of antibiotic therapy.

MATERIAL AND METHODS

This report was written in compliance with the STROBE Statement for observational studies. [24]

Clinical pathway elaboration

In 2004 we outlined, and in 2005 implemented, a CAP CP based on then current American Thoracic Society and British Thoracic Society guidelines. [22, 23] Our intent was to provide hospital clinicians with a concise and useful tool to manage patients with CAP. Our CAP CP comprises tools (i) to stratify patient risk and select the most appropriate setting of care, (ii) to indicate the fundamental diagnostic procedures, (iii) to select the best timing and choice of empirical antibiotic therapy (see Figure 1).

Study design

We conducted an observational retrospective study comparing two cohorts of patients admitted throughout 2005, the year the local CAP CP was implemented, and again in 2012, seven years after its original implementation. All patients in each cohort were followed up for 30 days from admission. The study was approved by the institutional ethics committee (study number: CE 157/14).

Setting

The study was conducted in a medium size teaching hospital in North-Western Italy. The hospital has 635 beds [25] and a catchment area of approximately half a million people [26].

Participants

We included all patients ≥ 18 years with a principal or secondary diagnosis of pneumonia and/or related complications (pleural effusion, empyema), i.e. ICD-9-CM codes 480-486, 510, 511, 518, consecutively admitted to our hospital from January 1st to December 31st in two separate years of 2005 and 2012. We also manually inspected medical records of patients with discharge diagnosis of other pulmonary diseases, in order to capture patients with respiratory failure that could represent CAP unreported in the Hospital Discharge Records (HDR), and included them in the study whenever appropriate.

Patients admitted from the community including nursing homes were included in the study in accordance with accepted definitions of CAP in the context of the pneumonia triad. [27]

Patients diagnosed with nosocomial pneumonia, including patients hospitalized for ≥ 2 days during the prior 90 days, and immunocompromised patients were excluded. Patients with malignancies in active treatment were excluded (we included patients with malignancies in remission for at least 5 years). Patients whose medical records were not available were excluded too.

Variables

Variables are detailed in Figure 2.

We investigated performance indicators suggested by Infectious Diseases Society of America/American Thoracic Society (IDSA/ATS) consensus guidelines. [28]

Data sources and measurements

Information about patients was gathered through the analysis of medical records, including attached documentation and hospital discharge data, by filling out an ad-hoc dataset. The lead author and last author manually inspected each record and assessed whether or not the clinical practices were in line with those recommended by the local CAP CP. Any disagreement was resolved by consensus.

Data about 30-day mortality from admission were collected through telephone interview.

Statistical methods

We carried out descriptive analyses by testing the difference in proportions of binary mortality outcomes using χ^2 tests and the difference in means of continuous outcomes (length of hospital stay, duration of antibiotic therapy) using Student's t tests.

To estimate the independent effects of demographic and clinical characteristics on the outcomes of interests we utilized four multivariable generalized linear models assuming a Binomial distribution of mortality outcomes and a Normal distribution of continuous outcomes (length of hospital stay and duration of antibiotic therapy), including appropriate

link functions. Regression models included four binary parameters indicating the adherence to diagnostic procedures such as execution of blood culture and urinary antigen tests, and the adherence to therapeutic interventions such as antibiotic therapy and treatment in intensive care unit (ICU). The models also included eight potential confounders of continuous age, sex, admission from nursing home or own home, presence of comorbidities, presence of criteria for severe CAP as identified by ATS, [28] year of admission to the hospital, stay in a respiratory or non-respiratory ward, performance of mechanical ventilation (MV). For the mortality binary outcomes, all predictor effects were exponentiated to allow interpretation as odds ratio.

RESULTS

Participants

564 patients were eligible for inclusion, 243 in 2005 and 321 in 2012 (Figure 3). Patients were admitted to 11 hospital departments: A&E, cardiology, infectious diseases, ICU, 3 internal medicine divisions, nephrology and dialysis, geriatrics, respiratory, and thoracic surgery. Information about patients and disease characteristics is illustrated in Tables 1 and 2. Mean age and proportion of patients with 5 or more comorbidities were both greater in 2012 than 2005 (respectively 75.4 vs. 69.0 years; $p<0.001$; and 19.3% vs. 9.1% of patients; $p=0.001$), despite a significant reduction, in 2012, of proportion of severe CAP as defined by ATS criteria [28] (5.6% of patients in 2012 vs. 10.7% in 2005; $p=0.026$).

