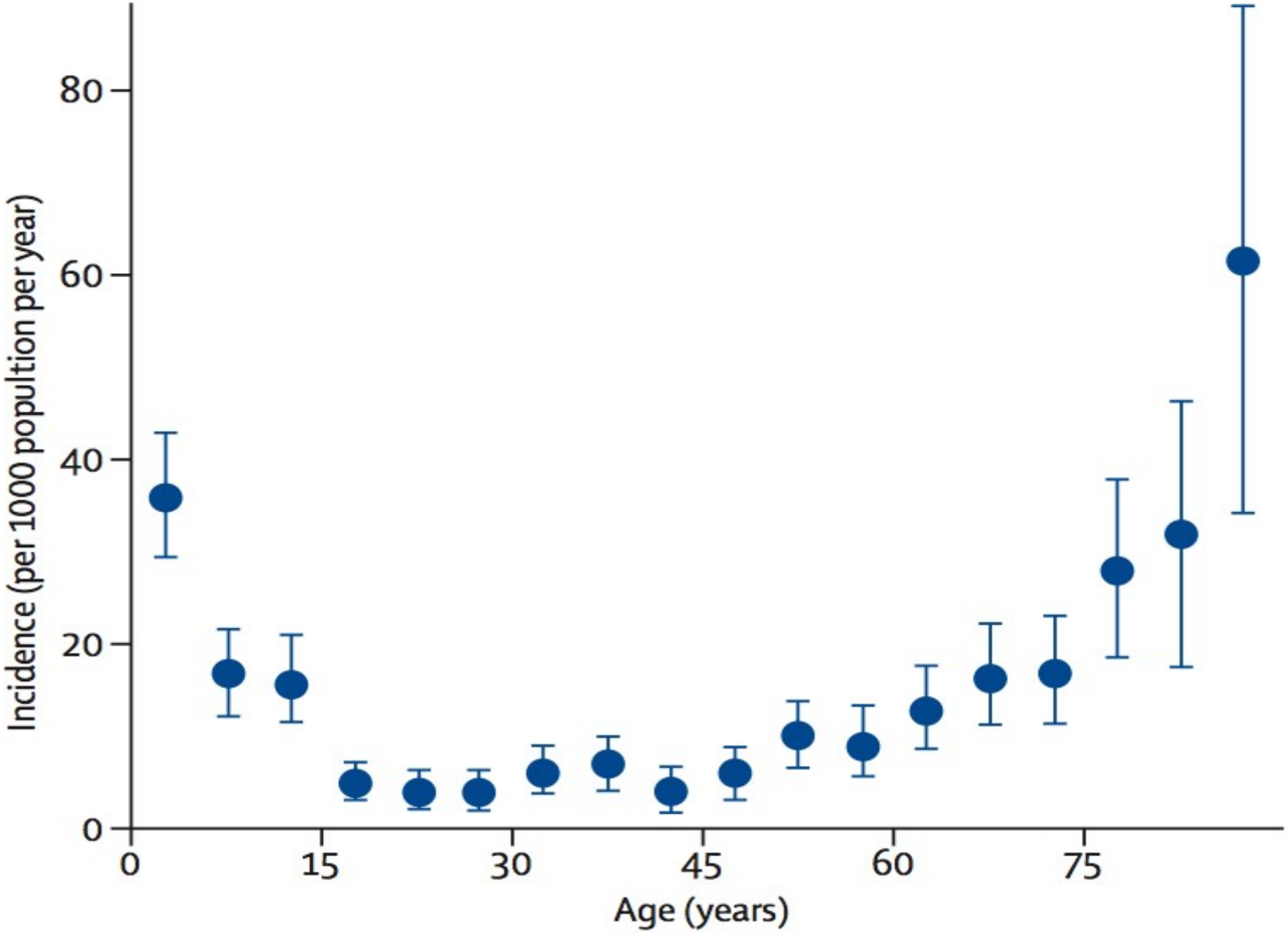
Place des traitements antibiotiques courts

Aurélien Dinh

Maladies infectieuses et tropicales, Hôpital R. Poincaré, Garches, APHP

Université Paris Saclay

plupart des pneumonies aigues communautaires (PAC)
nt retrouvées chez les patients âgés (> 65 ans).



Jordi & Chastre, AJRC

lan AP-HP pour
éserver l'efficacité
s antibiotiques
re 2017

tifier toute ATB > 7j

Antibiothérapie : des durées raccourcies pour les infections évoluant favorablement*

Infections		Durée AB (en jour)	Conditions
Infections respiratoires hautes	Sinusite maxillaire de l'adulte	5	
	Angine avec TDR** streptocoque positif	6	Amoxicilline
Infections respiratoires basses	Exacerbation de BPCO	5	seulement si AB requ
	Pneumonie communautaire de l'enfant	5	
	Pneumonie communautaire de l'adulte	5***	Evolution favorable rap
Bactériémies liées aux cathéters veineux centraux	Staphylocoque coagulase négative	5	Après retrait du cathé
	Streptocoque, entérocoque, BGN	7	Après retrait du cathé
	Staphylococcus aureus	14	Après retrait du cathé
	Thrombophlébite suppurée	21	
Bactériémies primaires non compliquées	Streptocoques oraux	5	
	Entérobactéries, entérocoques	7	
	Staphylococcus aureus, *Staphylococcus lugdunensis*	14	
Infections urinaires	Cystite aigüe	1	Fosfomycine-trométan
	Pyélonéphrite	7	Fluoroquinolones ou βlact injectables, sinon 10 jo
	Prostatite	14	Cotrimoxazole ou fluoroqui sinon 21 jours
Infections de la peau et des tissus mous	Dermo-hypodermite non nécrosante	7	
Infections intra abdominales	Perforation digestive opérée, appendicite opérée non perforée, cholécystite opérée	≤1	
	Péritonite localisée opérée	3	
	Péritonite généralisée opérée	4	
	Infection de liquide d'ascite	5	
	Diarrhées bactériennes nécessitant une antibiothérapie	3	
	Infection à *Clostridium difficile* toxinogène	10	

ecommandations

DSA/ATS guidelines (Metlay *et al*. CID 2019)

tients with CAP should be treated for a minimum of **5 days**.

e recommended duration for patients with **good clinical response** thin the first 2-3 d of therapy is 5 to 7 days total.

NICE recommendations (2019)

lay course of antibiotic therapy for patients with low severity CAP;

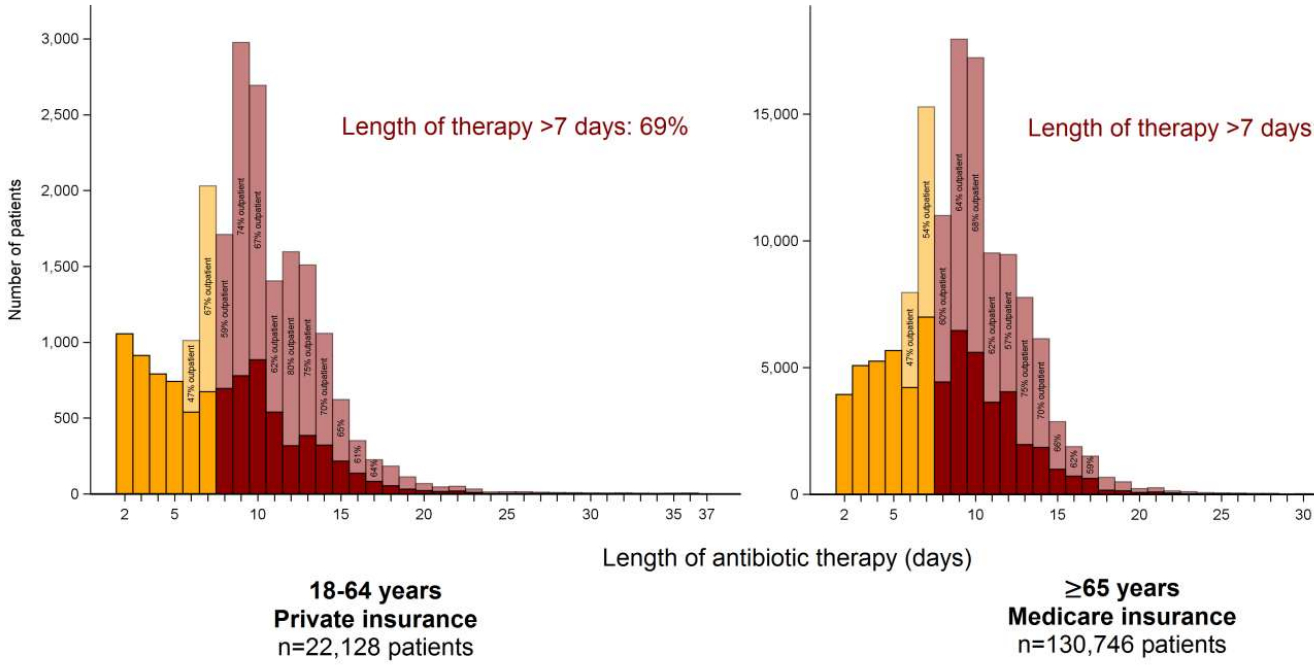
nsider a **7-10** day course of antibiotic therapy for patients with derate **and high severity** CAP.

