Centre Hospitalier Alès · Cévennes

GInGer
Groupe Infectio-Gériatrie

Les Publications du GInGér

GInGér 2025

- Recommandations Pneumonies d'inhalation et prévention des récurrences
- Recommandations Antibiothérapie sous cutanée (en cours)
- Recommandations IU masculines (en cours)
- Livre blanc sur les infections respiratoires à prévention vaccinale (SFGG, MCOOR)
- Étude Vaxisenior accepté JAMDA 11/12/2025 à 9h (N Weil et al.)

Veille bibliographique sur les études GinGer

2025 (9)

Characteristics of tuberculosis in elderly adults: A multicenter French study. Trichet, M.; Lanoix, J.; Diamantis, S.; Forestier, E.; Fraisse, T.; Brochard-Libois, J.; et al. *Infectious Diseases Now*,105226. December 2025.

Evaluation of subcutaneous amoxicillin/clavulanic acid pharmacokinetics as an alternative to the intravenous route in older patients—the PhASAge Study. Grégoire, N.; Mbarga, D.; Mirfendereski, H.; Stanke-Labesque, F.; Breilh, D.; Forestier, E.; et al . *Journal of Antimicrobial Chemotherapy*,dkaf381. November 2025.

Pneumocystis pneumonia in older non-HIV-infected patients: a French, multicentre, retrospective, cohort study. Barraud, A.; Larcher, R.; Gavazzi, G.; Fourmy, A.; Verdon, R.; Ancellin, S.; et al. on behalf GInGer (Groupe Infectio-Geriatrie) *Pneumonia*, 17(1): 34. December 2025.

Antibiotics at life's end: key role in treating end-of-life pneumonia?. Fraisse, T.; Putot, A.; Forestier, E.; Gavazzi, G.; Vayne-Bossert, P.; Roubaud-Baudron, C.; and Prendki, V. *Expert Review of Respiratory Medicine*, 19(4): 279–286. April 2025.

Aspiration pneumonia guidelines – Société de Pathologie Infectieuse de Langue Française 2025. Diamantis, S.; Fraisse, T.; Bonnet, E.; Prendki, V.; Andréjak, C.; Auquier, M.; et al. *Infectious Diseases Now*, 55(5): 105081. August 2025.

Prevention of aspiration pneumonia recurrences. Fraisse, T.; Prendki, V.; Putot, A.; Garcia-Carmona, C.; Perrin, M.; Chebib, N et al. *Infectious Diseases Now*, 55(6): 105102. September 2025.

Antibiotic susceptibility according to age of clinical strains from hospital respiratory samples: A nationwide study. Putot, A.; Couve-Deacon, E.; Ploy, M.; Fraisse, T.; Lanoix, J.; Prendki, V.; and Diamantis, S. *Infectious Diseases Now*, 55(7): 105133. November 2025.

National survey on aspiration pneumonia in elderly hospitalized or institutionalized patients in France in 2023. Vieilledent, L.; Fraisse, T.; Gavazzi, G.; Baudron, C.; Diamantis, S.; Gallien, S.; et al. *Infectious Diseases Now*, 55(7): 105113. November 2025.

Pharmacokinetics of Subcutaneous and Intravenous Ceftriaxone in an Older Population: The PhASAge Study. Roubaud-Baudron, C.; Fauchon, H.; Stanke-Labesque, F.; Paccalin, M.; Breilh, D.; Grégoire, et al. *Open Forum Infectious Diseases*, 12(6): ofaf313. May 2025

Résistances bactériennes

Résistances bactériennes

npj | antimicrobials & resistance Article

https://doi.org/10.1038/s44259-025-00144-w

The effect of commonly used non-antibiotic medications on antimicrobial resistance development in *Escherichia coli*

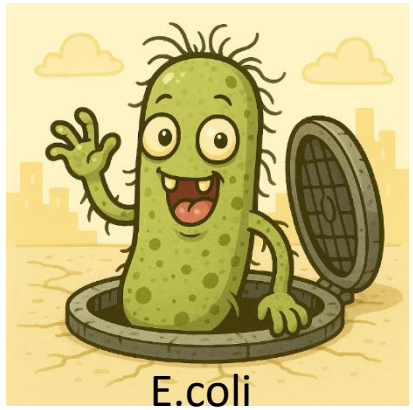
Check for updates

Hanbiao Chen[1], Sylvia A. Sapula[1], John Turnidge[2] & Henrietta Venter[1]

- Dans la lutte contre l'antibio-résistance le bon usage des antibiotiques est un élément clé
- Un certain nombre de médicaments non antibiotiques contribuent à l'augmentation des résistances bactériennes
  - Modification du microbiote (IPP …)
  - Effet direct antibactérien des statines
  - Effet favorisant la transformation bactérienne et les échanges génétiques plasmidiques (AINS)
  - Effet sur mutations (ISRS)
  - Sélection de pompes à efflux multi-drogues
- Ces traitements représentent 95 % des molécules vs AB

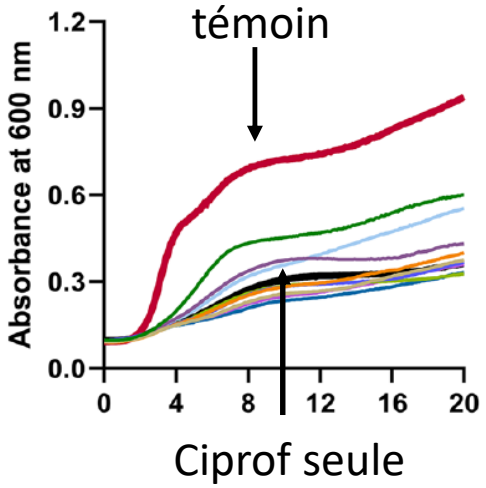
Résistances bactériennes

9 Molécules à usage « fréquent » chez le patient âgé	
Diclofenac*	Atorvastatine
Ibuprofene*	Acétaminophène
Pseudoéphédrine*	Furosémide
Tramadol*	Metfromine
	Témazepam