Adherence to diagnostic procedures

PSI was reported in 25.2% of patients in 2012 vs. 17.7% in 2005 ($p=0.032$) (Table 3). Influenza and pneumococcal vaccination was only recorded for 1 patient. Urinary antigen tests for *S. pneumoniae* and *L. pneumophila* were performed in a greater percentage of patients in 2012 compared to 2005 (56.4% and 57.6% respectively in 2012 vs. 22.6% and 48.6% in 2005), although there was a significant reduction of other diagnostic tests such as blood culture, sputum Gram stain and culture, brushings and bronchial lavage in the later year.

Adherence to therapeutic interventions

Adherence to clinical pathway in choice of initial empiric antibiotic therapy was 56.7% in 2012 vs. 68.8% in 2005 ($p=0.004$) (Table 4). The most common antibiotic treatment schemes in both years were levofloxacin (16.5% in 2012 vs. 11.5% in 2005), co-amoxiclav plus macrolide (14.9% vs. 11.5%) and levofloxacin plus ceftriaxone (10.0% vs. 12.8%) (data not shown in tables). There was no evidence of a difference ($p=0.183$) in the overall duration of antibiotic therapy between the two years. 75.7% of patients admitted in 2012 and 58.9% of those admitted in 2005 appropriately received oxygen therapy ($p<0.001$). 9.35% of patients in 2012 vs. 2.06% in 2005 ($p<0.001$) were treated with Mechanical Ventilation (MV): in detail, 9.0% of patients in 2012 vs. 1.2% in 2005 ($p<0.001$) were treated with non-invasive ventilation (NIV), while 1.3% of patients in 2012 vs. 1.7% in 2005 ($p=0.691$) were treated with invasive ventilation. 2.2% of patients in 2012 vs. 1.7% in 2005 were treated in ICU ($p=0.649$).

In-hospital and 30-day mortality

Mortality rates did not change significantly over time. In-hospital mortality was 13.1% in 2012 and 15.2% in 2005 ($p=0.468$). Thirty-day mortality was 15.9% in 2012 and 19.6% in 2005 ($p=0.283$).

Adjusted regression analyses (Table 5) showed that mortality was positively associated with age and severity of pneumonia and negatively associated with performance of urinary antigen tests for *S. pneumoniae* and *L. pneumophila*. Mortality was not associated with adherence to empirical antibiotic treatment in the CAP clinical pathway.

With each one year increase in age there was an 8.1% increase in odds of in-hospital mortality (95%CI 4.9% to 11.4%) and a 10.5% increase in odds of 30-days mortality (95%CI 6.8% to 14.3%), while keeping all other predictors constant. Subjects meeting the criteria for severe CAP had 74.3% greater odds of in-hospital mortality (95%CI 38.3% to 119.6%) and 86.8% greater odds of 30-day mortality (95%CI 46.2% to 138.5%) compared to subjects not meeting such criteria, while holding all other predictors constant. Performance of urinary antigen test was associated with 42.7% lower odds of in-hospital mortality (95%CI 21.5% to 85.0%) and 34.1% lower odds of 30-day mortality (95%CI 17.0% to 68.5%) compared to subjects who were not tested for urinary antigens, while holding all other predictors constant. Association between treatment in the ICU and mortality did not reach statistical significance at the 5% level. However, treatment in the ICU appears to result in lower odds of both in-hospital mortality (OR 0.5; 95%CI 0.1 to 2.8) and 30-day mortality (OR 0.3; 95%CI 0.1 to 2.0).

Length of hospital stay and duration of antibiotic therapy

Mean length of hospital stay was 11.5 days in 2012 and 11.7 days in 2005 ($p=0.831$). Mean duration of antibiotic therapy was 12.8 days in 2012 and 13.7 days in 2015 ($p=0.183$).

Regression analyses (Table 5) showed adherence to CP antibiotic treatment was associated with shorter mean length of hospital stay (-2.9 days; 95%CI -4.2 to -1.6 days) and with shorter mean duration of antibiotic therapy (-2.0 days; 95%CI -3.3 to -0.7 days). Admission from nursing home was associated with 3.2 days shorter mean length of hospital stay (95%CI -5.2 to -1.2 days) compared with admission from home. Mean duration of antibiotic therapy was 1.1 days shorter for subjects meeting the criteria for severe CAP (95%CI -1.7 to -0.5 days). With each one year increase in age there was a 0.1 days increase in mean duration of hospital stay (95%CI 0.02 to 0.1 days). Factors associated with increased length of hospital stay and duration of antibiotic therapy were: performance of MV (4.6 days; 95%CI 1.7 to 7.6 days; and 5.0 days; 95%CI 2.1 to 7.9 days respectively), admission to ICU (8.4 days; 95%CI 3.6 to 13.3 days; and 6.2 days; 95%CI 1.2 to 11.3 days respectively), admission to respiratory ward (4.2 days; 95%CI 2.2 to 6.3 days; and 4.4 days; 95%CI 2.4 to 6.4 days respectively) and performance of blood cultures (2.6 days; 95%CI 1.3 to 4.0 days; and 2.7 days; 95%CI 1.4 to 4.0 days respectively).