ur le terrain

uration of Antibiotic Use Among Adults With ncomplicated Community-Acquired Pneumonia equiring Hospitalization in the United States

H. Yi, Kelly M. Hatfield, James Baggs, Lauri A. Hicks, Arjun Srinivasan, Sujan Reddy, and John A. Jernigan

- Etude rétrospective
- Base de donnée informatique hospitalière (2012-2013)
- PAC simple
- 22 128 patients (2100 hopitaux)
- Durée moyenne 9,5j
- 70%>7j



Yi *et al.*

re infection specialists recommending short antibiotic treatment durations? An ESCMID international cross-sectional survey

abriel Macheda[1], Oliver J. Dyar[2], Amandine Luc[3], Bojana Beovic[4,5], Guillaume Béraud[6–8], Bernard Castan[9], y Gauzit[10], Philippe Lesprit[11], Pierre Tattevin[12], Nathalie Thilly[3,13] and Céline Pulcini[1,13]* on behalf of ESGAP and SPILF

Enquête internationale

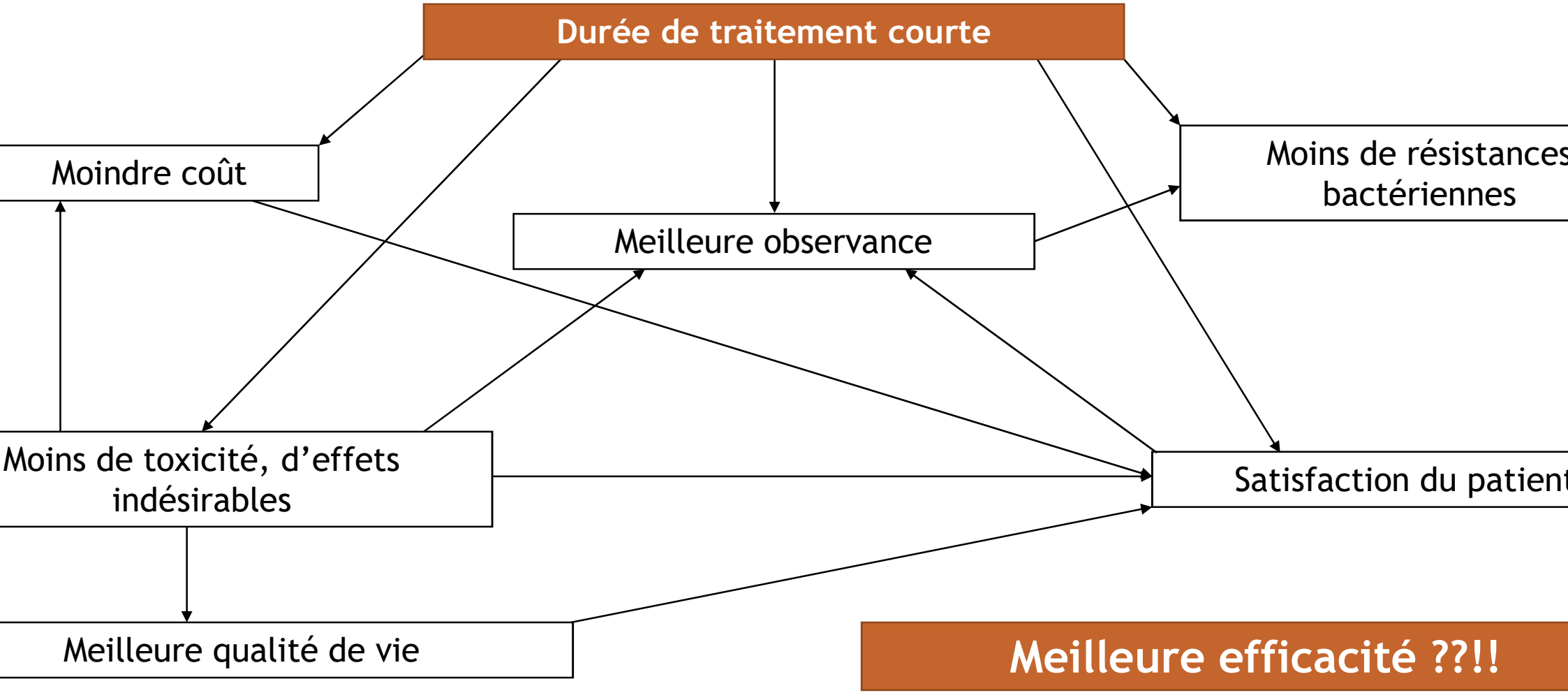
Interrogatoire (15 situations cliniques)

866 participants (experts : infectiologues, EMA, microbiologistes)

En France 46% ont recommandé une durée courte

Et pourtant !

térêt d'une durée courte pour une même efficacité !!