E.coli

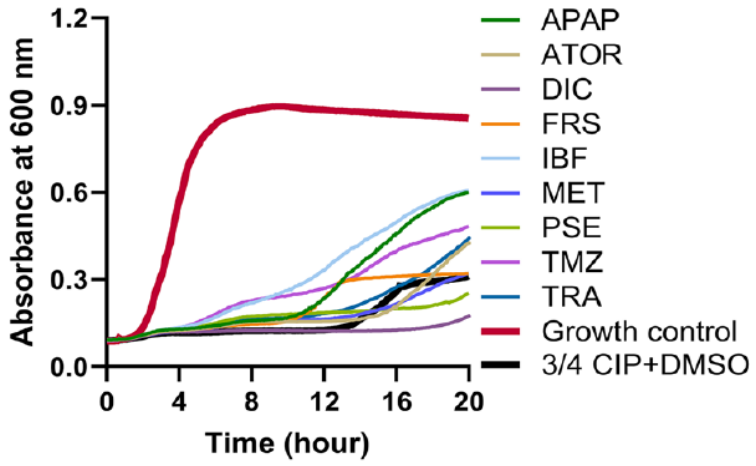
CIPROFLOXACINE

(C) E coli BW25113



Ciprof seule

(D) E coli 6146 (résident EHPAD)

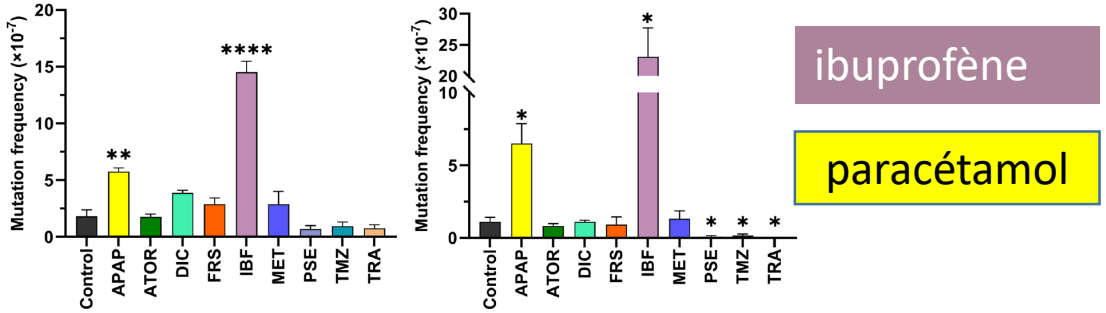


En présence d'ibuprofene, diclofenac ou acetaminophéne
La croissance est + rapide et + importante

Résistances bactériennes

1- L ’exposition aux MNAB induit des mutations chez E coli

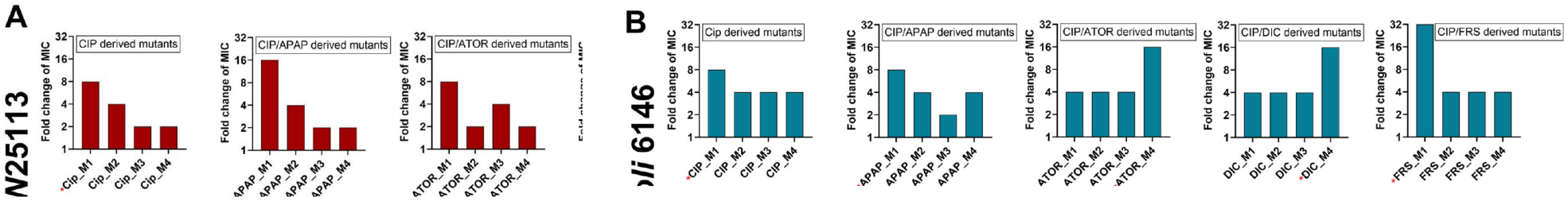
Fréquence de mutation



ibuprofène

paracétamol

2- L ’exposition aux MNAB induit des mutations de R à ciprofloxacine

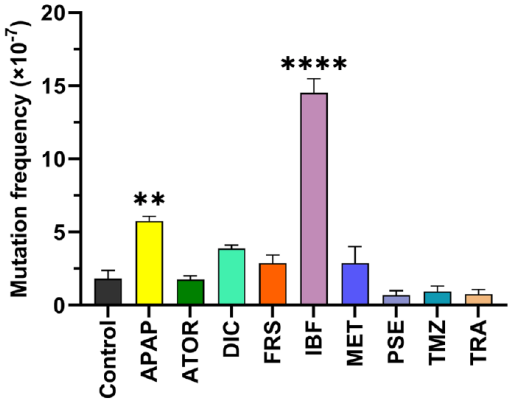


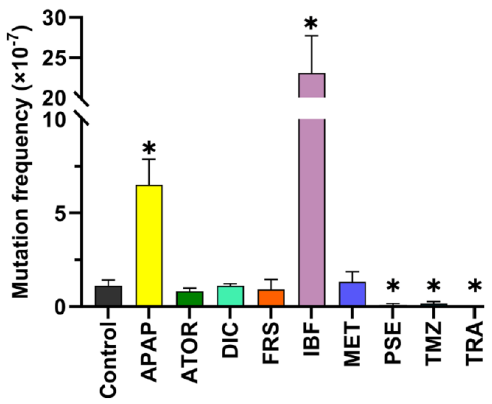
3- L ’exposition aux MNAB induit des résistances multiples

Parmi les mutants sélectionnés, certains avaient R ceftazidime, cefepime, minoccylcine

Résistances bactériennes

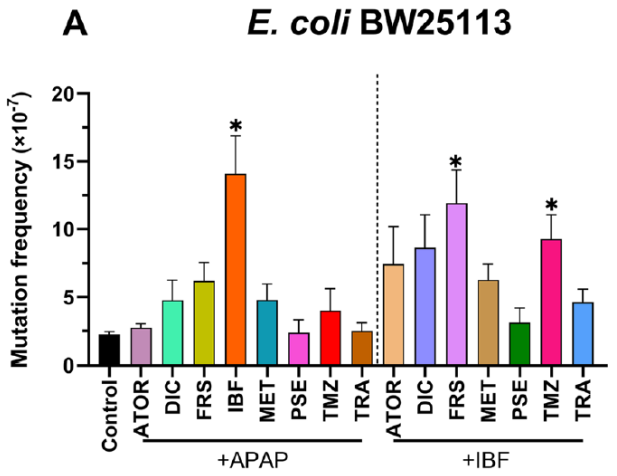
4- L’ association de 2 MNAB se potentialise