DISCUSSION

Our study aimed to provide an analysis of the clinical experience of a medium sized Italian teaching hospital, which is likely to be similar in other Western-European settings.

Summary of findings

Adherence to clinical pathway. In our hospital, adherence changed over time. PSI calculation was better documented in 2012 compared to 2005, although the proportion of patients that received antibiotic therapy adherent to clinical pathway (CP) was lower in 2012.

Concerning the performance of procedures aimed at obtaining an aetiological diagnosis, urinary antigen tests for *S. pneumoniae* and *L. pneumophila* were significantly increased in 2012 compared to 2005, despite a significant reduction in most other diagnostic tests, and performed in a significantly greater proportion of patients in the respiratory ward than in other wards.

Mortality. In-hospital and 30-day mortality did not significantly change over time after adjustment for adherence to CP, although their point estimates were lower in 2012 compared to 2005. In the adjusted regression analyses, age and severity of pneumonia emerged as the only predictors associated with an increased risk of in-hospital and 30-day mortality. Patients who were tested for urinary antigens had lower odds of in-hospital and 30-day mortality. Administration of empirical antibiotic therapy adherent to CP did not have a significant impact on mortality from CAP.

Clinical outcomes. Mean length of hospital stay and mean length of antibiotic therapy remained almost unchanged in 2012 and 2005, although they were significantly higher among patients hospitalized in the respiratory ward compared to those treated in other departments. The administration of an empirical antibiotic therapy adherent to CP was associated with a reduction in length of stay and duration of antibiotic therapy. Regression analysis confirmed these observations and also provided some evidence of an increased mean length of hospital stay and duration of antibiotic therapy associated with execution of blood culture, mechanical ventilation (MV) and treatment in ICU.

Comparison with the literature

Adherence to clinical pathway. The few studies carried out so far suggest that severity scores for pneumonia are rarely used in clinical practice. [21, 29, 30] The results of our study are in accord with those reported in the study by Blasi et al., [6] which shows that in Europe the application of PSI and CURB-65 appears well below the threshold recommended by the guidelines. The most encouraging results emerged from university hospitals, where PSI calculation was done in approximately 30% of cases, compared with 6% of cases in non-university hospitals, and CURB-65 calculations in around 40% vs. 14%.

In line with Dambrova et al. [31] we demonstrated an association between adherence to CP in choice of initial antibiotic therapy and reduced length of hospital stay and duration of antibiotic therapy.

The use of NIV in patients with CAP, both in the literature and in our study, remains controversial. [32, 33]

Mortality. In-hospital mortality in our sample was in line with European hospital mortality rates (0% to 17.5%). [6]

In our study, performance of urinary antigen tests was associated with lower mortality, although performance of blood cultures did not yield similar results. This is difficult to compare with existing literature, as such variables are often estimated in combination. For example, Uematsu et al. [11] in 2014 showed that combined performance of blood culture, sputum investigations and urinary antigen tests was associated with a 36% reduction of 30-day mortality ($p < 0.001$).

Some studies have found lower mortality when antibiotic treatment is adherent to guidelines. [15, 17-19] Menéndez et al. demonstrated that non-adherence was an independent risk factor

1 for treatment failure and mortality. [18] Nevertheless, Dambrava et al. [31] found adherence
2 not to be associated with mortality, also consistent with our findings.

3 *Clinical outcomes.* In our study, the average length of hospital stay was in line with the
4 European mean duration documented by Blasi et al. (9.0 days). [6]

5 6 **Data interpretation**

7 Overall, results from this study showed that clinical practice in our hospital changed over
8 time. Adherence to CP in the choice of empirical antibiotic therapy appeared to reduce over
9 time, while main diagnostic and therapeutic interventions (i.e. PSI calculation, execution of
10 urinary antigen tests, administration of oxygen therapy) improved.

11 These mixed results may explain why in-hospital and 30-day mortality did not significantly
12 change in 2012 compared to 2005. Mortality did not appear to be associated with compliance
13 to CP, except for performance of urinary antigen test, but did show association with patient
14 age and CAP severity. It is possible that impact on mortality due to poor compliance with
15 guideline recommended antibiotic therapy could have been cancelled out by improvements in
16 compliance with other diagnostic and therapeutic interventions.