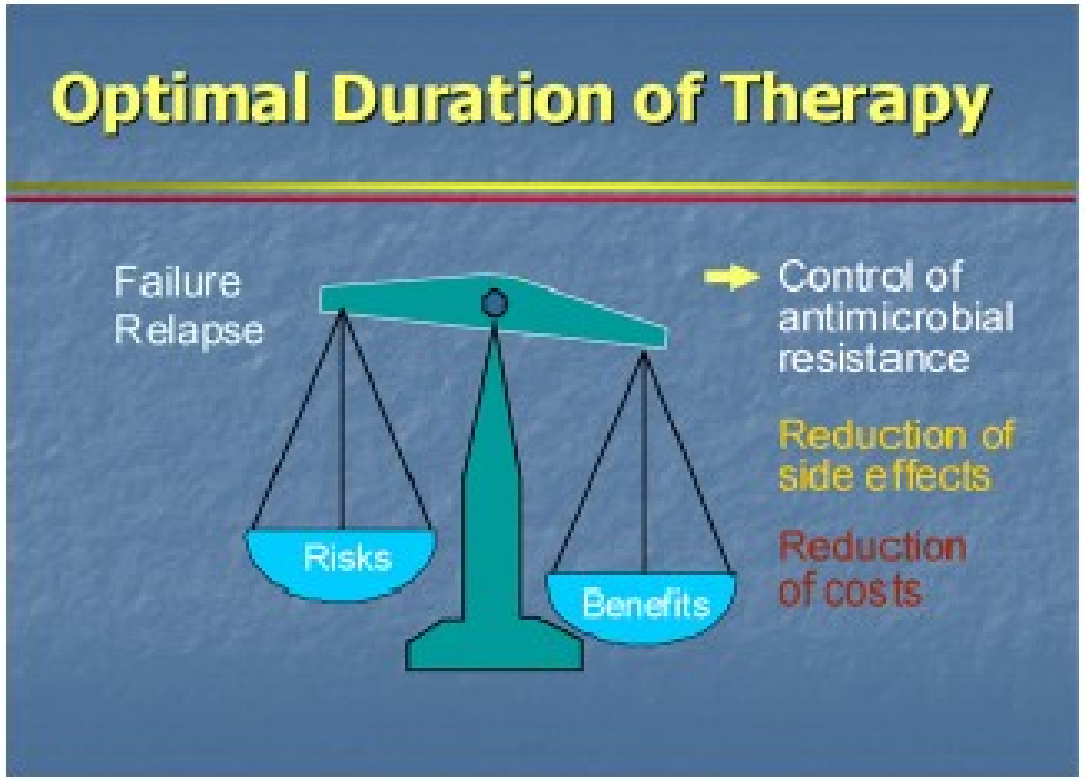


D'après Li JZ. Am Me

térêt individuel/collectif

ntolérance et EIG = échec et….émergence de résistances

Balance bénéfice/risque



Rubinstein E. Int J Antimicrob Agen

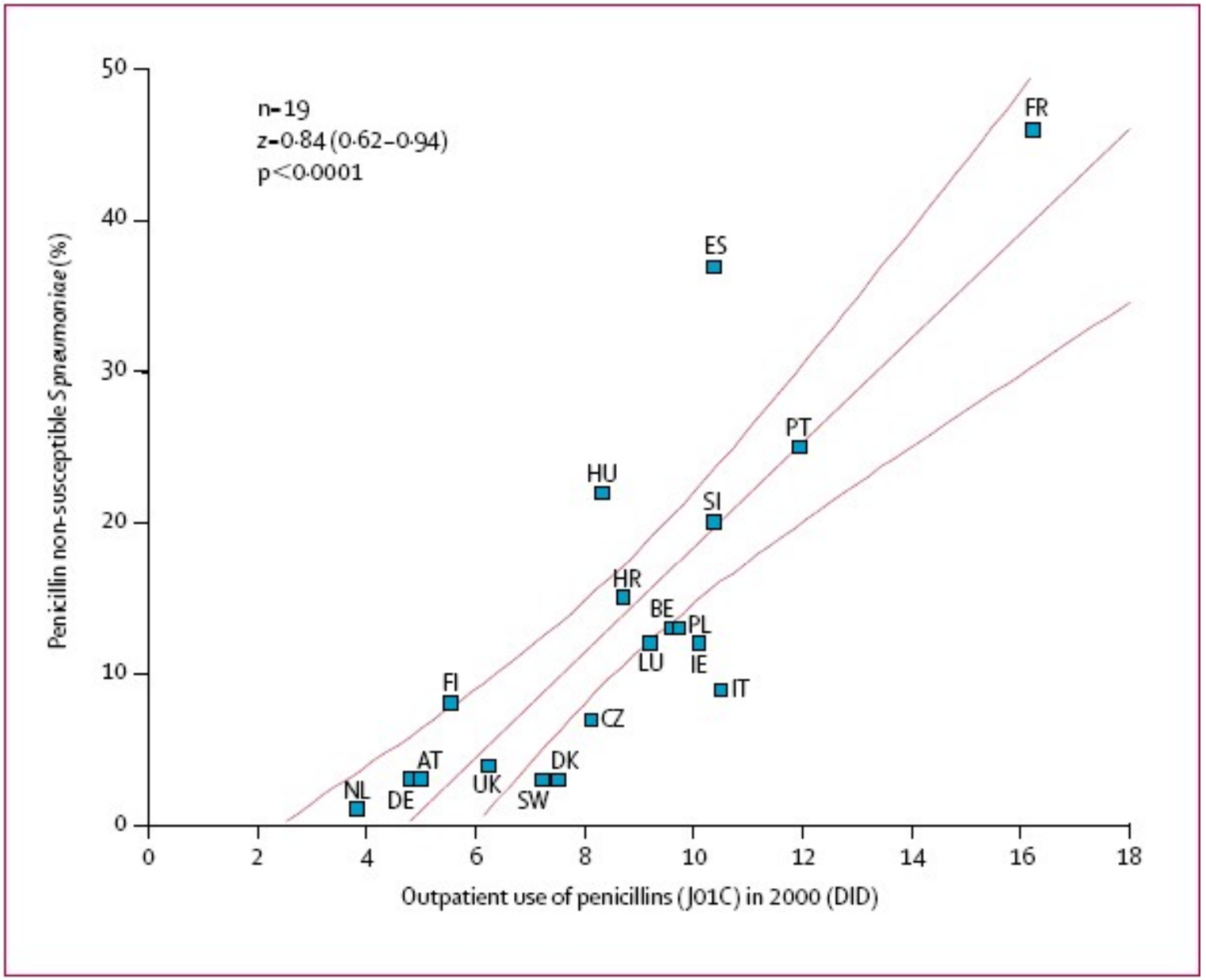


Figure 6: **Correlation between penicillin use and prevalence of penicillin non-susceptible *S pneumoniae***
AT, Austria; BE, Belgium; HR, Croatia; CZ, Czech Republic; DK, Denmark; FI, Finland; FR, France; DE, Germany; HU, Hungary; IE, Ireland; IT, Italy; LU, Luxembourg; NL, The Netherlands; PL, Poland; PT, Portugal; SI, Slovenia; ES, Spain; UK, England only.

OR de portage de pneumocoque péni R

	OR	IC 95%	P-value
se de béta-lactamines ns les 30 jours alables	3,0	1,1-8,3	0,03
us-dosage	5,9	2,1-16,7	0,002
rée de traitement (>5 rs)	3,5	1,3-9,8	0,02

Guillemot D, JA

omparison of 8 vs 15 Days of ntibiotic Therapy for Ventilator-Associated eumonia in Adults

Randomized Trial

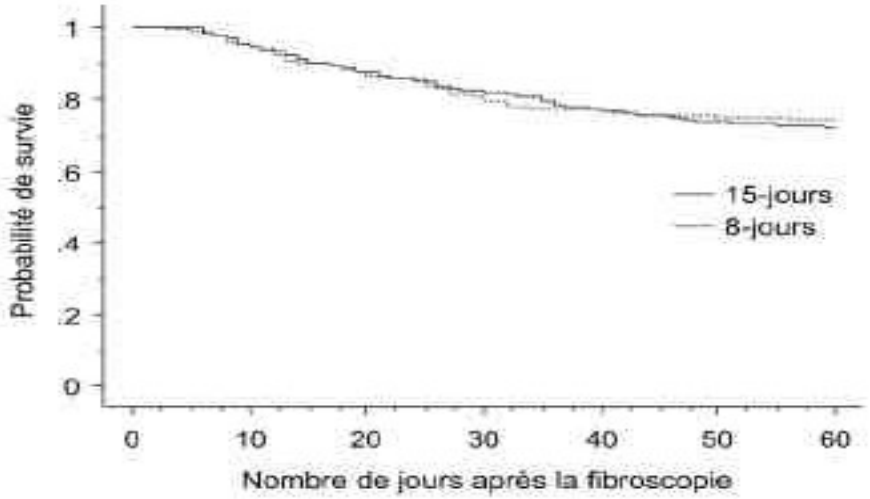


Fig. 2. Probabilité de survie (courbes de Kaplan-Meier) en fonction de la durée de traitement antibiotique (8 vs 15 jours) d'une pneumonie acquise sous ventilation mécanique [16].

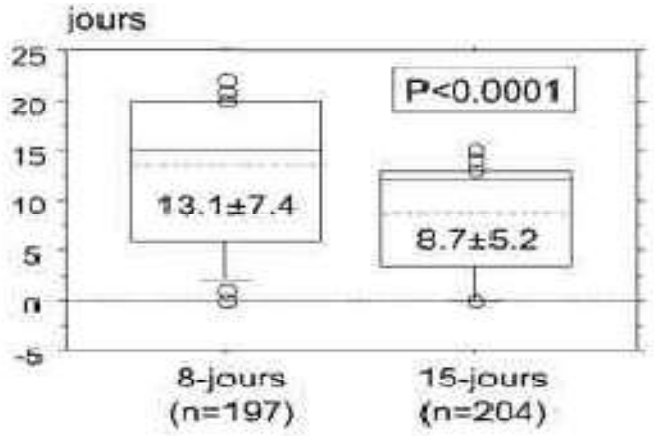


Fig. 3. Nombre de jours vivant sans antibiotique en fonction de la durée de traitement antibiotique d'une pneumonie acquise sous ventilation mécanique (d'après [16]).

ably, among patients who developed recurrent pulmonary infections, multiresistant pathogens emerged ficantly less frequently in those who had received 8 days of antibiotics (42.1% vs 62.3% of recurrent ctions; *P*=.04).