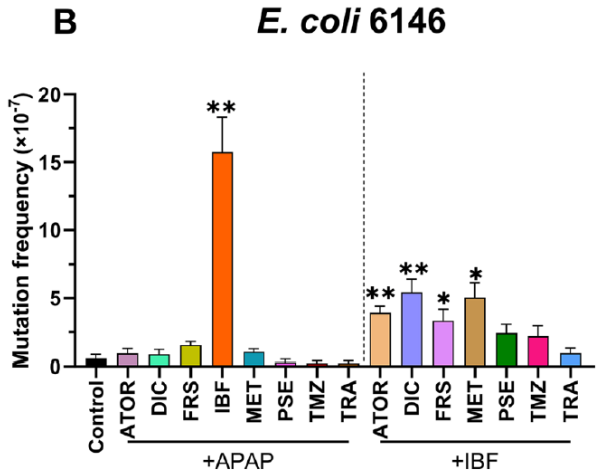




ibuprofène

paracétamol





paracétamol

ibuprofène

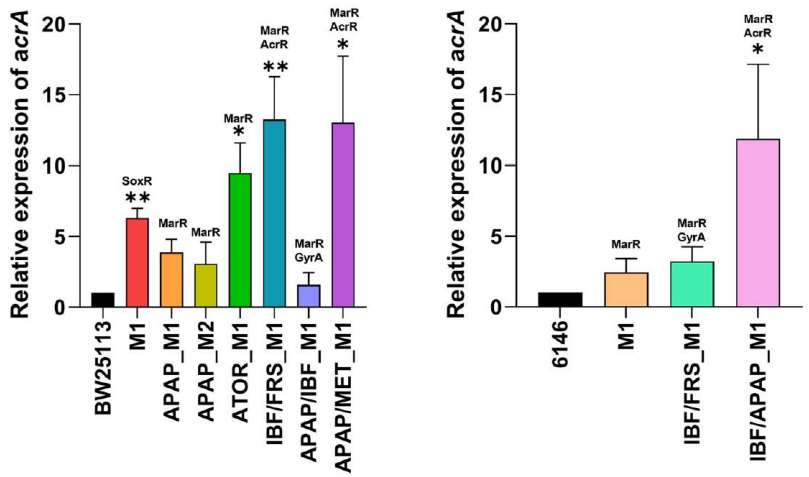
Si on met acetaminophene ou ibuprofene+ 1 autre MNAB on potentialise les mutations

Résistances bactériennes

Séquencage des mutants

Mutation de la cible (GyrA)

Mutation gène régulateur pompe d'efflux (acr A..;)



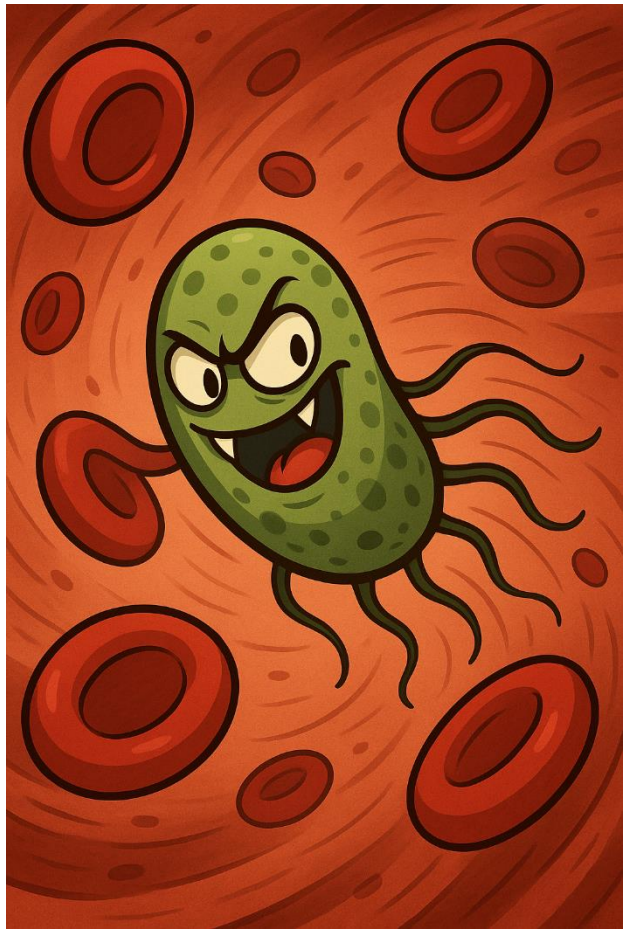
- Les médicaments non antibiotiques (en particulier acétaminophéne, les AINS, et le furosémide) ont un impact sur la résistance aux FQ en particulier par les pompes d'efflux
- Les pompes d'efflux sont un mécanisme de résistance non spécifique de la bactérie (stress) et leur hyperexpression est associée à une moins bonne réparation de l'ADN (favorise les résistances)

ONE HEALTH

Les infectiologues doivent apprendre à gérer la polymédication
Les gériatres doivent intégrer la résistance bactérienne

GInGer Groupe Infectio-Gériatrie

Sepsis et bactériémies



Sepsis

Un programme transversal = Parcours de soins

- Facteurs de risque de sepsis (âge, défaillances d'organe, fragilité, cancers et ttt immunosuppresseurs, diabète, dénutrition, maladie de système…)
- Dépister le sepsis face à une infection

Rechercher chez un adulte, la présence de 3 ou plus des 6 variables cliniques

a. Age >65 ans
b. Température >38°C
c. Pression artérielle systolique ≤110 mmHg
d. Fréquence cardiaque >110/min
e. Saturation périphérique en O2 ≤95%
f. Troubles des fonctions supérieures

- Agir sans délai en ville
- Traiter (surviving sepsis campaign)
  - Accès veineux et Remplissage par cristalloides
  - Prélever des hémocultures et débuter antibiothérapie (3h, 1h en cas de choc)
  - Surveillance continue?
  - Mobiliser passif, verticaliser, faire marcher…..
- Après l'épisode: rééduquer, suivi
- Prévention: vaccin et mesures d'hygiène

RECOMMANDER
LES BONNES PRATIQUES

RECOMMANDATION

Prise en charge du sepsis du nouveau-né, de l'enfant et de l'adulte : recommandations pour un parcours de soins intégré

