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Don't Automatically Add Empiric Anaerobic Coverage for Aspiration Pneumonia

Is anaerobic coverage needed for presumed aspiration pneumonia?

Not usually. Anaerobes come to mind as culprits in aspiration pneumonia. But more common causes are typical community- or hospital-acquired pneumonia bugs...*S. pneumoniae*, *S. aureus*, *Pseudomonas*, etc.

Use this as an opportunity to enhance antimicrobial stewardship.

In general, stick with your protocol for community-acquired (CAP), hospital-acquired (HAP), or ventilator-associated pneumonia (VAP).

Don't automatically cover anaerobes for pneumonia patients with aspiration risks...such as swallowing disorders or impaired consciousness.

But if these patients ALSO have severe gum disease or poor dentition, consider adding empiric anaerobic coverage. Evidence is limited...but anaerobic content of their aspirated secretions is higher.

In this case, adjust the regimen if possible...instead of adding another antibiotic. Many beta-lactam/beta-lactamase inhibitor combos have good anaerobic coverage...as do carbapenems.

For example, use piperacillin/tazobactam in your HAP/VAP regimen. Or with CAP, switch the beta-lactam portion of the regimen...such as from ceftriaxone to ampicillin/sulbactam.

If adding an anaerobic-specific antibiotic, lean toward metronidazole.

You may have heard clindamycin is for "above the belt" coverage of anaerobes plus strep and staph. But empiric pneumonia regimens already have gram-positive coverage...and metronidazole has a lower *C. diff* risk.

Don't automatically add anaerobic coverage if patients aspirate gastric contents with vomiting. Aspiration can lead to chemical pneumonitis...due to inflammation instead of infection.

But reassess in 2 to 3 days if empiric antibiotics are added when a patient decompensates after a vomiting event. Stop antibiotics if the chest X-ray is clear.

Use our chart, *Aspiration Pneumonia FAQs*, for treatment duration, prevention strategies, and more.

Key References:

-N Engl J Med 2019;380(7):651-63
-Clin Infect Dis 2016;63(5):e61-e111
-J Crit Care 2015;30(1):40-8

Hospital Prescriber's Letter. September 2019, No. 350915

Cite this document as follows: Article, Don't Automatically Add Empiric Anaerobic Coverage for Aspiration Pneumonia, Prescriber's Letter Hospital, September 2019