J. Chastre et al. JA

tion and Restricted Use of Antibiotics in a Medical
nsive Care Unit

on the Incidence of Ventilator-associated Pneumonia Caused by
otic-resistant Gram-negative Bacteria

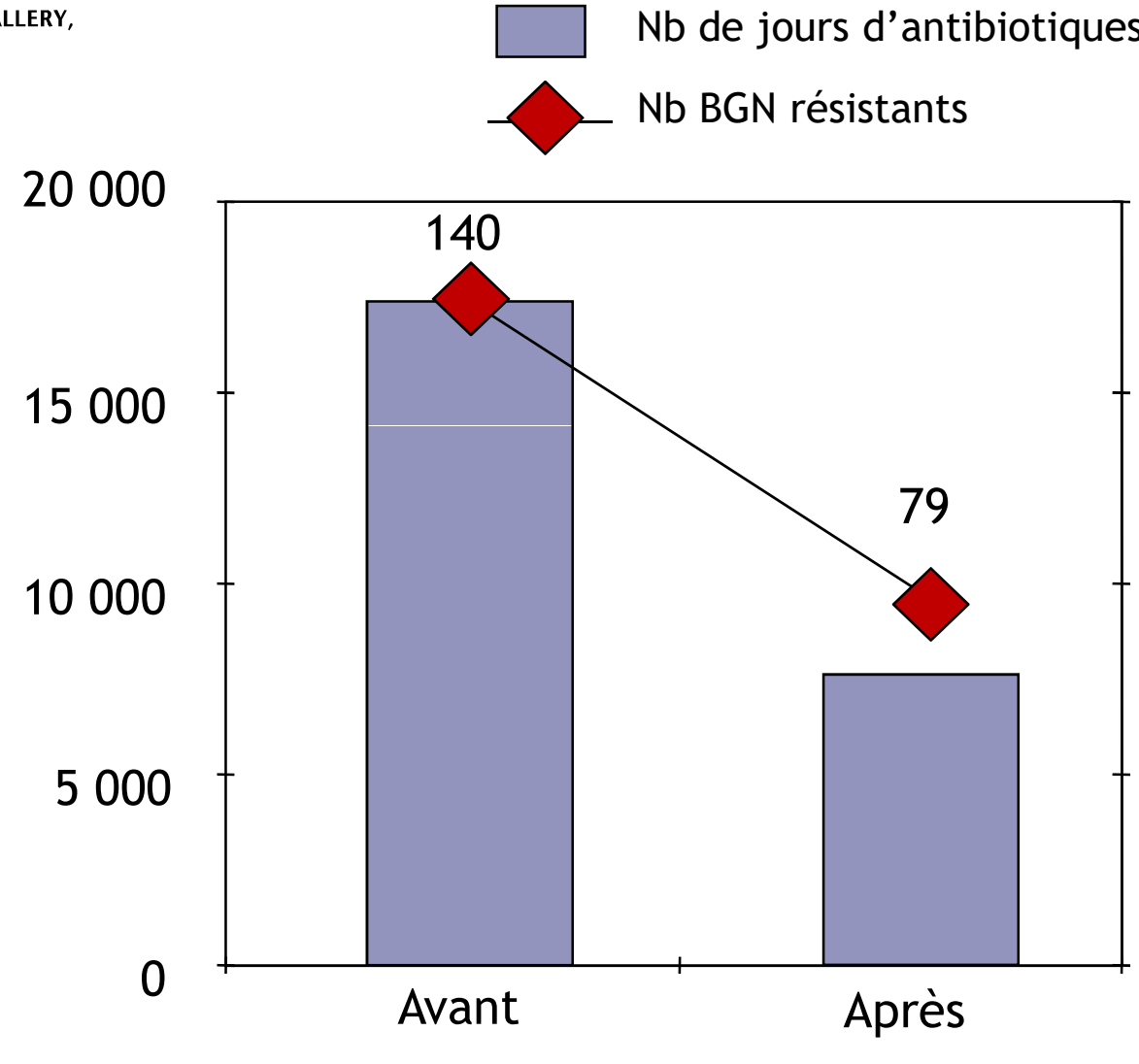
RUSON, GILLES HILBERT, FREDERIC VARGAS, RUDDY VALENTINO, CECILE BEBEAR, ANNIE ALLERY,
IE BEBEAR, GEORGES GBIKPI-BENISSAN, and JEAN-PIERRE CARDINAUD

tude avant/après en réanimation
3455 patients) sur 4 ans

ntervention

1. Restriction ceftazidime et ciprofloxacine
2. Rotation d'antibiotiques
3. Supervision des prescriptions par deux investigateurs

ith an appropriate control of dosing and duration of treatment."



Gruson D *et al*. Am J Respir Crit Care M

al Investigation

k of Aortic Dissection and Aortic Aneurysm Patients Taking Oral Fluoroquinolone

hang Lee, MD, ScD; Meng-tse Gabriel Lee, PhD; Yueh-Sheng Chen, MD; Shih-Hao Lee, MA; ng Chen, MD, PhD; Shyr-Chyr Chen, MD, MBA; Shan-Chwen Chang, MD, PhD

- tude cas témoins apparié
- 47 700 contrôles
- ata base Assurance maladie aïwan
- M de personnes suivi de 000 à 2011
- rescription de FQ dans année précédente
- isque d'anévrysme et issection aortique

Duration of Fluoroquinolone Use, d	Case/Person-years, No. (Incidence Rate, %)	Propensity Score–Adju Rate Ratio (95% CI)
<3 [Reference]	1432/147 495 (0.97)	1 [Reference]
3-14	33/1271 (2.60)	1.60 (1.10-2.52)[a]
>14	12/411 (2.92)	1.81 (0.91-3.17)

s Antibiotic Treatment Duration and Adverse Events in Patients italized With Pneumonia

ihospital Cohort Study

Vaughn, MD, MSc; Scott A. Flanders, MD; Ashley Snyder, MS; Anna Conlon, PhD; Mary A.M. Rogers, PhD, MS; Malani, MD; Elizabeth McLaughlin, MS, RN; Sarah Bloemers, MPH; Arjun Srinivasan, MD; Jerod Nagel, PharmD, BCPS; z, DO; Danielle Osterholzer, MD; Rama Thyagarajan, MD; Lama Hsaiky, PharmD, BCPS; Vineet Chopra, MD, MSc; N. Gandhi, MD

e 3. Association of Excess Antibiotic Treatment Duration With 30-Day Adverse Outcomes (*n* = 6481)*

omes at 30 Days	Appropriate Duration (*n* = 2090), *n (%)*†	Excess Duration (*n* = 4391), *n (%)*‡	Unadjusted OR per Excess Day (95% CI)§	Unadjusted *P* Value§	Adjusted OR per Excess Day (95% CI)§	A *P*
lity‖	40 (1.9)	88 (2.0)	0.99 (0.94–1.03)	0.52	1.01 (0.97–1.05)	0
nission‖	294 (14.1)	497 (11.3)	0.99 (0.96–1.02)	0.48	1.00 (0.98–1.03)	0
gency department visit‖	238 (11.4)	480 (10.9)	0.97 (0.94–1.00)	0.021	0.98 (0.95–1.01)	0
otic-associated adverse event¶	72 (3.4)	210 (4.8)	1.04 (1.01–1.07)	0.012	1.03 (1.00–1.06)	0
stridioides difficile infection**	11 (0.5)	22 (0.5)	0.92 (0.81–1.05)	0.21	0.93 (0.81–1.07)	0
vider-documented†††‡‡	43 (2.1)	87 (2.0)	1.00 (0.94–1.05)	0.86	0.99 (0.94–1.05)	0
ent-reported††§§	26/1132 (2.3)	114/2460 (4.6)	1.05 (1.02–1.08)	<0.001	1.05 (1.02–1.08)	0
osite adverse outcome‖	499 (23.9)	897 (20.4)	0.98 (0.96–1.00)	0.078	0.99 (0.97–1.01)	0

urgery | Original Investigation

ociation of Duration and Type of Surgical Prophylaxis n Antimicrobial-Associated Adverse Events