Validé par le Collège le 29 janvier 2025

Sepsis présentation et mortalité

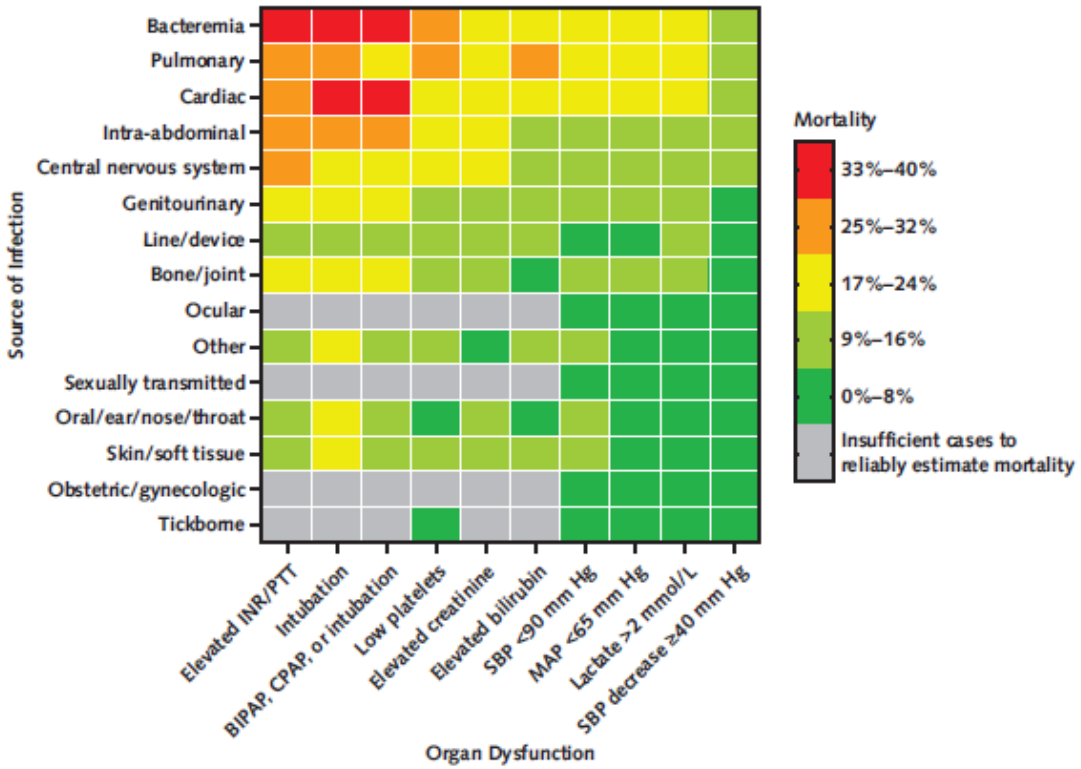
Annals of Internal Medicine

OBSERVATIONS: BRIEF RESEARCH REPORTS

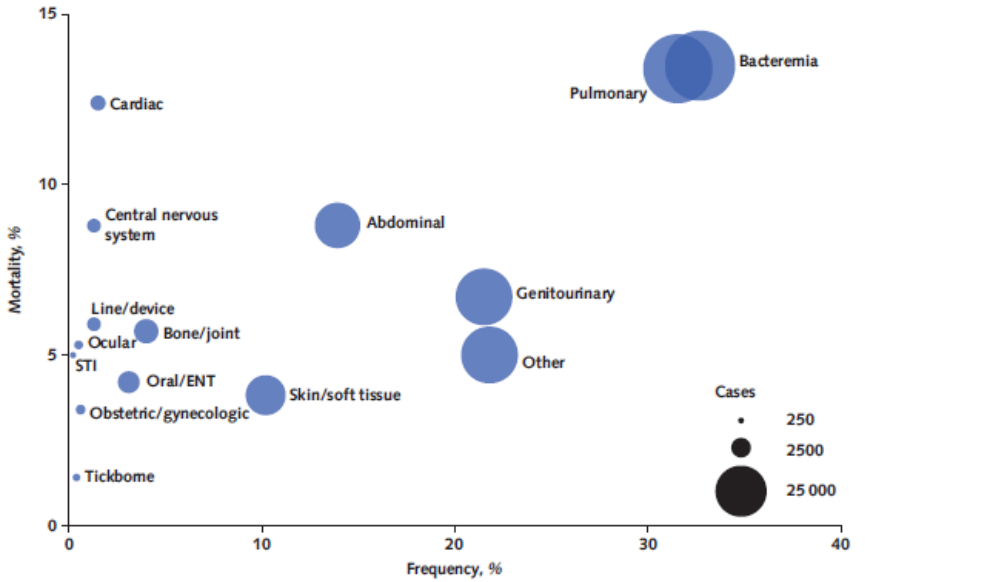
Heterogeneity of Sepsis Presentations and Mortality Rates