17 Reduced adherence to CP empiric antibiotic therapy in 2012 compared to 2005 may be due to
18 lack of dedicated resources available for implementation of the clinical guidelines. Although
19 recently in Italy there have been some efforts to promote implementation of clinical
20 guidelines, [34] the frequency and quality of dissemination is still subject to local initiative. A
21 recent Italian study [35] found that implementation of therapeutic recommendations,
22 including empirical antibiotic therapy, led to significantly better outcomes of CAP and/or
23 return to prior health status, especially in more severe cases of CAP.
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29 **Limitations of our study**

30 Our study limitations primarily stem from the observational study design, although we have
31 accounted for the most common potential confounders of the association between adherence
32 to CAP CP and clinical outcomes. As in any retrospective study, missing data can influence
33 the effect size of associations as well as their precision. Particularly, the data relating to
34 administration of antibiotics within 4 hours from access to A&E and data about
35 pneumococcal and influenza vaccinations were only partially complete, and such variables
36 could not be accounted for in the analyses. However, most variables were carefully recorded
37 and could be included in the analyses.

38 In 2005 the majority (62.96%) of CAP patients were treated in the hospital's respiratory ward,
39 while in 2012, due to a hospital-wide reorganisation, all CAP patients were treated in non-
40 respiratory wards. This could have potentially influenced both adherence to CAP CP and the
41 clinical outcomes assessed in our study. However, we have accounted for this potential
42 confounding effect by including ward type in the regression model.
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48 **CONCLUSION**

49 Adherence to CAP guidelines can progressively change over time, suggesting the need for
50 continual efforts to promote compliance with clinical guidelines.

51 In our study, mortality was not associated with compliance to the clinical pathway, but
52 appeared positively associated with patient age and CAP severity, and negatively associated
53 with performance of urinary antigen tests. Adherence to CP empirical antibiotic treatment
54 was associated with lower length of hospital stay and shorter duration of antibiotic therapy,
55 suggesting overall improvement in clinical care with adherence to the CP. Ongoing and
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comprehensive approaches to favour guidelines implementation may result in improvement of the overall management of CAP and help reduce burden on hospital services.

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Conflict of Interest: The authors declare that they have no conflict of interest.

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Figure 1. Main recommendations contained in the local CAP clinical pathway**(i) Stratification risk and choice of the most appropriate setting of care**

Pneumonia Severity Index calculation has to be performed in each patient presenting in A&D department with signs and/or symptoms suggestive for CAP, in order to guide clinicians in the choice of the most appropriate site of care:

- I-II PSI* risk class → extra-hospital management
- III PSI risk class → treatment in ambulatory setting or short hospitalization
- IV-V PSI risk class → in-hospital management

* Pneumonia Severity Index

(ii) Fundamental diagnostic procedures

Performance of blood culture and urinary antigen tests for *S. Pneumoniae* and *L. Pneumophila* are recommended for each patient.

(iii) Empirical antibiotic therapy

First dose of empirical antibiotic therapy has to be performed within 4 hours from access to A&D department.

The choice of the most appropriate antibiotic scheme might consider clinical aspects defining the following six category of patients

Category 1: inpatient, non-Intensive Care Unit treatment

- Macrolide
- Fluoroquinolone
- β -lactam + fluoroquinolone or macrolide

Category 2: patient with suspected aspiration from home

- Amoxicillin-clavulanate
- Levofloxacin + clindamycin/metronidazole

Category 3: patient with suspected aspiration from nursing home or in Intensive Care Unit treatment

- β -lactam (ampicillin/sulbactam or high dose ampicillin or other active β -lactams) + clindamycin/metronidazole

Category 4: patient with suspected *P. aeruginosa* infection

- Anti-Pseudomonas β -lactam (piperacillin-tazobactam, cefepime, imipenem or meropenem) + fluoroquinolone \pm aminoglycoside
- Anti-Pseudomonas β -lactam + aminoglycoside + macrolide

Category 5: inpatient, Intensive Care Unit treatment without risk for *P. aeruginosa* infection

- β -lactam + fluoroquinolone
- Fluoroquinolone \pm clindamycin

Category 6: inpatient, Intensive Care Unit treatment with risk for *P. aeruginosa* infection

- Anti-Pseudomonas β -lactam (piperacillin-tazobactam, cefepime, imipenem or meropenem) + fluoroquinolone
- Aminoglycoside + fluoroquinolone or macrolide
- Aztreonam + fluoroquinolone \pm aminoglycoside

