



TENNESSEE DEPARTMENT OF HEALTH
HEALTHCARE-ASSOCIATED INFECTIONS AND ANTIMICROBIAL RESISTANCE PROGRAM
Surveillance Definitions



PNEUMONIA 1 (PNEU1)

(Last updated January, 2011)

Pneumonia (PNEU) is identified by using a combination of radiologic, clinical and laboratory criteria. Report PNEUs that are ventilator-associated (i.e., patient was intubated and ventilated at the time of or within 48 hours before the onset of the event).

NOTE: There is no minimal period of time that the ventilator must be in place in order for the PNEU to be considered ventilator-associated.

Primary vs. secondary attribution: Because a fever is a non-specific sign of infection, it is possible that an individual may run a fever due to more than one infection at a time. It would be impossible to determine which infection (if not both) was the cause of the fever. Therefore, if all other criteria besides fever are met, both infections would be reported if surveillance for both of these events were being performed.

Source: NHSN September 2011 Newsletter

URL: www.cdc.gov/nhsn/PDFs/Newsletters/newsletter-Sept-2011.pdf

NOTE: Although CDC provided interpretive guidance related to primary vs. secondary attribution in the September NHSN Newsletter, TDH has asked that IPs apply this interpretive guidance starting January 2011 to ensure a full calendar year of comparable data.

Location of attribution: The inpatient location where the patient was assigned on the date of the PNEU event, which is further defined as the date when the first clinical evidence appeared or the date the specimen used to meet the PNEU criterion was collected, whichever came first.

EXAMPLE: Patient is intubated and ventilated in the Operating Room and then is admitted to the MICU. Within 24 hours of admission to the MICU, patient meets criteria for PNEU. This is reported to NHSN as VAP for the MICU, because the Operating Room is not an inpatient location and no denominator data are collected there.

EXAMPLE: patient on the Respiratory ICU (RICU) of Hospital A had the endotracheal tube and ventilator removed and is discharged home a few hours later. The ICP from Hospital B calls the next day to report that this patient has been admitted to Hospital B with a PNEU. This VAP should be reported to NHSN for, and by Hospital A and attributed to the RICU. No additional ventilator days are reported.

EXCEPTION: If a VAP develops within 48 hours of transfer from one inpatient location to another in the same facility, the infection is attributed to the transferring location. This is called the Transfer Rule and examples are shown below:

- Patient on a ventilator in the SICU is transferred to the surgical ward. Thirty six (36) hours later, the patient meets the criteria for PNEU. This is reported to NHSN as VAP for the SICU.
- Patient is transferred to the medical ward from the MSICU after having ventilator removed. Within 24 hours, the patient meets criteria for a PNEU. This is reported to NHSN as a VAP for the MSICU.
- Patient on a ventilator is transferred from the medical ward to the coronary care ICU (CCU). After 4 days in the CCU, the patient meets the criteria for a PNEU. This is reported to NHSN as a VAP for the CCU.



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Ventilator: A device to assist or control respiration continuously, including of the weaning period, through a tracheostomy or by endotracheal intubation.

NOTE: Lung expansion devices such as intermittent positive-pressure breathing (IPPB); nasal positive end-expiratory pressure (PEEP); and continuous nasal positive airway pressure (CPAP, hypoCPAP) are not considered ventilators unless delivered via tracheostomy or endotracheal intubation (e.g., ET-CPAP).

Algorithms for Clinically Defined Pneumonia

DEFINITION: Patient must meet **ONE** ☐ of the following criteria for Pneumonia 1:

Patients in Any Age Group (Last updated June, 2008)

☐ Criterion:

- Patient has two or more serial chest radiographs with at least **ONE** ☐ of the following:
 - △ infiltrate is **ONE** ☐ of the following^{1,2}:
 - ☐ new
 - ☐ progressive and persistent
 - △ consolidation
 - △ cavitation
 - △ pneumatoceles, in infants ≤ 1 year old

NOTE: In patients **without** underlying pulmonary or cardiac disease (e.g. respiratory distress syndrome, bronchopulmonary dysplasia, pulmonary edema, or chronic obstructive pulmonary disease), one definitive chest radiograph is acceptable¹.

AND

- Patient has at least **ONE** ☐ of the following:
 - △ Fever ($>38^{\circ}\text{C}$ or $>100.4^{\circ}\text{F}$) with no other recognized cause
 - △ leukopenia (<4000 WBC/mm³) or leukocytosis ($\geq 12,000$ WBC/mm³)
 - △ For adults ≥ 70 years old, altered mental status with no other recognized cause

AND

- Patient has at least **TWO** ☐ of the following:
 - △ change in sputum production including **ONE** ☐ of the following:
 - ☐ new onset of purulent sputum³
 - ☐ change in character of sputum⁴
 - ☐ increased respiratory secretions
 - ☐ increased suctioning requirements



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- △ symptoms of **ONE** □ of the following:
 - new onset cough
 - worsening cough
 - dyspnea
 - tachypnea⁵
- △ exam findings of **ONE** □ of the following:
 - rales⁶
 - bronchial breath sounds
- △ worsening gas exchange indicated by **ONE** □ of the following:
 - O₂ desaturations (e.g., PaO₂/FiO₂ ≤ 240)⁷
 - increased oxygen requirements
 - increased ventilator demand