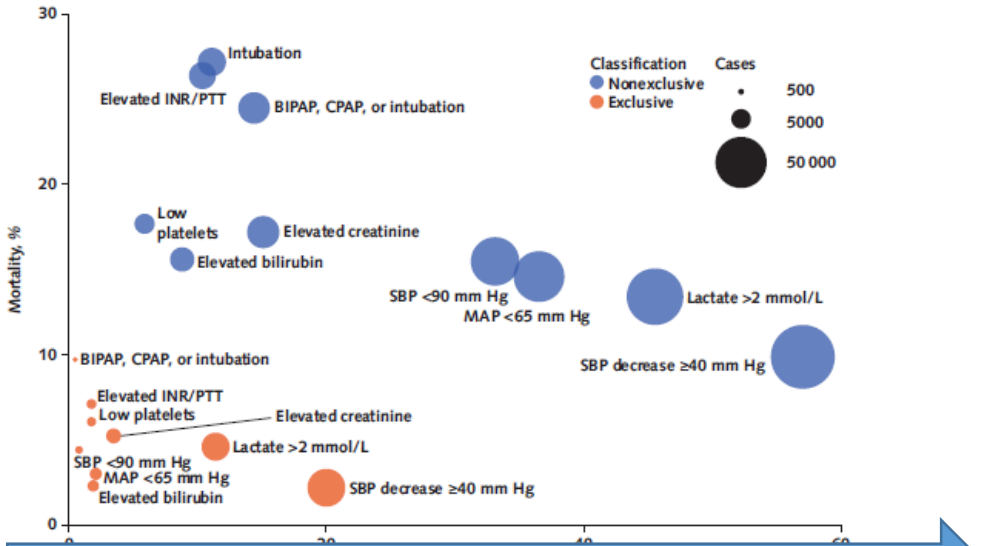
Bielberg et al, 2024

75 000 sepsis
Age moyen 67 ans



mortalité





fréquence

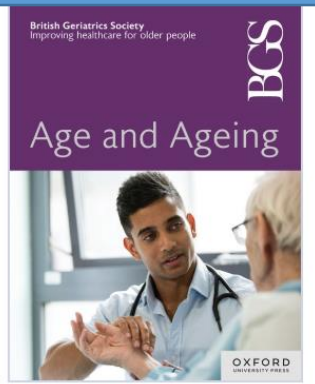
Atypie sémiologique

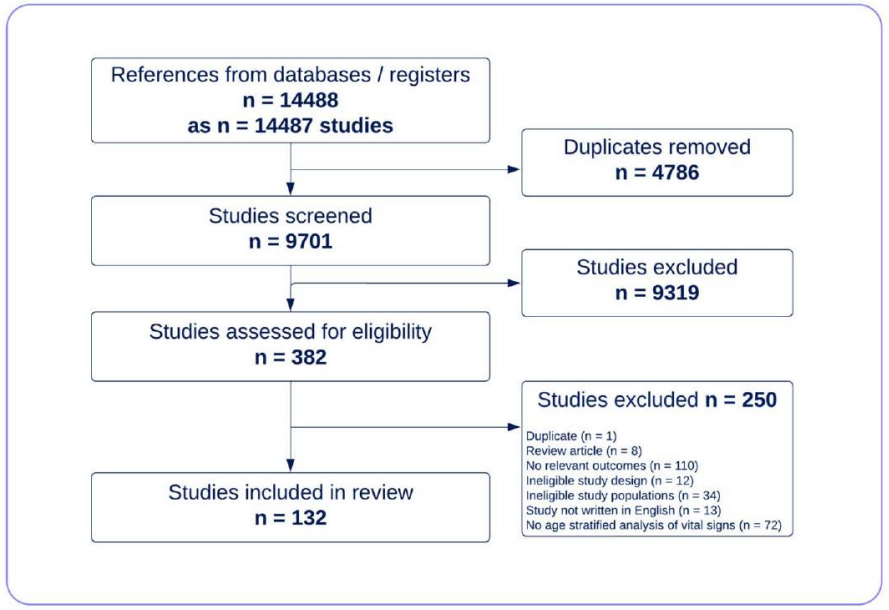
clinique Infections bactériennes fn âge

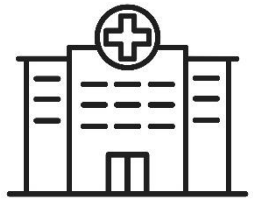
SYSTEMATIC REVIEW

Is age associated with different vital signs in adults presenting to hospital with bacterial infection? A systematic review and meta-analysis

Phoebe Tupper[1], Oliver Redfern[1], Charlotte H. Harrison[1], Stephen Gerry[2], Christopher Biggs[1], Bethany Walker[1], Peter Watkinson[1,3,4]

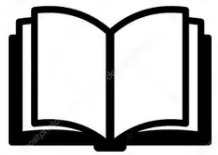






Patients Hospitalisés pour infection bactérienne suspectée ou prouvée

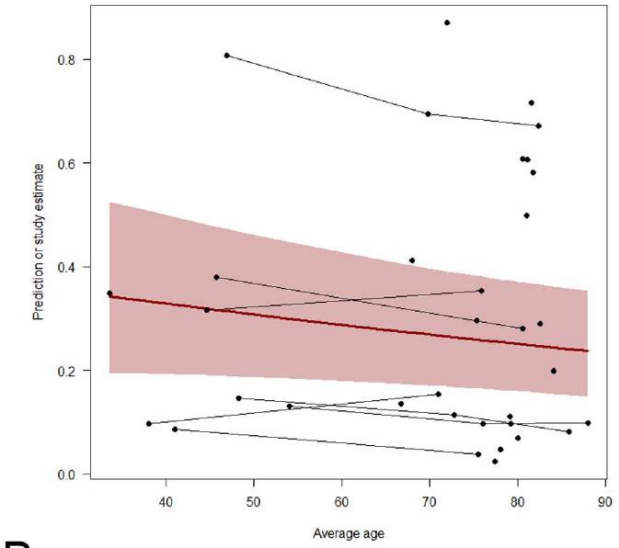
(Poumon, urine, bactériémie, peau et T mou, endocardite, intra abdominal, méningite)



- **132 études**
- **110.475 patients**
  - ✓ **Données T° (114), FC (64), FR (43)**
  - ✓ **Inf clinique (67), bact (41)**