Figure 2. Variables in detail

(i) personal details and medical history
admission year, admission ward, sex, age, residence at home or nursing home, smoke, anti-Pneumococcal and anti influenza vaccination
(ii) comorbidities
(iii) radiological characteristics of pneumonia
monolateral or bilateral infiltrates in chest x-ray
(iv) presence of pleural effusion or empyema
(v) presence of criteria for severe CAP, as identified by American Thoracic Society [27]
(vi) risk stratification through Pneumonia Severity Index
(vii) diagnostic interventions
procedures aimed to obtain an etiological diagnosis (such as blood culture, urinary antigen tests for <i>S. pneumoniae</i> and <i>L. pneumophila</i> , sputum Gram stain and culture, lung brushing or biopsy, bronchoalveolar lavage, bronchial lavage, quantitative endotracheal aspirate, other) and to manage pleural effusion and/or empyema (such as thoracentesis, chest drainage, video-assisted thoracic surgery)
(viii) in-hospital therapeutic interventions
timing of administration of the first antibiotic dose, adherence of initial empiric antibiotic therapy to the recommendations of our local clinical pathway (see Figure 1), performance of switch therapy from intravenous to oral therapy, antibiotic therapy duration, oxygen and low molecular weight heparin administration
(ix) in-hospital clinical evolution
need for invasive and non invasive mechanical ventilation (Mechanical Ventilation), transfer to Intensive Care Unit (ICU)
(x) clinical outcomes
length of hospital stay, in-hospital mortality, 30-day mortality

