Short notes on pneumonia.

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Abstract

Pneumonia is a common acute respiratory infection that affects the alveoli and distal airways. It is a major public health problem associated with high morbidity, short-term and long-term mortality in all age groups worldwide. Pneumonia is roughly classified into community-acquired pneumonia and hospital-acquired pneumonia. A variety of microorganisms, including bacteria, respiratory viruses, and fungi, can cause pneumonia, and their prevalence varies widely geographically. Pneumonia is more common in susceptible individuals, such as children under the age of five and older adults with previous chronic medical conditions.

Keywords: Pneumonia, Lung parenchyma, Community-acquired pneumonia.

Introduction

Pneumonia was defined as an infection of the lung parenchyma. Health care workers should remember that pneumonia is not a single disease, but rather an umbrella term for a range of syndromes caused by different organisms with different symptoms and sequelae. I have. Among other things, many attempts have been made to classify pneumonia based on etiology, the clinical setting in which the patient was infected, and the pattern of pulmonary parenchymal involvement [1].

Pneumonia is a common and well-recognized respiratory infection that occurs in primary care settings. Confirmation of the usual symptoms usually initiates a typical course of action that includes a physical examination and possibly imaging tests to confirm clinical suspicion. Further testing depends on the location of treatment (outpatient *vs* inpatient) and other specific criteria. Empiric antibiotic therapy is the cornerstone of treatment, and knowledge of local and regional microbial susceptibility and resistance improves the success rate of outpatient treatment of pneumonia, regardless of demographic and/or concomitant morbidity Increase. Special circumstances and scenarios that may arise, such as unresolved pneumonia, pediatric or geriatric populations, and travel-related infections, require more careful consideration of medical history, physical examination, and antibiotic selection [2].

Differential diagnosis of pneumonia includes asthma, Chronic Obstructive Pulmonary Disease (COPD), pulmonary edema, and malignancy, non-infectious consolidation of the lung, pleurisy, pulmonary embolism, foreign body aspiration, bronchiectasis, and bronchiolitis. When differentiation becomes difficult, parameters such as C-reactive protein, erythrocyte sedimentation rate, procalcitonin level, white blood cell count, and body temperature can be used to make the diagnosis. A diagnosis of pneumonia should be considered in patients with acute fever or chills and cough, which can be productive. Additional symptoms commonly observed are fatigue, anorexia, and pleuritic chest pain. Important components of medical history include recent travel, history of underlying lung disease, and smoking history [3].

The presence of these findings is not indicative of pneumonia, as a history of alcoholism or bloody sputum is associated with a relatively high risk of developing pneumonia. Physical examination findings commonly evaluated in patients with pneumonia include decreased breath sounds, palpable fremitus, and crackling sounds. Tachypnea and hypotension are more worrying symptoms that may be observed and warrant urgent investigation. It is important to maintain a high level of suspicion because immunocompromised and elderly patients and those in nursing homes often do not have overt pneumonia symptoms compared to the general population [4].

Pneumonia should be treated with antibiotics. The antibiotic of choice for first-line therapy is amoxicillin dispersible tablets. Most cases of pneumonia require oral antibiotics, which are often prescribed at health centers. These cases can also be diagnosed at the community level by trained health professionals and treated with inexpensive oral antibiotics. Hospitalization is recommended only for severe pneumonia [5].

Conclusion

Disease development is highly dependent on the host's immune response, and pathogen characteristics are less important. Patients with pneumonia often present with respiratory and systemic symptoms, and diagnosis is based on both clinical and radiological findings. Identifying the causative pathogen is very important. Delayed or inadequate antibiotic treatment can lead to worse outcomes. New antibiotic and non-antibiotic therapies, as well as rapid and accurate diagnostic tests that

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can detect pathogens and antibiotic resistance, will improve the treatment of pneumonia.

References

1. Falkenhorst G, Remschmidt C, Harder T, et al. Effectiveness of the 23-valent pneumococcal polysaccharide vaccine (PPV23) against pneumococcal disease in the elderly: systematic review and meta-analysis. PLoS One. 2017;12(1):e0169368.
2. Segal LN, Methe BA, Nolan A, et al. HIV-1 and bacterial pneumonia in the era of antiretroviral therapy. Proc Am Thorac Soc. 2011;8(3):282-7.
3. Pomilla PV, Brown RB. Outpatient treatment of community-acquired pneumonia in adults. Ann Am Thorac Soc. 1994;154(16):1793-802.
4. Faverio P, Aliberti S, Bellelli G, et al. The management of community-acquired pneumonia in the elderly. Eur J Intern Med. 2014;25(4):312-9.
5. Singhi S, Dhawan A, Kataria S, et al. Clinical signs of pneumonia in infants under 2 months. Arch Dis Childh Lond. 1994;70(5):413-7

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