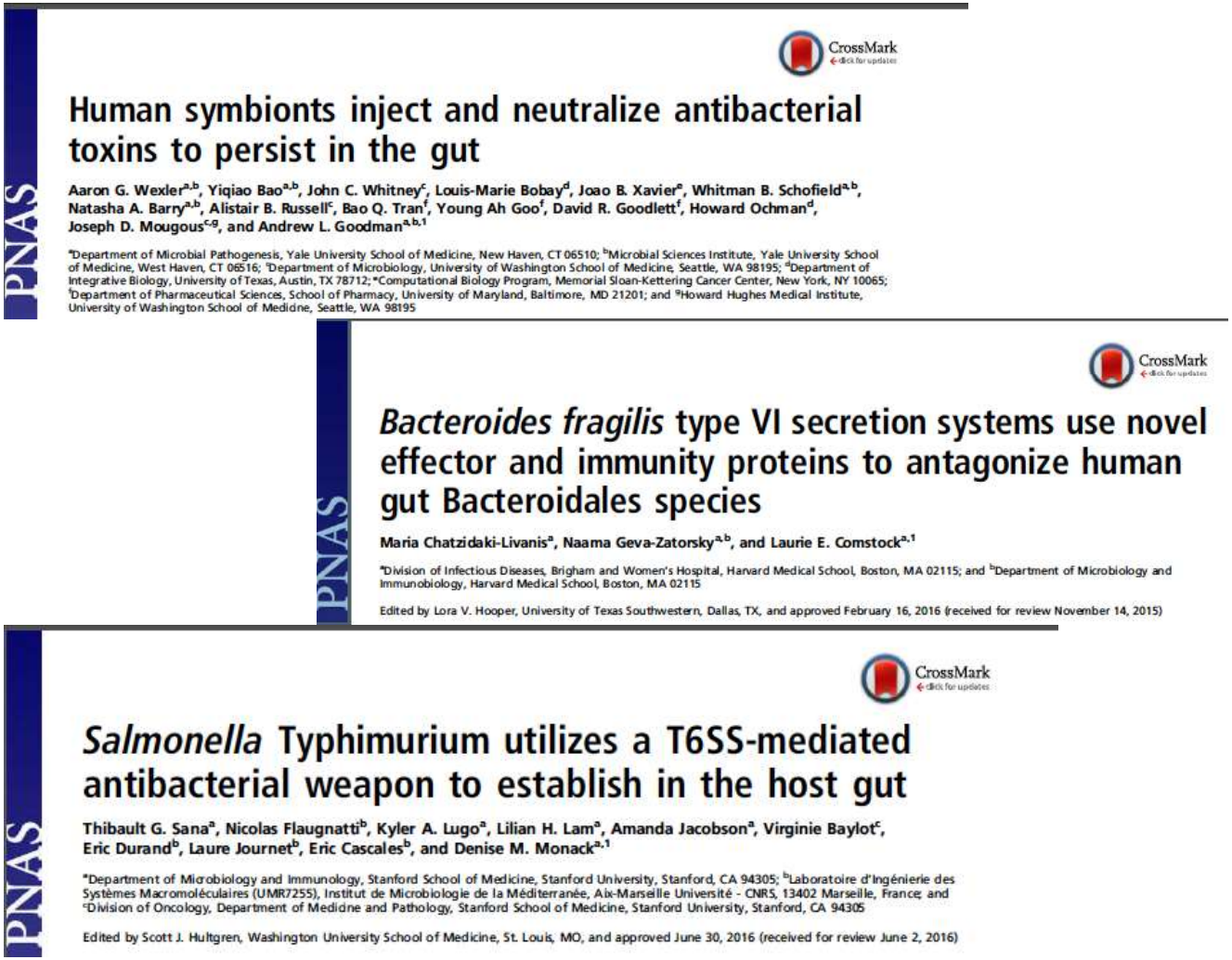
anch-Elliman, MD, MMSc; William O'Brien, MS; Judith Strymish, MD; Kamal Itani, MD; Wyatt, MD; Kalpana Gupta, MD, MPH

Durée ATB prophylaxie (h)	ISO	IRA	ICD
<24	1 (ref)	1 (ref)	1 (ref)
24-48	0.96 (0.71-1.29)	1.03 (0.95-1.12)	1.08 (0.89-1.31)
48-<72	0.73 (0.42-1.30)	1.22 (1.08-1.39)	2.43 (1.80-3.27)
⩾72	0.99 (0.49-2.00)	1.82 (1.54-2.16)	3.65 (2.40-5.55)

Chaque jour compte !

JAMA Su

icrobiote barrière et risque infectieux



PNAS

CrossMark

Human symbionts inject and neutralize antibacterial toxins to persist in the gut

Aaron G. Wexler[a,b], Yiqiao Bao[a,b], John C. Whitney[c], Louis-Marie Bobay[d], Joao B. Xavier[e], Whitman B. Schofield[a,b], Natasha A. Barry[a,b], Alistair B. Russell[c], Bao Q. Tran[f], Young Ah Goo[f], David R. Goodlett[f], Howard Ochman[d], Joseph D. Mougous[c,g], and Andrew L. Goodman[a,b,1]

[a]Department of Microbial Pathogenesis, Yale University School of Medicine, New Haven, CT 06510; [b]Microbial Sciences Institute, Yale University School of Medicine, West Haven, CT 06516; [d]Department of Microbiology, University of Washington School of Medicine, Seattle, WA 98195; [d]Department of Integrative Biology, University of Texas, Austin, TX 78712; [e]Computational Biology Program, Memorial Sloan-Kettering Cancer Center, New York, NY 10065; [f]Department of Pharmaceutical Sciences, School of Pharmacy, University of Maryland, Baltimore, MD 21201; and [g]Howard Hughes Medical Institute, University of Washington School of Medicine, Seattle, WA 98195

PNAS

CrossMark

Bacteroides fragilis type VI secretion systems use novel effector and immunity proteins to antagonize human gut Bacteroidales species

Maria Chatzidaki-Livanis[a], Naama Geva-Zatorsky[a,b], and Laurie E. Comstock[a,1]

[a]Division of Infectious Diseases, Brigham and Women's Hospital, Harvard Medical School, Boston, MA 02115; and [b]Department of Microbiology and Immunobiology, Harvard Medical School, Boston, MA 02115

Edited by Lora V. Hooper, University of Texas Southwestern, Dallas, TX, and approved February 16, 2016 (received for review November 14, 2015)

PNAS

CrossMark

Salmonella Typhimurium utilizes a T6SS-mediated antibacterial weapon to establish in the host gut

Thibault G. Sana[a], Nicolas Flaugnatti[b], Kyler A. Lugo[a], Lilian H. Lam[a], Amanda Jacobson[a], Virginie Baylot[c], Eric Durand[b], Laure Journet[b], Eric Cascales[b], and Denise M. Monack[a,1]

[a]Department of Microbiology and Immunology, Stanford School of Medicine, Stanford University, Stanford, CA 94305; [b]Laboratoire d'Ingénierie des Systèmes Macromoléculaires (UMR7255), Institut de Microbiologie de la Méditerranée, Aix-Marseille Université - CNRS, 13402 Marseille, France; and [c]Division of Oncology, Department of Medicine and Pathology, Stanford School of Medicine, Stanford University, Stanford, CA 94305

Edited by Scott J. Hultgren, Washington University School of Medicine, St. Louis, MO, and approved June 30, 2016 (received for review June 2, 2016)

- Effet barrière vis-à vis des bactéries exogènes “résistan à la colonisation”
  - élimination totale la souche exogèn
  - maintien de la souche exogène e sous-dominance
- La flore digestive stimule l’immunité locale et générale

ectious Diseases
R ARTICLE

IDSA Infectious Diseases Society of America hivma hiv medicine association OXFORD

# of Subsequent Sepsis Within 90 Days After a Hospital y Type of Antibiotic Exposure

John A. Jernigan, Alison Laufer Halpin, Lauren Epstein, Kelly M. Hatfield, and L. Clifford McDonald