Figure 3

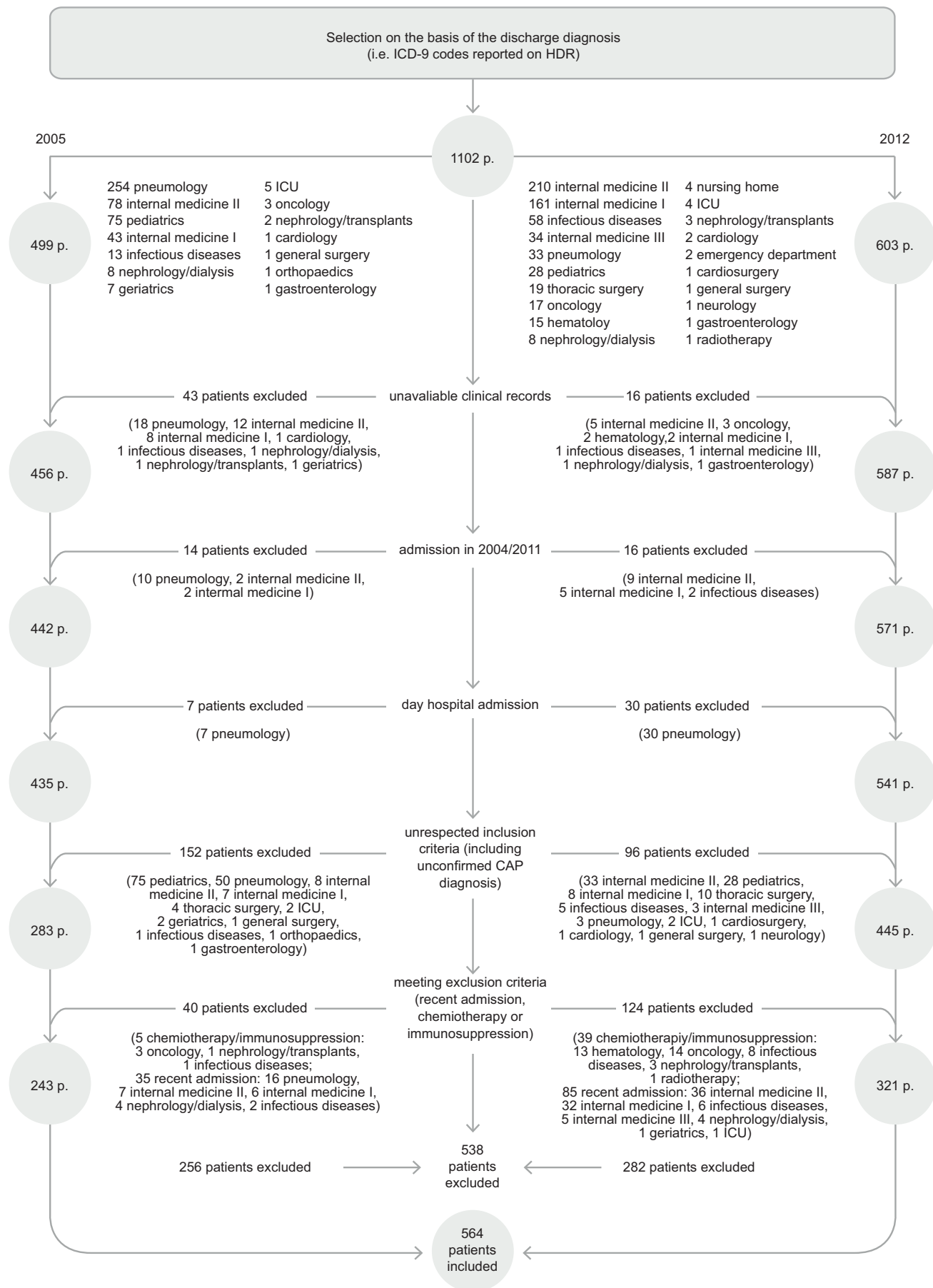


Table 1. Socio-demographic and clinical characteristics of the sample

	2005	2012	total	<i>p-value</i>
Age in years, mean (SD)	69.03 (20.69)	75.36 (15.58)	72.64 (18.22)	< 0.0001
Sex, % (n)				
male	57.61 (140)	56.39 (181)	56.91 (321)	0.771
female	42.39 (103)	43.61 (140)	43.09 (243)	
Admission from, % (n)				
home	90.95 (221)	85.98 (276)	88.12 (497)	0.071
nursing home	9.05 (22)	14.02 (45)	11.88 (67)	
Smoking, % (n)				
smokers	20.58 (50)	16.20 (52)	18.09 (102)	
never smokers	38.68 (94)	35.83 (115)	37.06 (209)	0.087
ex smokers	20.16 (49)	29.28 (94)	25.35 (143)	
not assessed	20.58 (50)	18.69 (60)	19.50 (110)	
Comorbidity, % (n)				
systemic hypertension	36.21 (88)	51.40 (165)	44.86 (253)	< 0.001
ischemic cardiopathy	17.28 (42)	19.00 (61)	18.26 (103)	0.601
heart failure	19.34 (47)	25.55 (82)	22.87 (129)	0.082
cerebrovascular disease	18.11 (44)	35.20 (113)	27.84 (157)	< 0.001
diabetes mellitus	16.05 (39)	21.18 (68)	18.97 (107)	0.124
malignancy	11.52 (28)	24.92 (80)	19.15 (108)	< 0.001
chronic liver disease	9.05 (22)	11.53 (37)	10.46 (59)	0.342
chronic kidney disease	13.99 (34)	12.15 (39)	12.94 (73)	0.519
chronic lung disease	24.69 (60)	28.66 (92)	26.95 (152)	0.293
non-neoplastic haematological disease*	2.06 (5)	6.54 (21)	4.61 (26)	0.012
diseases non otherwise classified	65.02 (158)	76.01 (244)	71.28 (402)	0.004
≥ 5 comorbidities	9.05 (22)	19.31 (62)	14.89 (84)	0.001

Note: in bold are the variables for which there is evidence at the 5% level of a difference between 2005 and 2012

* non-immunosuppressive non-neoplastic haematological disease such as anemia and myelodysplastic diseases

Table 2. Radiological aspects of pneumonia and criteria for severe CAP

	2005	2012	total	<i>p-value</i>
Radiological aspect, % (n)				
XR monolateral infiltrates	79.83 (190)	80.70 (255)	80.32 (445)	0.800
XR bilateral infiltrates	20.17 (48)	19.30 (61)	19.68 (109)	
pleuric effusion	31.69 (77)	30.22 (97)	30.85 (174)	0.708
pleuric empyema	3.29 (8)	3.12 (10)	3.19 (18)	0.906
Criteria for severe CAP, % (n)				
invasive mechanical ventilation	1.65 (4)	1.25 (4)	1.42 (8)	0.691
septic shock	2.47 (6)	2.18 (7)	2.30 (13)	0.821
respiratory rate > 30 breaths/minute	7.82 (19)	0.93 (3)	3.90 (22)	< 0.001
paO ₂ /FiO ₂ < 250	0.41 (1)	0.62 (2)	0.53 (3)	0.732
multilobar infiltrates	25.51 (62)	24.30 (78)	24.82 (140)	0.741
confusion/disorientation	20.16 (49)	19.00 (61)	19.50 (110)	0.730
uremia (Blood Urea Nitrogen > 20 mg/dl)	26.75 (65)	3.12 (10)	13.30 (75)	< 0.001
leukopenia (WBC < 4000/mm ³)	6.17 (15)	4.36 (14)	5.14 (29)	0.335
thrombocytopenia (platelets < 100000/mm ³)	8.64 (21)	6.54 (21)	7.45 (42)	0.347
hypothermia (body temperature < 36°C)	0	0	0	-
systolic blood pressure < 90 mmHg	2.47 (6)	4.05 (13)	3.37 (19)	0.303
severe CAP as defined by ATS*, % (n)	10.70 (26)	5.61 (18)	7.80 (44)	0.026
at least 1 major criteria	3.29 (8)	3.12 (10)	3.19 (18)	0.906
at least 2 of the first 3 minor criteria	1.23 (3)	2.18 (7)	1.77 (10)	0.399
at least 3 minor criteria	9.05 (22)	2.18 (7)	5.14 (29)	< 0.001