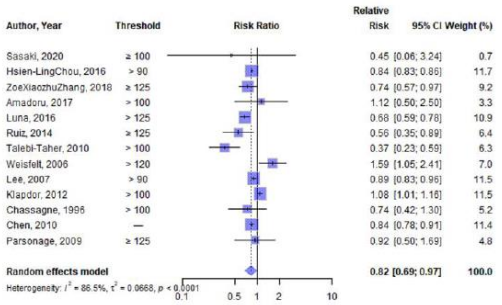
clinique Infections bactériennes fn âge

37762 Patients
Moins de tachycardie
FC moins rapide (-5bpm)



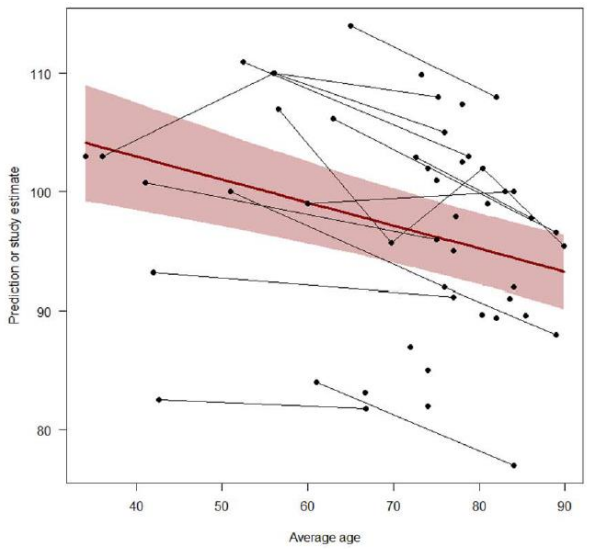
B

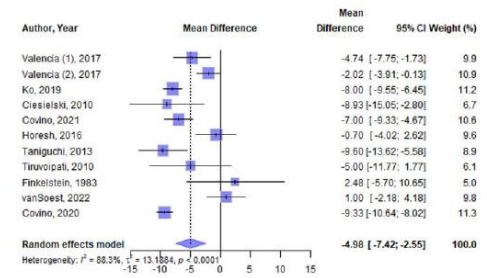
FC >90 à 125



D

Pas de différence selon âge pour survenue d'hypotension.
TAS plus élevée chez SA

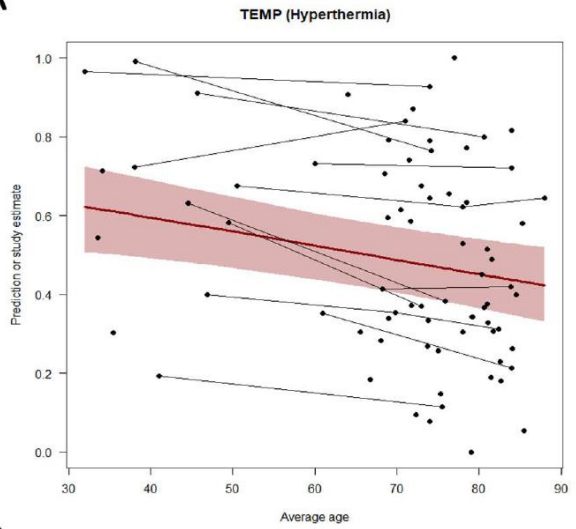




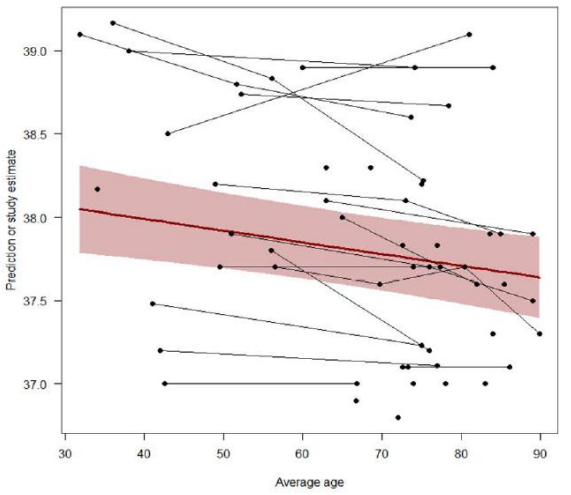
clinique Infections bactériennes fn âge

38696 Patients
Moins de fièvre
T° moins élevée(-0,14°C)
Hypothermie pas plus fréquente chez S âgé

A

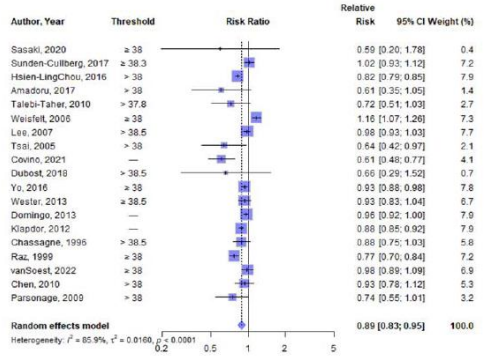


B

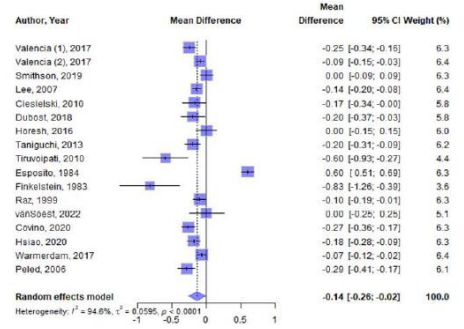


C

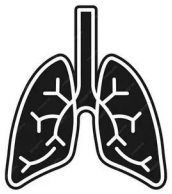
Seuil fievre 37,8 à 38,5°



D

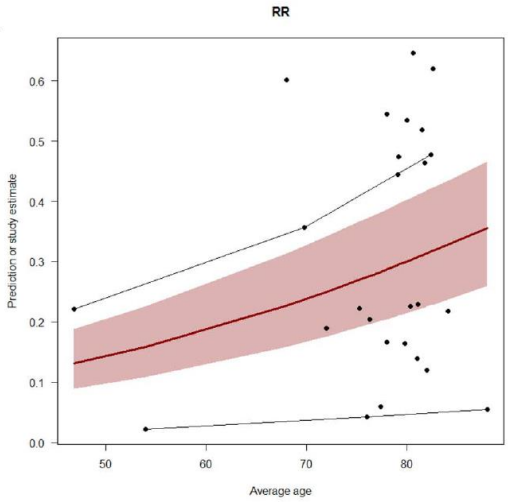


clinique Infections bactériennes fn âge



31748 Patients
Plus de tachypnée
FR plus rapide (+1cpm)
Pas de différence de Sa02

A



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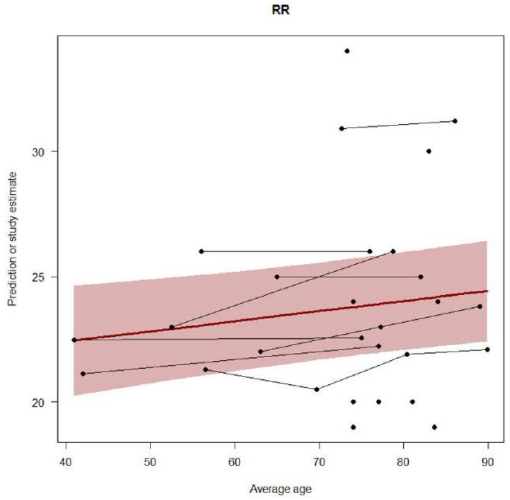
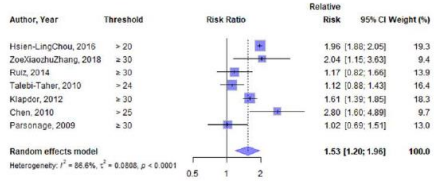


