|  |  |
| --- | --- |
|  | **Please read the checklist for submitting comments at the end of this form.** We cannot accept forms that are not filled in correctly or arrive after the deadline. In addition to your comments below, we would like to hear your views on these questions:1. Are there any cost saving interventions or examples of innovative approaches that should be considered for inclusion in this guideline?
2. Are there any aspects of diagnosing Community Acquired Pneumonia and Hospital Acquired Pneumonia for which guidance is needed (beyond microbiological tests to determine causal agents)?
3. Is it more important to update our guidance on duration of antibiotic treatment for under 18s with Community Acquired Pneumonia or to cover diagnosis of Community Acquired Pneumonia and Hospital Acquired Pneumonia for this age group?

[Developing NICE guidance: how to get involved](https://www.nice.org.uk/process/pmg22/chapter/introduction) has a list of possible areas for comment on the draft scope.  |
| Organisation name – Stakeholder or respondent (if you are responding as an individual rather than a registered stakeholder please leave blank): | **The Faculty of Pharmaceutical Medicine of the Royal Colleges of Physicians of the UK (FPM)** |
| DisclosurePlease disclose any past or current, direct or indirect links to, or funding from, the tobacco industry. | **None** |
| Name of person completing form: | **Ben Cottam** |
| Type | [for office use only] |
| **Comment****No.** | Page numberor **‘general’** for comments on the whole document | **Line****number** or **‘general’** for comments on the whole document | CommentsInsert each comment in a new row.Do not paste other tables into this table, as your comments could get lost – type directly into this table. |
| Example | 3 | 55 | The draft scope currently excludes people who have already been diagnosed. We feel this group should be included because…. |
| 1 | General | General | The FPM is concerned by the proposed revisions and the rationale provided for the work required. Whilst it is common in other guidance such as CDC (US) and ERS to group pneumonias with a single-entry portal from an epidemiological point of view, the definition of acute lower respiratory infections which may be part of the differential diagnosis of bacterial pneumonia include acute bronchitis and bronchiolitis, which may be a result of various virus infections. Thus, the rationale seems inappropriate to limit to differences between SARS-CoV-2 infection and later pneumonitis, and not including the contribution of several other respiratory virus families that are now resurging as the SARS-CoV-2 disease profile is changing.The preamble incorrectly states that bacteria are the most common cause of pneumonia. In fact, multiple studies have demonstrated that viral pneumonia is at least as frequent, but that it is not appropriately diagnosed and treated. This contributes to the inappropriate prescription of antibiotics, which do not relieve viral pneumonia unless it has bacterial superinfection, contributing to extending antimicrobial resistance. Whilst immunocompromised patients are excluded from the guidance, consideration might be given to pneumonia caused by fungal infections or opportunistic infections which are increasingly common among individuals living in poor quality, mould infested housing.FPM urges NICE to adapt this scope of work and consider working on guidance for the diagnosis and management of lower respiratory tract infection and pneumonia in different populations, working with expert societies and practitioners to define the appropriate prevention, diagnosis and management strategies required in various patient types: a good example of the outputs that such an approach can result in can be found here: <https://www.cdc.gov/pneumonia/management-prevention-guidelines.html>. Indeed, the majority of this guidance would be equally applicable to practice in the UK. |
| 2 | Section 3.1 | 3 | Groups that will be coveredThe proposal to produce one guideline across individuals of all ages is almost impossible unless it is clearly sectioned, as the pattern of disease and organisms causing pneumonia in children differ from those in adults. Whilst the existing the three guidances proposed to be merged are separated for hospital acquired pneumonia, community acquired pneumonia and paediatric pneumonia, it is not clear that this document will be sectioned in this way.HAP is more likely to be caused by multidrug resistant organisms and the preponderance of the latter differs markedly between institutions, which requires local advice on the extent and nature of the MDDR organisms prevalent within the particular institution with relevant local antibiotic policies informed by expert infectious disease consultation.  |
| 3 | 4 | 5, 7 and 10 | Diagnosis and severity are important and where to treat people in hospital. Can there be consideration of remote consultations (which may take place with older patients or patients with comorbidity)? It is difficult to apply PSI and even CURB 65. CRP and PCT should be in context with clinical judgement. Neither works well in young adults who are increasingly hospitalised with influenza. |
| 4 | 4 | 5,7, 10 | Can there be some comments or referrals to determine the difference between asthma and COPD exacerbations and CAP. Some patients will have both, with exacerbation triggered by viral CAP. Some will have a bacterial element to exacerbations. |
| 5 | 4 | 11 | In the CAP section the diagnosis needs to deal with viral only and those that progress to bacterial super infections. Recently, with RSV, flu and COVID these superinfections are becoming more important. |
| 6 | 4 | 18 | CAP antibiotic treatment – something needs to be included regarding failed treatment and how and what to provide if antibiotic treatment is to be switched for immediate failure or failure within 3 days after stopping the course of antibiotics. |
| 7 | 4 | 27, 28 | HAP needs more elements of stewardship and needs both more breadth of recommendations for antibiotics and guidance on not just IV oral switch but switch or de-escalation. How to deal with patients who develop HAP who are already on long term prophylaxis for example pip tazo also needs consideration. It also needs guidance for what to do when patients fail treatment.  |
| 8 | 4 | 27, 28  | More elements of ‘Start Smart - Then Focus’ should be included in the guideline. |
| 9 | 6 | HAP antibiotics | HAP antibiotics should be reviewed as there are changes in resistance patterns and MDDRs since the guideline was written – the clinical trial evidence for HAP is not the only driver. |
| 10 | 7 | Microbiological tests | The limitation of microbiology when patients are already taking prophylactic antibiotics or are on antibiotics that have failed should be added. |
| 11 | 7 | Microbiological tests | The limitations of obtaining specimens in HAP often a challenge due to inability to cough also needs to be recognised. |
| 12 | 9  | 21 | Make sure that all the different settings are considered including remote consultation. Use IDSA recent guidance form 2019 (CAP) and 2016 (HAP) on CDC web site. |
| 13 | 12 | 8 | PROs are what clinical trials align to and for CAP treated in the community is the most important thing for patients especially those that have pneumonia more than once such as asthmatics. Can the outcome be carefully split between CAP and HAP and paediatrics? |