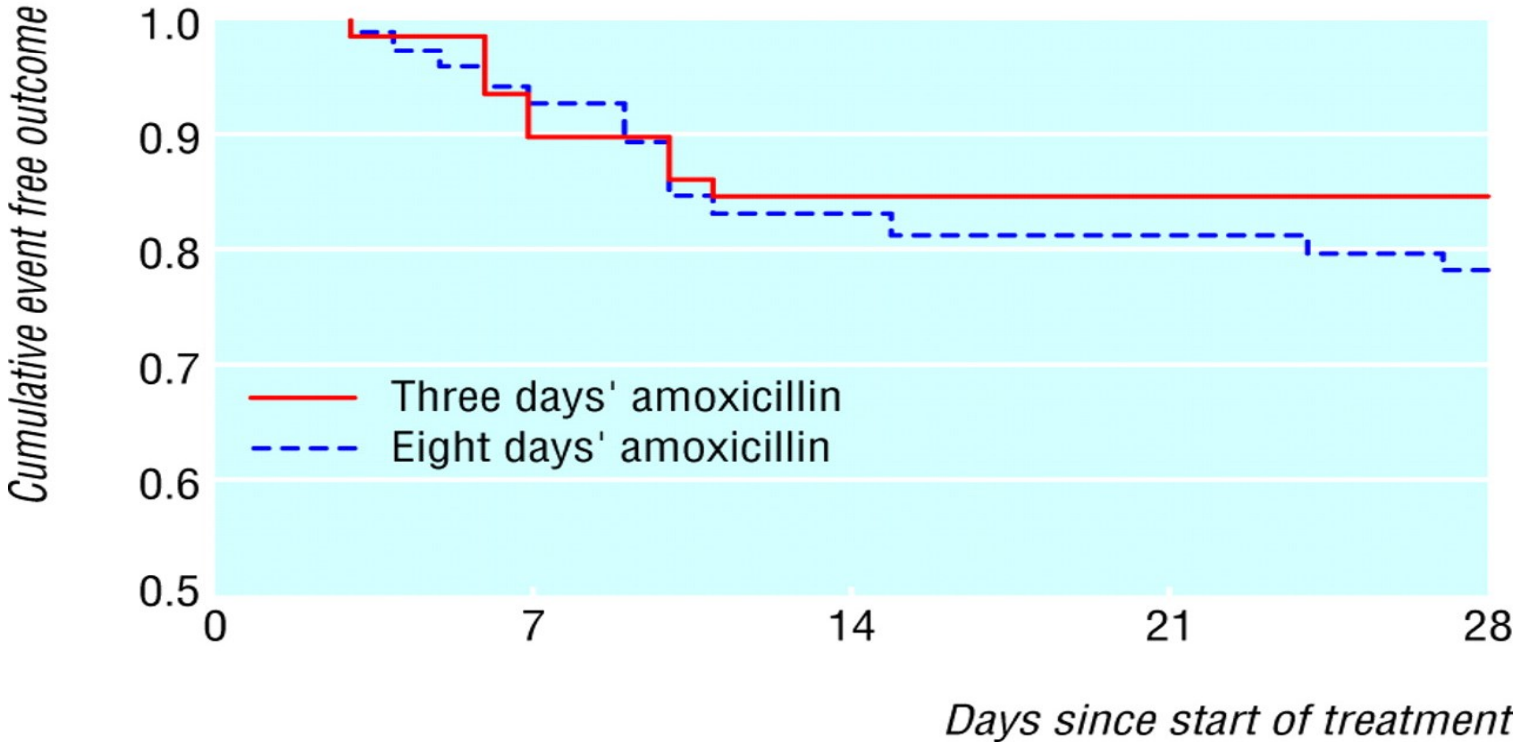
Antibacterial Exposure	OR (95% CI)	
	Primary Outcome: Severe Sepsis/Septic Shock[b]	Sec Out Se
High-risk antibacterial agents[d]	1.65 (1.59–1.70)	1.49 (1
Low-risk antibacterial agents[e]	1.07 (1.02–1.13)	1.04 (1
Control antibacterial agents[f]	1.22 (1.12–1.34)	1.20 (1
No exposure to antibacterial agents	Reference	Refere
Antibiotic classes exposed to during stay, No.		
≥4	2.23 (2.12–2.36)	1.92 (1
3	1.80 (1.72–1.89)	1.57 (1
2	1.49 (1.43–1.56)	1.36 (1
1	1.30 (1.25–1.35)	1.26 (1
0	Reference	Refere
Duration of antibacterial therapy, d		
≥14	2.17 (2.06–2.29)	1.89 (1
7–13	1.68 (1.61–1.75)	1.52 (1
3–6	1.41 (1.36–1.47)	1.34 (1
1–2	1.23 (1.18–1.29)	1.16 (1
0	Reference	Refere

Research

BMJ

ffectiveness of discontinuing antibiotic treatment after three days ersus eight days in mild to moderate-severe community acquired neumonia: randomised, double blind study

chida el Moussaoui, Corianne A J M de Borgie, Peterhans van den Broek, Willem N Hustinx, Paul Bresser, Guido E an den Berk, Jan-Werner Poley, Bob van den Berg, Frans H Krouwels, Marc J M Bonten, Carla Weenink, Patrick M Bossuyt, Peter Speelman, Brent C Opmeer, Jan M Prins

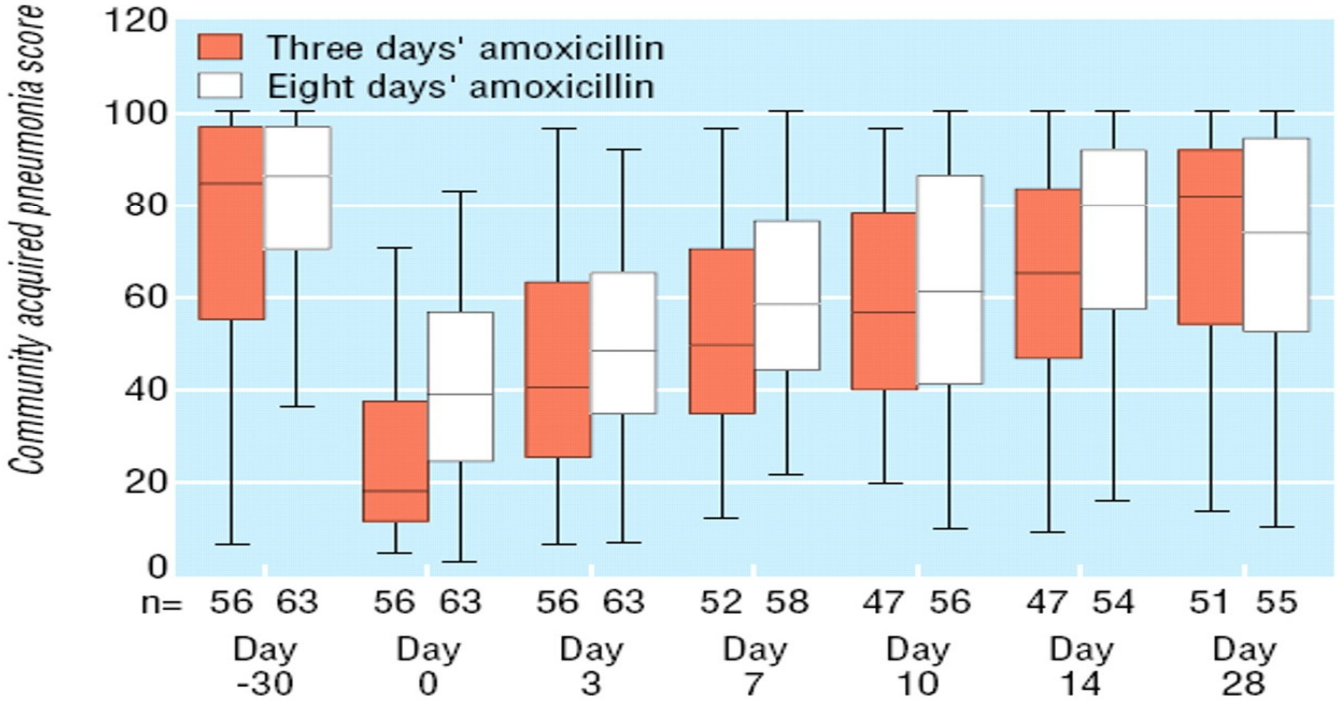


El Moussaoui et al. B

rincipe

Diminuer l'inoculum jusqu'au niveau où l'immunité peut contrôler l'infection (« stériliser »)

- RCT
- PAC non sévère
- 3 vs 8j de peni A



El Moussaoui et al. B

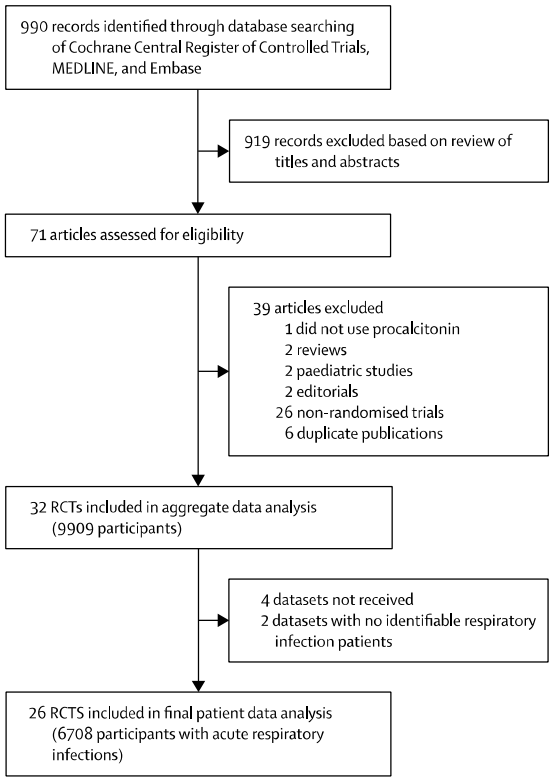

FIFTY SHADES OF GREY
ORIGINAL MOTION PICTURE SOUNDTRACK

ers une durée individualisée ?