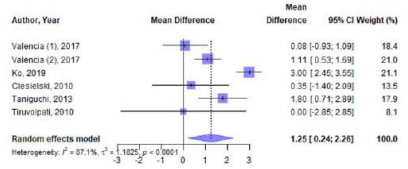
C

Fqce tachypnée

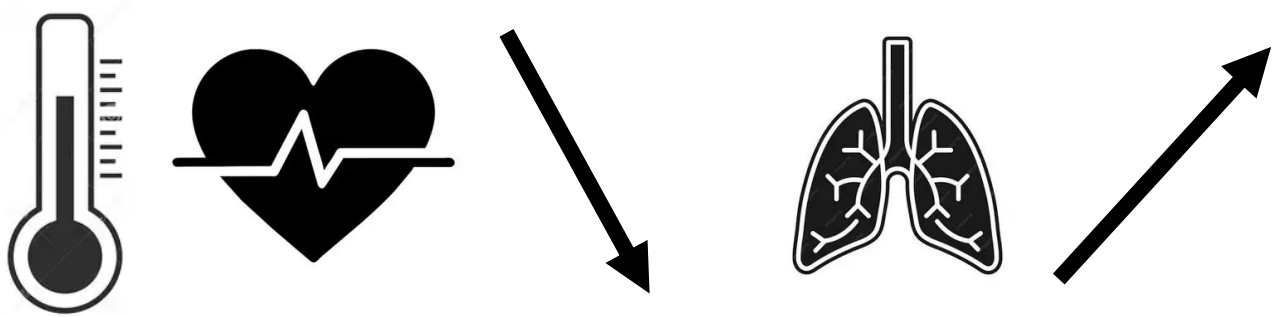


D

FRespiratoire



clinique Infections bactériennes fn âge



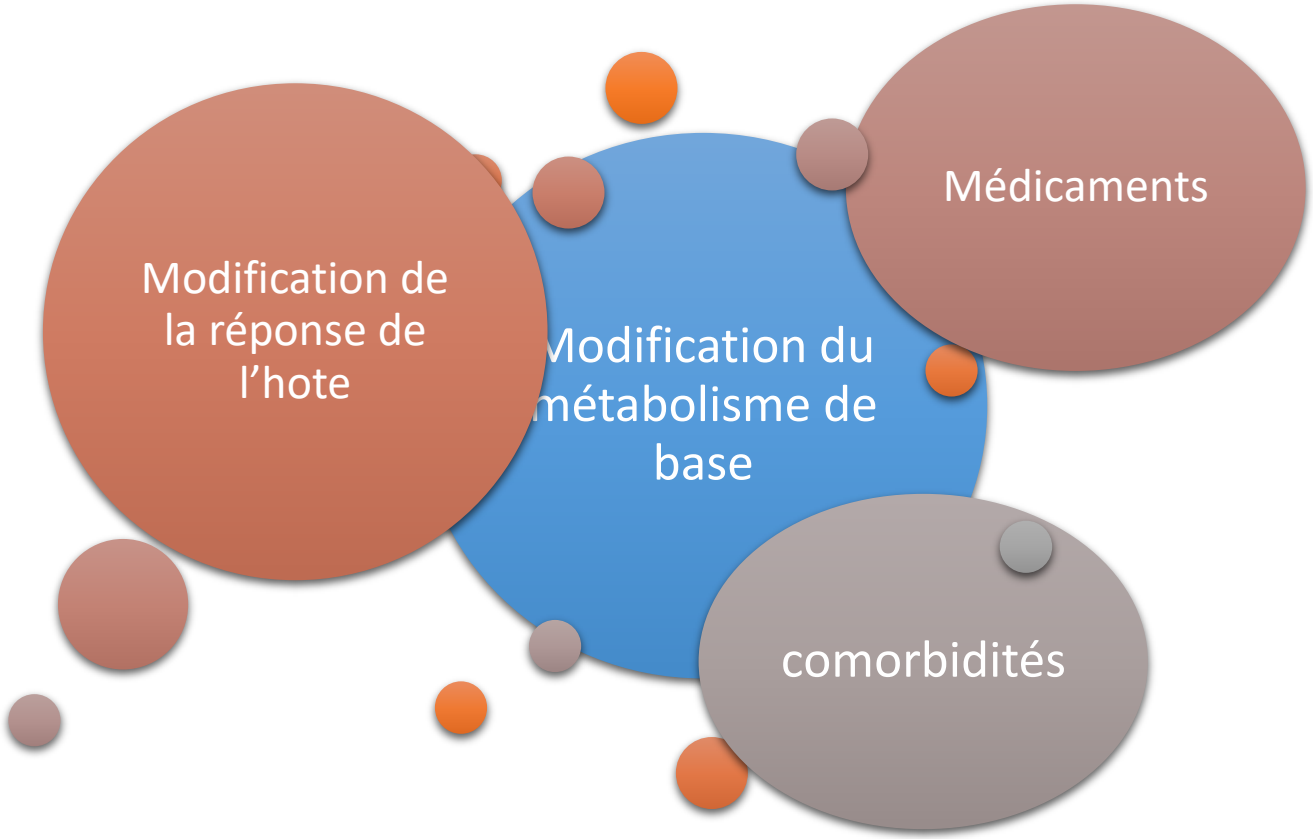
Pensez à mesurer la Fréquence respiratoire

- **Grande hétérogénéité selon les études (ancienneté, type d'inf, documentation…)**
  - ⇒ **analyse de sous groupe par type d'infection, selon documentation microbiologique… tendance retrouvée mais NS**
- **De nombreux biais dans les études**

129/132 à haut risque (sélection des patients, mesure des constantes rétrospective…)

- **Des différences statistiques mais faibles clinquement (0,14°C, 1cpm)**

clinique Infections bactériennes fn âge



La fragilité et les comorbidités=> Sd gériatrique
hospitalisation plus précoce chez lesP âgés

vaccins

Couverture vaccinale

Le point sur

Santé publique France

Couverture vaccinale grippe / Covid

Date de publication : 18 juillet 2025

ÉDITION NATIONALE

Couvertures vaccinales contre la grippe et la Covid-19 des résidents et des professionnels en établissements sociaux et médico-sociaux (ESMS)

Résultats clés

Enquête 2600 EHAD (35%) 2024-2025

	grippe	COVID
Résidents EHPAD	82,7%	63,6%
Personnel	21%	4,3%
AS/pers d service/ASH	17%	3,2%
Médecins/pharmacien	56%	30%

Tableau 6. Raisons pour lesquelles le nombre d'actions mises en place pour promouvoir la vaccination antigrippale a baissé ou que peu d'actions sont mises en place, saison 2024-2025, France (n= 482)

Raisons	Proportions d'Ehpad répondants	
	%	IC95%
Forte réticence à la vaccination au sein de l'équipe	71,4	67,1 - 75,4
Turn over des équipes	26,6	22,7 - 30,7
Impression que les actions ne sont pas efficaces	19,1	15,7 - 22,9
Moins de temps	19,1	15,7 - 22,9
Manque de personnel	17,0	13,8 - 20,7
Manque de motivation	13,3	10,4 - 16,6
Absence de médecin ou d'IDE coordonnateur	2,7	1,4 - 4,6

Des couvertures vaccinales grippe/COVID inférieures aux objectifs
Tendance à la baisse se confirme surtout COVID
Chez les soignants (-16% vs 2007)
Stabilité de la vaccination antigrippale des résidents

Couverture vaccinale

DGS-Urgent n°2025-27 : Mise à disposition de doses complémentaires pour la campagne de vaccination contre la grippe saisonnière 2025-2026 et rappel des modalités d'immunisation du nouveau-né contre le VRS

