

Akute Bronchitis

Rationale Antibiotikatherapie in der hausärztlichen Versorgung

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Akute Bronchitis

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- Allgemeines
- ABx?
- Point of care
- Talking Points

■ Ätiologie

- > 90% viral bedingt
 - Bakteriell: *Mycoplasma pneumoniae*, *Chlamydophila pneumoniae* (ggf: *Bordetella pertussis*!)

■ Klinik

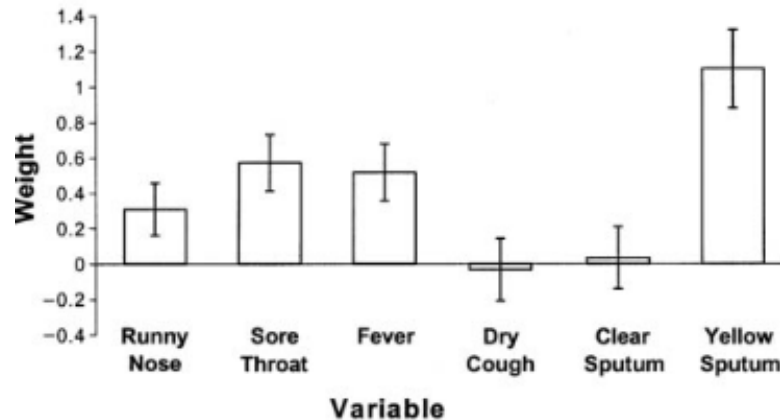
- Akute Infektion der großen Luftwege
- Krankheitsgefühl
 - Husten (Dauer bis zu 6 Wochen)

■ Diagnostik

- Bei unkompliziertem Verlauf nicht notwendig (T 1a, Empfehlungsstärke: A)
- Ggf. Infektdiagnostik wenn Abgrenzung Pneumonie schwierig
- Sputumfarbe?!?

Quelle: DEGAM Leitlinie Nr. 11 Akuter Husten, 2014

Sputum Farbe ein guter Prädiktor?



Murray, Fam Practice, 2000

■ Frage:

- „Indikationen für eine Antibiotikaverschreibung sind für mich gelb/grünes Sputum“

-> **knapp 40%** der befragten HA bejahten diese Aussage!
Salm et al., 2017 (unpublished)

■ Fazit

- Bei der akuten Bronchitis ist die Sputumfarbe ist **kein guter Prädiktor!**

-> DEGAM Leitlinie Nr. 11 Akuter Husten, 2014

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Rationale Antibiotikatherapie

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■ 1. Wahl:

➤ Kein Antibiotikum!

- Nur bei Pneumonieverdacht -> **Amoxicillin** 3x/d für 5-7 Tage

■ Indikationen im Einzelfall

- schwere kardiale oder respiratorische Vorerkrankungen
- angeborene oder erworbene Immundefekte
- ältere Patienten (> 75 Jahre)

(Evidenzlevel T IV / Empfehlungsstärke C)

EbM-Guidelines, Rabady/Sönnichsen, 2015

DEGAM Leitlinie Nr. 11 Akuter Husten, 2014

Management of infection guidance for primary care for consultation, Public Health England, 2016

Efficacy of anti-inflammatory or antibiotic treatment in patients with non-complicated acute bronchitis and discoloured sputum: randomised placebo controlled trial

 OPEN ACCESS

Carl Llor *associate professor*¹ *senior visiting research fellow*³, Ana Moragas *associate professor*¹, Carolina Bayona *general practitioner*⁴, Rosa Morros *senior clinical pharmacologist*^{2,5}, Helena Pera *clinical research associate*², Oleguer Plana-Ripoll *PhD fellow*^{2,6}, Josep M Cots *associate professor*⁷, Marc Miravittles *senior researcher*⁸

BMJ 2013;347:f5762 doi: 10.1136/bmj.f5762 (Published 4 October 2013)

- RCT mit 416 Teilnehmern
 - Ibuprofen: 136
 - Amoxicillin-Clavulansäure: 137
 - Placebo: 143
- Im Durchschnitt 11 Hustentage

➤ Keinen signifikanten Unterschied in der Anzahl der Hustentage!

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Aabenhus R, Jensen JUS, Jørgensen KJ, Hróbjartsson A, Bjerrum L

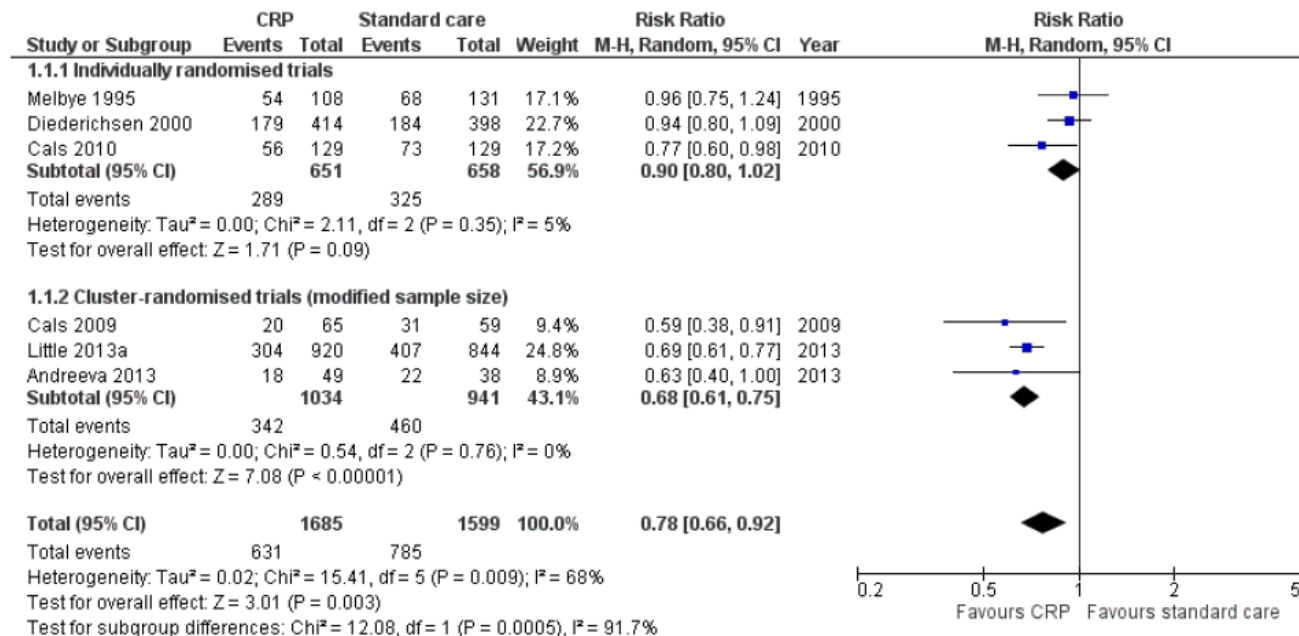
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6 randomisierte kontrollierte Studien mit 3284 Teilnehmern