Note: in bold are the variables for which there is evidence at the 5% level of a difference between 2005 and 2012

*American Thoracic Society

Table 3. Adherence to diagnostic procedures and its main findings

	2005	2012	total	p-value
PSI (Pneumonia Severity Index) calculation, % (n)	17.70 (43)	25.23 (81)	21.99 (124)	0.032
I class	4.65 (2)	12.35 (10)	9.68 (12)	
II class	4.65 (2)	8.64 (7)	7.26 (9)	
III class	13.95 (6)	20.99 (17)	18.55 (23)	0.146
IV class	60.47 (26)	37.04 (30)	45.16 (56)	
V class	16.28 (7)	20.99 (17)	19.35 (24)	
History investigation about vaccinations, % (n)	0.41 (1)	0	0.01 (1)	0.250
Procedures for etiological diagnosis, % (n)				
blood culture	60.91 (148)	64.17 (206)	62.77 (354)	0.426
positive	24.32 (36)	9.71 (20)	15.82 (56)	< 0.001
<i>S. pneumoniae</i>	2.78 (1)	35.00 (7)	14.29 (8)	
<i>S. aureus</i>	2.78 (1)	10.00 (2)	5.36 (3)	
coagulase-negative Staphylococci	66.67 (24)	40.00 (8)	57.14 (32)	
<i>Pseudomonas vesicularis</i>	2.78 (1)	0	1.79 (1)	0.020
Enterobacteriaceae	8.33 (3)	5.00 (1)	7.14 (4)	
Saprophytic	16.67 (6)	10.00 (2)	14.29 (8)	
urinary antigen test for <i>S. pneumoniae</i>	22.63 (55)	56.39 (181)	41.84 (236)	< 0.001
positive	3.64 (2)	6.08 (11)	5.51 (13)	0.487
urinary antigen test for <i>L. pneumophila</i>	48.56 (118)	57.63 (185)	53.72 (303)	0.032
positive	1.69 (2)	4.32 (8)	3.30 (10)	0.212
sputum Gram stain	19.75 (48)	0.93 (3)	9.04 (51)	< 0.001
sputum culture	29.63 (72)	19.31 (62)	23.76 (134)	0.004
lung brushing or biopsy	4.94 (12)	1.25 (4)	2.84 (16)	0.009
bronchoalveolar lavage (BAL)	4.94 (12)	8.72 (28)	7.09 (40)	0.083
bronchial lavage (BL)	10.70 (26)	0.31 (1)	4.79 (27)	< 0.001
quantitative endotracheal aspirate	1.23 (3)	2.49 (8)	1.95 (11)	0.285
other	61.73 (150)	45.17 (145)	52.30 (295)	< 0.001
Procedures for pleural effusion/empyema, % (n)				
thoracentesis	22.35 (19)	14.95 (16)	18.23 (35)	0.187
chest drainage	9.41 (8)	9.35 (10)	9.38 (18)	0.988
video-assisted thoracic surgery	37.50 (3)	10.00 (1)	22.22 (4)	0.163

Note: in bold are the variables for which there is evidence at the 5% level of a difference between 2005 and 2012