Add extra rows if needed

|  |
| --- |
| **Checklist for submitting comments*** Use this comment form and submit it as a **Word document (not a PDF)**.
* Complete the disclosure about links with, or funding from, the tobacco industry.
* Include **page and line number (not section number)** of the text each comment is about.
* Combine all comments from your organisation into 1 response. **We cannot accept more than 1 response from each organisation**.
* Do not paste other tables into this table – type directly into the table.
* Ensure each comment stands alone; do not cross-refer within one comment to another comment.
* **Clearly mark any confidential information or other material that you do not wish to be made public. Also, ensure you state in your email to NICE that your submission includes confidential comments.**
* **Do not name or identify any person or include medical information about yourself or another person** from which you or the person could be identified as all such data will be deleted or redacted.
* Spell out any abbreviations you use
* For copyright reasons, **do not include attachments** such as research articles, letters or leaflets. We return comments forms that have attachments without reading them. The stakeholder may resubmit the form without attachments, but it must be received by the deadline.
* **We do not accept comments submitted after the deadline stated for close of consultation.**

**Note:** We reserve the right to summarise and edit comments received during consultations, or not to publish them at all, if we consider the comments are too long, or publication would be unlawful or otherwise inappropriate.Comments received during our consultations are published in the interests of openness and transparency, and to promote understanding of how recommendations are developed. The comments are published as a record of the comments we received, and are not endorsed by NICE, its officers or advisory Committees.**Data protection**The information you submit on this form will be retained and used by NICE and its advisers for the purpose of developing its guidance and may be passed to other approved third parties. Please do not name or identify any individual patient or refer to their medical condition in your comments as all such data will be deleted or redacted. The information may appear on the NICE website in due course in which case all personal data will be removed in accordance with NICE policies.By submitting your data via this form you are confirming that you have read and understood this statement.For more information about how we process your data, please see our [privacy notice](https://www.nice.org.uk/privacy-notice). |