Biomarker: C-reaktives Protein (CRP)

Figure 4. Forest plot of comparison: I C-reactive protein - antibiotic prescribing: all trials, outcome: I.I C-reactive protein - antibiotics prescribed at index consultation. All trials (cluster-RCTs modified sample size):.



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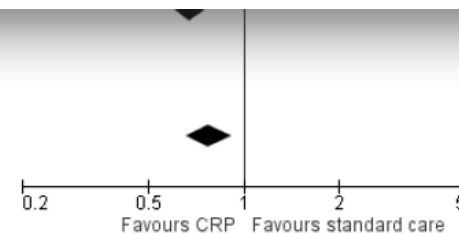
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Study or Subgroup	CRP Events	CRP Total	Standard care Events	Standard care Total	Weight	Risk Ratio M-H, Random, 95% CI	Year	Risk Ratio M-H, Random, 95% CI
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Authors' conclusions

A point-of-care biomarker (e.g. C-reactive protein) to guide antibiotic treatment of ARIs in primary care can reduce antibiotic use, although the degree of reduction remains uncertain. Used as an adjunct to a doctor's clinical examination this reduction in antibiotic use did not affect patient-reported outcomes, including recovery from and duration of illness. However, a possible increase in hospitalisations is of concern. A more precise effect estimate is needed to assess the costs of the intervention and compare the use of a point-of-care biomarker to other antibiotic-saving strategies.

Subtotal (95% CI)	1034	941	43.1%	0.68 [0.61, 0.75]
Total events	342	460		
Heterogeneity: Tau ² = 0.00; Chi ² = 0.54, df = 2 (P = 0.76); I ² = 0%				
Test for overall effect: Z = 7.08 (P < 0.00001)				
Total (95% CI)	1685	1599	100.0%	0.78 [0.66, 0.92]
Total events	631	785		
Heterogeneity: Tau ² = 0.02; Chi ² = 15.41, df = 5 (P = 0.009); I ² = 68%				
Test for overall effect: Z = 3.01 (P = 0.003)				
Test for subgroup differences: Chi ² = 12.08, df = 1 (P = 0.0005), I ² = 91.7%				



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Stellenwert: Point of Care Testung

Eur Respir J 2010; 36: 601–607
DOI: 10.1183/09031936.00163309
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Procalcitonin guidance and reduction of antibiotic use in acute respiratory tract infection

O. Burkhardt*, **S. Ewig[#]**, **U. Haagen[†]**, **S. Giersdorf[†]**, **O. Hartmann[†]**, **K. Wegscheider⁺**,
E. Hummers-Pradier[§] and **T. Welte***

- **RCT: Standardversorgung vs. PCT geführte AB-Therapie**
- **Reduktion der antimikrobiellen Medikation um 41,6% in der PCT Gruppe**

Appropriate Antibiotic Use for Acute Respiratory Tract Infection in Adults: Advice for High-Value Care From the American College of Physicians and the Centers for Disease Control and Prevention

Aaron M. Harris, MD, MPH; Lauri A. Hicks, DO; and Amir Qaseem, MD, PhD, MHA, for the High Value Care Task Force of the American College of Physicians and for the Centers for Disease Control and Prevention*

Talking Points for Clinicians When Discussing the Use of Antibiotics in Patients With ARTI

The average adult has 2 to 3 episodes of ARTI per year.
Symptoms usually resolve in 1 to 2 weeks, but cough can last up to 6 weeks.
Symptomatic treatment tailored to patient preferences may provide relief.
Antibiotics do not cure most ARTIs or reduce time to resolution of symptoms.
Antibiotics cause many serious adverse effects and should be reserved for patients with confirmed group A streptococcal pharyngitis.

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Symptomatische Therapie

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Allgemeine Therapiemaßnahmen

- Keine Antibiotika **A**
- Aufklärung des Patienten über den Spontanverlauf eines akuten Erkältungshustens **A**
- Ausreichende Trinkmenge
- Wasserdampfinhalationen bei 43 Grad
- Analgetika bei Bedarf zur Symptomlinderung (z.B. Paracetamol, Ibuprofen)
- Therapie mit Expektoranzen nicht notwendig **B**
- Antitussiva nur in Ausnahmefällen (stark gestörter Nachtschlaf; kurzfristig) **B**
- Phytopharmaka können möglicherweise zur Symptomlinderung beitragen
Cave: mögliche Hepatotoxizität beachten

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