CT ?

fect of procalcitonin-guided antibiotic treatment on ortality in acute respiratory infections: a patient level eta-analysis

p Schuetz, Yannick Wirz*, Ramon Sager*, Mirjam Christ-Crain, Daiana Stolz, Michael Tamm, Lila Bouadma, Charles E Luyt, Michel Wolff, Chastre, Florence Tubach, Kristina B Kristoffersen, Olaf Burkhardt, Tobias Welte, Stefan Schroeder, Vandack Nobre, Long Wei, Heiner C Bucher, li Annane, Konrad Reinhart, Ann R Falsey, Angela Branche, Pierre Damas, Maarten Nijsten, Dylan W de Lange, Rodrigo O Deliberato, ina F Oliveira, Vera Maravić-Stojković, Alessia Verduri, Bianca Beghé, Bin Cao, Yahya Shehabi, Jens-Ulrik S Jensen, Caspar Corti, H van Oers, Albertus Beishuizen, Armand R J Girbes, Evelien de Jong, Matthias Briel*, Beat Mueller*



et al. Lancet 2017

	Control (n=3372)	Procalcitonin group (n=3336)
Age, years	61·2 (18·4)	60·7 (18·8)
Sex		
Men	1910 (57%)	1898 (57%)
Women	1462 (43%)	1438 (43%)
Clinical setting		
Primary care	501 (15%)	507 (15%)
Emergency department	1638 (49%)	1615 (48%)
ICU	1233 (37%)	1214 (36%)
Primary diagnosis		
Total upper acute respiratory infection	280 (8%)	292 (9%)
Common cold	156 (5%)	149 (4%)
Rhino-sinusitis, otitis	67 (2%)	73 (2%)
Pharyngitis, tonsillitis	46 (1%)	61 (2%)
Total lower acute respiratory infection	3092 (92%)	3044 (91%)
Community-acquired pneumonia	1468 (44%)	1442 (43%)
Hospital-acquired pneumonia	262 (8%)	243 (7%)
Ventilator-associated pneumonia	186 (6%)	194 (6%)
Acute bronchitis	287 (9%)	257 (8%)
Exacerbation of COPD	631 (19%)	621 (19%)
Exacerbation of asthma	127 (4%)	143 (4%)
Other lower acute respiratory infection	131 (4%)	144 (4%)
Procalcitonin dose on enrolment		
Data available	2590 (77%)	3171 (95%)
<0·1 µg/L	921 (36%)	981 (31%)
0·1–0·25 µg/L	521 (20%)	608 (19%)
>0·25–0·5 µg/L	308 (12%)	383 (12%)
>0·5–2·0 µg/L	358 (14%)	520 (16%)
>2·0 µg/L	482 (19%)	679 (21%)

Data are mean (SD) or n (%). ICU=intensive care unit. COPD=chronic obstructive pulmonary disease.

ésultats

	Control (n=3372)	Procalcitonin group (n=3336)	Adjusted OR (95% CI)*, p value	$p_{interaction}$
Overall				
30-day mortality	336 (10%)	286 (9%)	0·83 (0·7 to 0·99), p=0·037	..
Treatment failure	841 (25%)	768 (23%)	0·90 (0·80 to 1·01), p=0·068	..
Length of ICU stay, days	13·3 (16·0)	13·7 (17·2)	0·39 (–0·81 to 1·58), p=0·524	..
Length of hospital stay, days	13·7 (20·6)	13·4 (18·4)	–0·19 (–0·96 to 0·58), p=0·626	..
Antibiotic-related side-effects	336/1521 (22%)	247/1513 (16%)	0·68 (0·57 to 0·82), p<0·0001	..

	Control (n=3372)	Procalcitonin group (n=3336)	Adjusted OR or difference (95% CI), p value*	$p_{interaction}$
Overall				
Initiation of antibiotics	2894 (86%)	2351 (70%)	0·27 (0·24 to 0·32), p<0·0001	..
Duration of antibiotics, days†	9·4 (6·2)	8·0 (6·5)	–1·83 (–2·15 to –1·5), p<0·0001	..
Total exposure of antibiotics, days‡	8·1 (6·6)	5·7 (6·6)	–2·43 (–2·71 to –2·15), p<0·0001	..

Schuetz et al. Lan

ORIGINAL ARTICLE

ocalcitonin-Guided Use of Antibiotics or Lower Respiratory Tract Infection

Huang, D.M. Yealy, M.R. Filbin, A.M. Brown, C.-C.H. Chang, Y. Doi, nnino, J. Fine, M.J. Fine, M.A. Fischer, J.M. Holst, P.C. Hou, J.A. Kellum, an, M.C. Kurz, S. Lotfipour, F. LoVecchio, O.M. Peck-Palmer, F. Pike, nty, R.L. Sherwin, L. Southerland, T. Terndrup, L.A. Weissfeld, J. Yabes, and D.C. Angus, for the ProACT Investigators*

Objectif effet utilisation PCT pour ATB des infections respiratoires vs PEC comparer prise en ch habituelle

RCT PCT rendu vs non rendu aux cliniciens pour patient avec suspicion infection respiratoire au SAU (14 hôpitaux)

Outcome	Procalcitonin (N=826)	Usual Care (N=830)	Difference (95% or 99.86% CI)†
Patients with final diagnosis of community-acquired pneumonia			
No. of patients	167	161	
Antibiotic-days by day 30	7.8±7.0	7.2±6.0	0.7 (–1.7 to 3.1)
Received any antibiotics by day 30 — estimated no./total no. (%)¶	148/167 (88.6)	154/161 (95.9)	–7.3 (–16.8 to 2.2)
Antibiotic prescription in ED — estimated no./total no. (%)¶‖	120/167 (71.9)	123/161 (76.3)	–4.4 (–19.9 to 11.0)
Antibiotic-days during hospital stay	3.9±3.0	4.1±3.1	–0.2 (–1.5 to 1.1)
Hospital length of stay — days	5.8±4.9	5.9±4.2	–0.1 (–1.2 to 1.1)

Criteria for Clinical Stability

Temperature ≤100°F
Heart rate ≤100 beats/min
Respiratory rate ≤24 beats/min
Systolic blood pressure ≥90 mmHg
Arterial oxygen saturation ≥90% or Po_2 ≥60 mmHg on room air
Ability to maintain oral intake
Normal mental status

istorique des critères de stabilité

Associé à bon pronostic (Halm *et al*. 2002)

Critère de sortie d'hospitalisation (Halm *et al*. 1998 ; 2002)

Critère de relais per os (Rhew *et al*. 2001)

Critère d'arrêt après 48h ? (Uranga *et al*. 2016)

Critère d'arrêt « quasi immédiat » >> PTC, AIR

rnal Medicine | Original Investigation | LESS IS MORE

ion of Antibiotic Treatment mmunity-Acquired Pneumonia ticenter Randomized Clinical Trial

MD; Pedro P. España, MD; Amaia Bilbao, MSc, PhD; Jose María Quintana, MD, PhD;
a, MD; Maider Intxausti, MD; Jose Luis Lobo, MD, PhD; Laura Tomás, MD; Jesus Camino, MD;
MD; Alberto Capelastegui, MD, PhD

