Editorial Comment

Community-Acquired Pneumonia in an Aging Population

As the overall US population grows older, two features related to community acquired pneumonia (CAP) operate to simultaneously reduce and increase its incidence. Generally, Americans aged ≥ 65 years tend to remain healthy despite their increasing age. However, some body systems cannot resist the depredations of age, even among healthy people. Factors such as smoking (which is, fortunately, on the decline in the United States), other exposures, and past pulmonary infections may predispose some to develop CAP later in life. As a result, even though those aged ≥ 65 years are healthier today than that age group might have been decades ago, and even though the population with CAP may be older now than in past years, the number of patients with CAP appears to stay the same as the general population ages.

In this issue, Dr. Liu asserts that penicillin-resistant organisms are on the rise, as are multidrug-resistant bacteria. In some cases, the usual first-line medications for CAP—a macrolide or doxycycline—may be replaced with a second-line medication, such as a respiratory fluoroquinolone. Dr. Liu reviews the literature on the use of the respiratory fluoroquinolones in the outpatient management of CAP. He discusses a number of important issues, such as the increasing prevalence of drug-resistant infections among older patients, including those who live independently at home.

In addition, Dr. Liu addresses central nervous system adverse events related to fluoroquinolone use, such as dizziness and headache, as well as the gastrointestinal effects, such as drug-related nausea, vomiting, and diarrhea. Unfortunately, older patients tend not to tolerate these particular adverse events very well, even though they are generally mild. An unsteady older person may be more likely to fall or to drive erratically when faced with the same degree of dizziness that would hardly bother a younger person. Furthermore, the older US population is becoming more overweight and more likely to have diabetes mellitus, just as we have seen in the younger population. This may require a more cautious approach to the use of respiratory fluoroquinolones, particularly gatifloxacin, to avoid QT prolongation. Dr. Liu presents a balanced picture of fluoroquinolone use, citing a recent meta-analysis that found treatment benefits were only modestly better in people treated for CAP with respiratory fluoroquinolones than in those treated with other types of drugs.

With resistance to levofloxacin (the best tolerated of the respiratory fluoroquinolones) increasing, and with less-than-expected breakthrough bacteremia observed with the first-line drugs, what is a practitioner to do? We do not really

have the answer, but Dr. Liu's article may help guide us toward a better understanding of the role of the respiratory fluoroquinolones in treating CAP in older patients.

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