Table 4. Adherence to therapeutic interventions

	2005	2012	total	<i>p-value</i>
Distribution of patients within clinical categories identified by guidelines % (n)				
1) inpatient, non-ICU* treatment	96.71 (235)	96.26 (309)	96.45 (544)	
2) patient with suspected aspiration from home	1.23 (3)	0.62 (2)	0.89 (5)	
3) patient with suspected aspiration from nursing home or in ICU treatment	0.41 (1)	1.56 (5)	1.06 (6)	
4) patient with suspected P. aeruginosa infection	0.41 (1)	1.25 (4)	0.89 (5)	0.151
5) inpatient, ICU treatment without risk for P. aeruginosa infection	1.23 (3)	-	0.53 (3)	
6) inpatient, ICU treatment with risk for P. aeruginosa infection	-	0.31 (1)	0.18 (1)	
Antibiotic therapy adherent to guidelines, % (n)				
in patients of category 1	70.26 (163)	58.58 (181)	63.59 (344)	0.005
in patients of category 2	33.33 (1)	0	20.00 (1)	0.361
in patients of category 3	0	0	0	-
in patients of category 4	0	25.00 (1)	20.00 (1)	0.576
in patients of category 5	33.33 (1)	-	33.33 (1)	-
in patients of category 6	-	0	0	-
Administration of the first antibiotic dose, % (n)				
within 4 hours from A&E presentation	96.00 (24)	99.59 (243)	99.26 (267)	0.047
within 4 hours from admission to ward	54.92 (106)	69.66 (202)	63.77 (308)	< 0.001
Switch therapy, % (n)	23.31 (55)	30.94 (99)	27.70 (154)	0.047
Intra-hospital antibiotic therapy duration in days, mean (SD)	10.71 (7.17)	10.56 (6.39)	10.63 (6.73)	0.7925
Post-discharge prescription duration in days, mean (SD)	6.20 (2.52)	4.79 (2.33)	5.39 (2.33)	< 0.0001
Antibiotic therapy total duration in days, mean (SD)	13.66 (8.18)	12.78 (6.65)	13.14 (7.33)	0.1825
Oxygen administration, % (n)	58.85 (143)	75.70 (243)	68.44 (386)	< 0.001
MV (mechanical ventilation), % (n)	2.06 (5)	9.35 (30)	6.21 (35)	< 0.001
Administration of low molecular weight heparin, % (n)	53.09 (129)	58.88 (189)	56.38 (318)	0.170

Note: in bold are the variables for which there is evidence at the 5% level of a difference between 2005 and 2012

* Intensive Care Unit

Table 5. Multivariable regression analyses for in-hospital and 30-day mortality, length of hospital stay and duration of antibiotic therapy

	in-hospital mortality		30-day mortality		length of hospital stay		duration of antibiotic therapy	
	N=561		N=495		N=561		N=505	
	OR	95%CI	OR	95%CI	MD	95%CI	MD	95%CI
Socio-demographic characteristics and other potential confounders								
Age in years (continuous)	1.081	1.049,1.114	1.105	1.068,1.143	0.052	0.016,0.089	-0.003	-0.038,0.033
Male gender (vs. female gender)	0.803	0.454,1.419	0.628	0.348,1.133	0.850	-0.424,2.124	0.411	-0.792,1.615
Admission from nursing home (vs. from own home)	1.118	0.544,2.300	1.409	0.648,3.063	-3.222	-5.232,-1.213	-1.770	-3.619,0.079
Five or more comorbidities (vs. less than five)	1.601	0.827,3.102	1.243	0.627,2.464	1.150	-0.621,2.921	1.421	-0.233,3.075
ATS criteria for CAP severity (continuous)	1.743	1.383,2.196	1.868	1.462,2.385	-0.287	-0.903,0.329	-1.111	-1.694,-0.527
Admission in 2012 (vs. admission in 2015)	1.081	0.491,2.377	0.863	0.387,1.923	1.297	-0.723,3.318	0.659	-1.224,2.541
Stay in a respiratory ward (vs. stay in a non-respiratory ward)	0.847	0.351,2.042	0.750	0.304,1.851	4.225	2.152,6.299	4.363	2.377,6.349
Mechanical Ventilation	0.968	0.289,3.243	1.102	0.340,3.575	4.638	1.688,7.587	5.017	2.115,7.919
Adherence to diagnostic procedures								
Blood culture	0.677	0.377,1.213	0.600	0.328,1.097	2.631	1.259,4.003	2.728	1.417,4.039
Urinary Antigen tests	0.427	0.215,0.850	0.341	0.170,0.685	0.033	-1.407,1.473	-0.164	-1.535,1.207
Adherence to therapeutic interventions								
Antibiotic therapy adherent to clinical pathway	0.830	0.468,1.471	0.957	0.526,1.738	-2.868	-4.186,-1.550	-2.004	-3.265,-0.743
Treatment in ICU	0.452	0.073,2.817	0.305	0.047,1.983	8.409	3.547,13.272	6.237	1.170,11.303

Note: in bold are the variables for which there is evidence at the 5% level of a difference between 2005 and 2012