Infants ≤1 Year Old
(Last updated June, 2008)

□ Criterion:

- Patient has two or more serial chest radiographs with at least **ONE** △ of the following:
 - △ infiltrate is **ONE** □ of the following^{1,2}:
 - new
 - progressive and persistent
 - △ consolidation
 - △ cavitation
 - △ pneumatoceles, in infants ≤ 1 year old

NOTE: In patients **without** underlying pulmonary or cardiac disease (e.g. respiratory distress syndrome, bronchopulmonary dysplasia, pulmonary edema, or chronic obstructive pulmonary disease), one definitive chest radiograph is acceptable¹.

AND

- Patient has worsening gas exchange indicated by **ONE** △ of the following:
 - △ O₂ desaturations
 - △ increased oxygen requirements
 - △ increased ventilator demand

AND

- Patient has at least **THREE** △ of the following:
 - △ temperature instability with no other recognized cause



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- △ leukopenia (<4000 WBC/mm³) or leukocytosis ($\geq 15,000$ WBC/mm³) and left shift ($\geq 10\%$ band forms)
- △ change in sputum production including **ONE** ☐ of the following:
 - ☐ new onset of purulent sputum³
 - ☐ change in character of sputum⁴
 - ☐ increased respiratory secretions
 - ☐ increased suctioning requirements
- △ symptoms of **ONE** ☐ of the following:
 - ☐ apnea
 - ☐ tachypnea⁵
 - ☐ nasal flaring with retraction of chest wall
 - ☐ nasal flaring with grunting
- △ exam findings of **ONE** ☐ of the following:
 - ☐ wheezing
 - ☐ rales⁶
 - ☐ rhonchi
- △ cough
- △ bradycardia (<100 beats/min) or tachycardia (>170 beats/min)

Child >1 Year Old and ≤ 12 Years Old
(Last updated June, 2008)

☐ Criterion:

- Patient has two or more serial chest radiographs with at least **ONE** △ of the following:
 - △ infiltrate is **ONE** ☐ of the following^{1,2}:
 - ☐ new
 - ☐ progressive and persistent
 - △ consolidation
 - △ cavitation
 - △ pneumatoceles, in infants ≤ 1 year old

NOTE: In patients **without** underlying pulmonary or cardiac disease (e.g. respiratory distress syndrome, bronchopulmonary dysplasia, pulmonary edema, or chronic obstructive pulmonary disease), one definitive chest radiograph is acceptable¹.

AND



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- Patient has at least **THREE** **Δ** of the following:

- Δ at least **ONE** **□** of the following:

- fever ($>38.4^{\circ}\text{C}$ or $>101.1^{\circ}\text{F}$) or hypothermia ($<36.5^{\circ}\text{C}$ or $<97.7^{\circ}\text{F}$) with no other recognized cause
 - leukopenia ($<4000\text{ WBC/mm}^3$) or leukocytosis ($\geq 15,000\text{ WBC/mm}^3$)

- Δ change in sputum production including **ONE** **□** of the following:

- new onset of purulent sputum³
 - change in character of sputum⁴
 - increased respiratory secretions
 - increased suctioning requirements

- Δ symptoms of **ONE** **□** of the following:

- new onset cough
 - worsening cough
 - dyspnea
 - apnea
 - tachypnea⁵

- Δ exam findings of **ONE** **□** of the following:

- rales⁶
 - bronchial breath sounds

- Δ worsening gas exchange indicated by **ONE** **□** of the following:

- O₂ desaturations (e.g., pulse oximetry $<94\%$)
 - increased oxygen requirements
 - increased ventilator demand

Footnotes to Algorithms: (Last updated June, 2008)

¹Occasionally, in non-ventilated patients, the diagnosis of health care – associated pneumonia may be quite clear on the basis of symptoms, signs, and a single definitive chest radiograph. However, in patients with pulmonary or cardiac disease (for example, interstitial lung disease or congestive heart failure) the diagnosis of pneumonia may be particularly difficult. Other non-infectious conditions (for example, pulmonary edema from decompensated congestive heart failure) may simulate the presences of pneumonia. In these more difficult cases, serial chest radiographs must be examined to help separate infectious from noninfectious pulmonary processes. To help confirm difficult cases, it may be useful to review radiographs on the day of diagnosis, 3 days prior to the diagnosis and on days 2 and 7 after the diagnosis. Pneumonia may have rapid onset and progression, but does not resolve quickly. Radiographic changes of pneumonia persist for several weeks. As a result, rapid radiographic resolution suggests that the patient does not have pneumonia but rather a noninfectious process such as atelectasis or congestive heart failure.

²Note that there are many ways of describing the radiographic appearance of pneumonia. Examples include, but are not limited to, “air-space disease”, “focal opacification”, “patchy areas of increased density”. Although perhaps not specifically delineated as pneumonia by the radiologist, in the



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appropriate clinical setting these are alternative descriptive wording should be seriously considered as potentially positive findings.