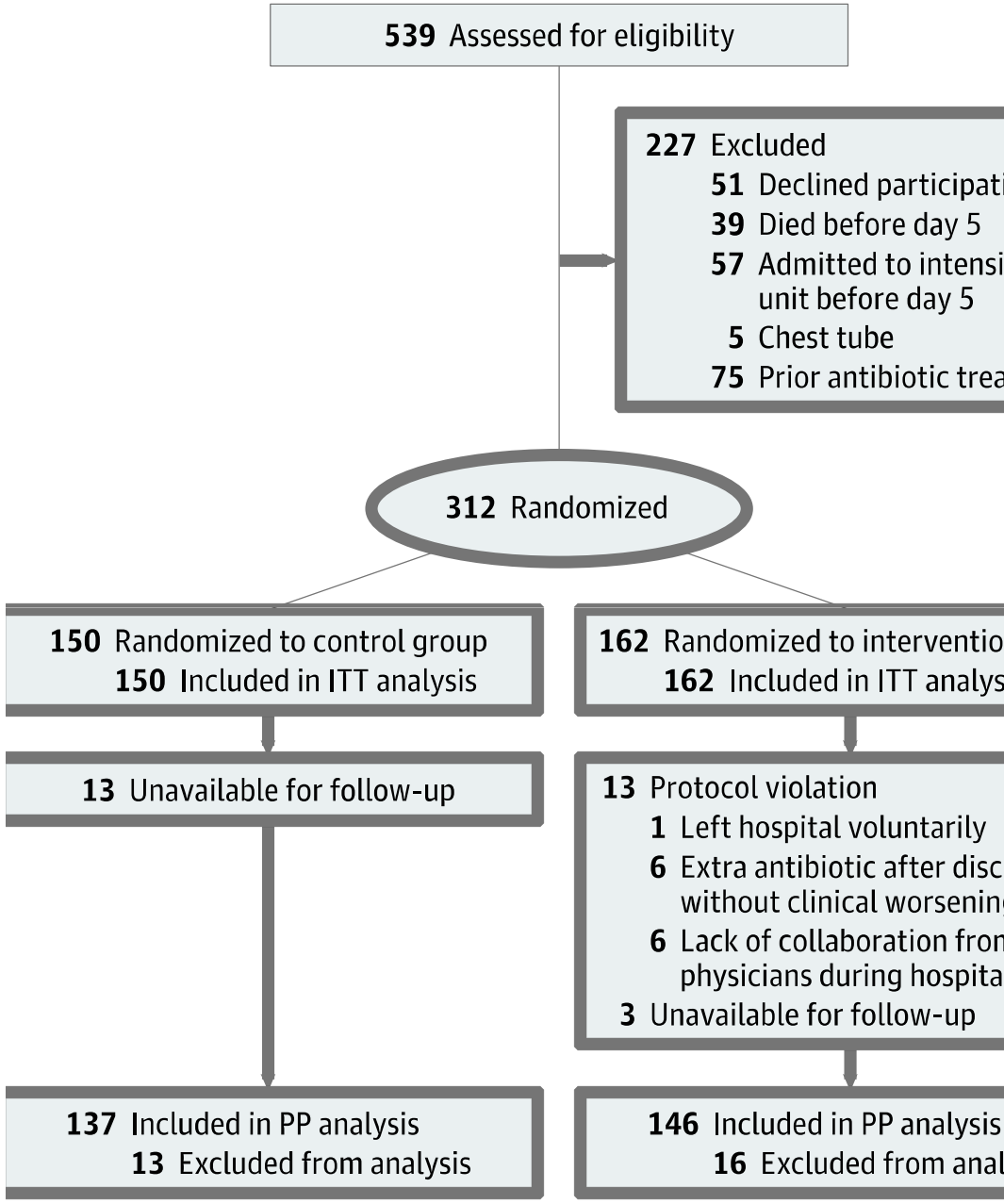
ssai de non infériorité
ulticentrique (4 hôpitaux)
012-2013
12 patients

andomisation à J5

- Arrêt à 48h d'obtention des critères de stabilité
- Arrêt selon clinicien en charge

bjectif :

- Guérison clinique J10 et J30
- QdV CAP J5 et J10 (questionnaire 18 items : 0-90)



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Baseline Characteristics of Study Participants[a]

eristic	Control Group (n = 150)	Intervention Group (n = 162)
an (SD), y	66.2 (17.9)	64.7 (18.7)
	95 (63.3)	101 (62.3)
le	55 (36.7)	61 (37.7)
nt smoker	32 (21.3)	36 (22.6)
r smoker	68 (45.3)	71 (44.7)
er smoker	50 (33.3)	52 (32.7)
consumption (yes)	24 (16.1)	17 (10.5)
idities		
disease	4 (2.7)	4 (2.5)
disease	38 (25.3)	39 (24.1)
estive heart failure	14 (9.3)	12 (7.4)
rovascular disease	16 (10.7)	9 (5.6)
disease	12 (8.0)	12 (7.4)
	21 (14)	27 (16.7)
tes	25 (16.7)	21 (13.0)
n Comorbidity Index, (IQR)	1 (0-2)	1 (0-2)
n Comorbidity Index, ized		
	61 (40.7)	70 (43.2)
	37 (24.7)	47 (29.0)
	52 (34.7)	45 (27.8)
lex, mean (SD)[b]	0.6 (1.6)	0.4 (1.3)
s		
	89 (59.3)	102 (63.0)
	61 (40.7)	60 (37.0)
e, mean (SD)	83.7 (33.7)	81.8 (33.8)

Eligibility

Patients ≥ 18 years old, hospitalized with a diagnosis of CAP. Pneumonia is defined as pulmonary infiltrate on chest X-ray not seen previously plus at least one symptom compatible with pneumonia such as cough, fever, dyspnea, and/or chest pain.

ATB :

- 80% des patients traités par FQ
- 10% beta lactamines +ML

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utcome

e 2. Results for the Primary Study Outcomes

ome	Control Group	Intervention Group	*P* Value
nt-to-Treat Analysis			
l No. of participants	150	162	
cal success, No. (%)[a]			
day 10	71 (48.6)	90 (56.3)	.18
day 30	132 (88.6)	147 (91.9)	.33
symptom questionnaire score, mean (SD)[b]			
day 5	24.7 (11.4)	27.2 (12.5)	.10
day 10	18.6 (9.0)	17.9 (7.6)	.69
Protocol Analysis			
l No. of participants	137	146	
cal success, No. (%)[a]			
day 10	67 (50.4)	86 (59.7)	.12
day 30	126 (92.7)	136 (94.4)	.54
symptom questionnaire score, mean (SD)[b]			
day 5	24.3 (11.4)	26.6 (12.1)	.16
day 10	18.1 (8.5)	17.6 (7.4)	.81

R : Antibiothérapie des Infections Respiratoires
RC 2016

nsultation
CLUSION
ébut de
biothérapie

Critère de stabilité
= RANDOMISATION
Appel téléphonique

CRITERE PRINCIPAL
Consultation

CRITERES SECONDAIRES
Appel téléphonique

J0

JS

J15

J30

BRAS EXPERIMENTAL

BRAS CONTROLE

FIN DE
TRAITEMENT
Appel téléphonique

FIN DE
TRAITEMENT
Appel téléphonique

Antibiothérapie - Bras Expérimental
Antibiothérapie - Bras Contrôle

lez jusqu'au bout du traitement ?

thebmj

BMJ 2017;358:j3418 doi: 10.1136/bmj.j3418 (Published 2017 July 26) Page 1 of 5

ANALYSIS

The antibiotic course has had its day

With little evidence that failing to complete a prescribed antibiotic course contributes to antibiotic resistance, it's time for policy makers, educators, and doctors to drop this message, argue **Martin Llewelyn and colleagues**

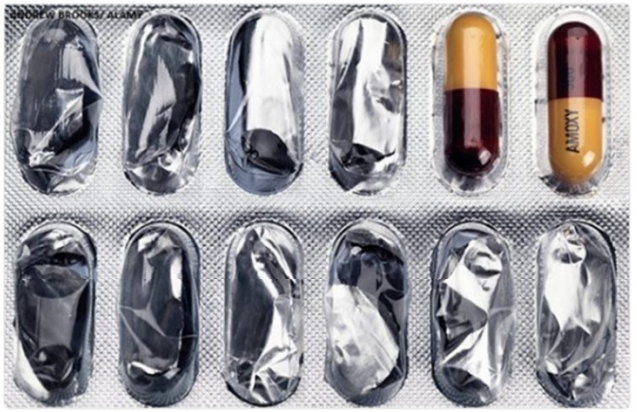
Martin J Llewelyn *professor of infectious diseases*[1 2], Jennifer M Fitzpatrick *specialist registrar in infection*[2], Elizabeth Darwin *project manager*[3], SarahTonkin-Crine *health psychologist*[4], Cliff Gorton *retired building surveyor*[5], John Paul *consultant in microbiology*[6], Tim E A Peto *professor of infectious diseases*[7], Lucy Yardley *professor of health psychology*[8], Susan Hopkins *consultant in infectious diseases and microbiology*[9], Ann Sarah Walker *professor of medical statistics and epidemiology*[3]

Vous avez retweeté

The BMJ @bmj_latest · 31 juil.

Response to our analysis article on completing #antibiotics courses from @BSACandJAC bmj.com/content/358/bm...

À l'origine en anglais



EDITION FR — HUFFPOST — EN ASSOCIATION AVEC LE GROUPE Le Monde

POLITIQUE ÉCONOMIE INTERNATIONAL CULTURE LE BON LIEN C'EST LA VIE LE HUFFPLAY PLUS

C'EST LA VIE

Antibiotiques: Non, vous n'êtes pas obligés de finir la boîte si vous vous sentez mieux

Selon une étude, aller systématiquement jusqu'au bout du traitement antibiotique augmenterait le risque de résistance aux médicaments

27/07/2017 11:16 CEST | Actualisé 27/07/2017 11:16 CEST

AFP

resistance. For example, in materials supporting Antibiotic Awareness Week 2016 WHO advised patients to "always complete the full prescription, even if you feel better, because stopping treatment early promotes the growth of drug-resistant bacteria."[4] Similar advice appears in national campaigns in

Changement de paradigme !!

onclusions

Quand peut on arrêter un traitement antibiotique ?

Infection respiratoire : quand/dès que « ça va mieux »

Vacciner !

Le plus court des traitement c’est l’absence de traitement