³Purulent sputum is defined as secretions from the lungs, bronchi, or trachea that contain ≥ 25 neutrophils and ≤ 10 squamous epithelial cells per low power field (x100). If your laboratory reports these data qualitatively (e.g., “many WBCs” or “few squames”), be sure their descriptors match this definition of purulent sputum. This laboratory confirmation is required because written clinical descriptions of purulence are highly variable.

⁴A single notation of either purulent sputum or change in character of the sputum is not meaningful; repeated notations over a 24-hour period would be more indicative of the onset of an infectious process. A change in character of sputum refers to color, consistency, odor, and quantity.

⁵In adults, tachypnea is defined as respiration rate > 25 breaths per minute. Tachypnea is defined as > 75 breaths per minute in premature infants born at < 37 weeks gestation and until the 40th week; > 60 breaths per minute in infants < 2 months old; > 50 breaths per minute in infants 2 to 12 months old; and > 30 breaths per minute in children > 1 year old.

⁶Rals may be described as “crackles”.

⁷This measure of arterial oxygenation is defined as the ratio of the arterial tension (PaO₂) to the inspiratory fraction of oxygen (FiO₂)

GENERAL COMMENTS: *(Last updated June, 2008)*

1. Physician diagnosis of pneumonia alone is not an acceptable criterion for health care–associated pneumonia.
2. Although specific criteria are included for infants and children, pediatric patients may meet any of the other pneumonia specific site criteria.
3. Ventilator-associated pneumonia (i.e. pneumonia in persons who had a device to assist or control respiration continuously through a tracheostomy or by endotracheal intubation within the 48-hour period before the onset of infection, inclusive of the weaning period) should be so designated when reporting data.
4. When assessing a patient for presence of pneumonia, it is important to distinguish between changes in clinical status due to other conditions such as myocardial infarction, pulmonary embolism, respiratory distress syndrome, atelectasis, malignancy, chronic obstructive pulmonary disease, hyaline membrane disease, bronchopulmonary dysplasia, etc. Also, care must be taken when assessing intubated patients to distinguish between tracheal colonization, upper respiratory tract infections (e.g., tracheobronchitis), and early onset pneumonia. Finally, it should be recognized that it may be difficult to determine health care–associated pneumonia in the elderly, infants, and immunocompromised patients because such conditions may mask typical signs or symptoms associated with pneumonia. Alternate specific criteria for the elderly, infants and immunocompromised patients have been included in this definition of health care–associated pneumonia.
5. Health care–associated pneumonia can be characterized by its onset: early or late. Early onset pneumonia occurs during the first 4 days of hospitalization and is often caused by *Moraxella catarrhalis*, *H. influenzae*, and *S. pneumoniae*. Causative agents of late onset pneumonia are frequently gram negative bacilli or *S. aureus*, including methicillin-resistant *S. aureus*. Viruses (e.g.



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influenza A and B or respiratory syncytial virus) can cause early and late onset nosocomial pneumonia, whereas yeasts, fungi, legionellae, and *Pneumocystis carinii* are usually pathogens of late onset pneumonia.

6. Pneumonia due to gross aspiration (for example, in the setting of intubation in the emergency room or operating room) is considered health care associated if it meets any specific criteria and was not clearly present or incubating at the time of admission to the hospital.

7. Multiple episodes of health care–associated pneumonia may occur in critically ill patients with lengthy hospital stays. When determining whether to report multiple episodes of health care–associated pneumonia in a single patient, look for evidence of resolution of the initial infection. The addition of or change in pathogen alone is not indicative of a new episode of pneumonia. The combination of new signs and symptoms and radiographic evidence or other diagnostic testing is required.

8. Positive Gram stain for bacteria and positive KOH (potassium hydroxide) mount for elastin fibers and/or fungal hyphae from appropriately collected sputum specimens are important clues that point toward the etiology of the infection. However, sputum samples are frequently contaminated with airway colonizers and therefore must be interpreted cautiously. In particular, *Candida* is commonly seen on stain, but infrequently causes healthcare-associated pneumonia.

Abbreviations: (Last updated June, 2008)

BAL – bronchioalveolar lavage

EIA – enzyme immunoassay

FAMA – fluorescent-antibody staining of membrane antigen

IFA – immunofluorescent antibody

LRT – lower respiratory tract

PCR – polymerase chain reaction

PMN – polymorphonuclear leukocyte

RIA – radioimmunoassay

REPORTING INSTRUCTIONS: (Last updated June, 2008)

- There is a hierarchy of specific categories within the major type pneumonia (PNEU). Even if a patient meets criteria for more than one specific site, report only one:
 - If a patient meets criteria for both PNU1 and PNU2, report PNU2.
 - If a patient meets criteria for both PNU2 and PNU3, report PNU3.
 - If a patient meets criteria for both PNU1 and PNU3, report PNU3.
- Report concurrent lower respiratory tract infection (e.g. abscess or empyema) and pneumonia with the same organism(s) as pneumonia.
- Lung abscess or empyema without pneumonia is classified as LUNG.
- Bronchitis, tracheitis, tracheobronchitis, or bronchiolitis without pneumonia are classified as BRON.