Mesdames, Messieurs,

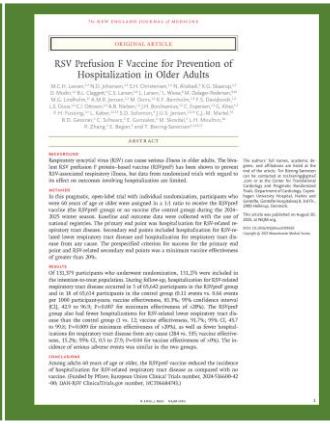
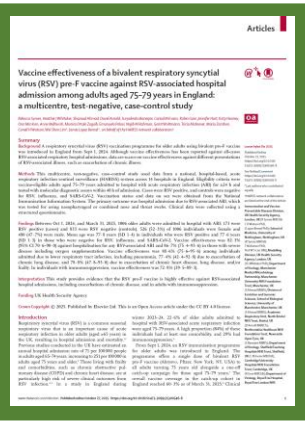
Compte tenu de l'évolution de la situation épidémique, deux points sont portés à votre attention :

1. Concernant la grippe saisonnière

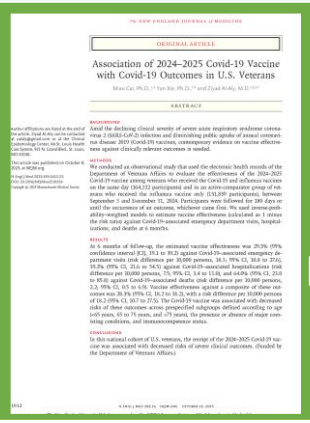
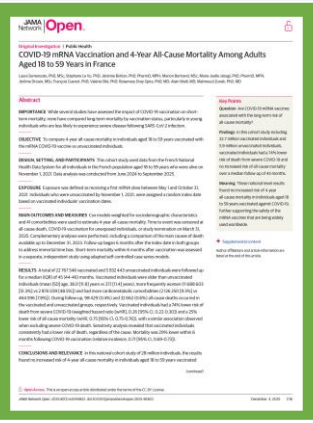
Grâce à votre engagement, **plus de 10,3 millions de patients ont déjà été vaccinés contre le virus de la grippe en ville depuis octobre.** Cette dynamique est essentielle pour atteindre les objectifs de couverture vaccinale et protéger les populations à risque.

Afin de maintenir la tendance, nous invitons les professionnels qui n'auraient plus de stocks suffisants à s'approvisionner sans attendre auprès de leur grossiste-répartiteur ou directement auprès du laboratoire.

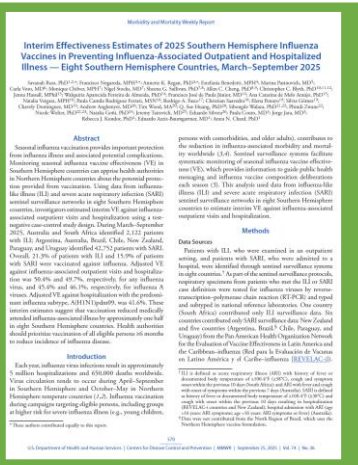
Efficacité vaccinale VRS

 JAMA 2025 Vaccins VRS Hospitalisations D surie et al	 NEJM 2025 Vaccin VRS (Abrysvo) Hospitalisations MCH Lassen et al	 Lancet Inf dis 25 Vaccin VRS (Abrysvo) Hospitalisations R Symes et al
Étude observationnelle cas témoin > 60 ans	**Essai clinique randomisé pragmatique (phase IV)**	Étude observationnelle rétrospective cas/témoins 75-79 ans
N=6951 (821 VRS+ cas) Hospitalisations 15% de vaccinés	**131 276 (ITT) (65642vs65634)** Hospitalisations liées VRS 1 saison 2024-2025	N= 1006 (173 cas H VRS+) Hospitalisation Taux de vaccination 32%
EV 2 saisons **58%** S1 69%, S2 48%	**EV 83 %,** (1 saison) EV Hospit cardio respi 10% (cf sous etude JAMA 2025, Lassen et al)	**EV (1 saison) 82%** EV forme sévère (O2) 86,7% EV exacerbation comorb; 78%
EV plus faible ID et patho CV EV idem Arexvy vs Abrysvo	EIG similaires entre les 2 groupes 5 attribués au vaccin (PF, malaise…)	EV 73% ID ou patho CV 77%
Étude CDC	consortium danois, **support PFIZER**	UK Health Security Agency

Efficacité vaccinale COVID

 NEJM 2025 Vaccin COVID Cs Urgences Hospitalisations M Cai et al	 JAMA network 2025 Vaccins COVID Mortalité Long terme L Semenzato et al	 Lancet Inf dis 2025 Vaccin Covid Hospitalisation CH Hansen et al
Cohorte observationnelle 2024-25, vétérans US	Cohorte nationale (18-59 ans), Existe-t-il surmortalité à long terme lié au vaccin?	Cohorte danoise nationale sur registre **Tous les danois > 65 ans** (1/10/24)
164.132 vaccin grippe+covid 131.839 vaccin grippe	**22,7 Millions Exposé vaccin ARN** **5,7 Millions Non vacciné (1/11/20)**	894 560 participants **Couverture vaccinale 91,7% (dans les 4 mois)**
EV Passage urgences 29% **EV hospit 39%** EV décès 64% Confirmé en sous groupe	Vaccinés+ âgés, + comorbides, + femmes, - défavorisés	88,8% BNT162b2.JN.1 et 11,2%mRNA1273JN.1
	Mortalité toute cause -25% (vaccin), H COVID -74% Effet sur mortalité persiste Covid exclus (K, CV…) Possible biais de comportement/social	Vaccin **BNT 70%** Hospit, 76% décès Vaccin **mRNA 84,9%** Hospit, 95,8% décès Pop non comparable (mRNA + jeune,-com)
Biais sélection (vétéran) Même Variant moins sévère	Mortalité à 6 mois -29% (COVID +++) **Pas de surmortalité à long terme voir réduction**	EV sur variants KP31, XEC Pas de baisse de protection à 4 mois
Département des vétérans	EPI-PHARE (ANSM-CNAM)	Registres nationaux danois

Efficacité vaccinale grippe

		
SPF 2025 **Épidémie IRA** **Efficacité vaccin** **Grippe 2024-25**	**Lancet Inf dis 2025** **Vaccin HD** **Hospitalisations** **ND Johansen et al**	**MMWR2025** **Épidémie grippe** **Efficacité vaccin** **Saison 2025** **Hém Sud** **S Russ et al**
Données françaises 2024-25	Pool 2 essais randomisés (GalFLU, DanFLU) sur 2 ou 3 saisons grippales	Données 8 pays **hémisphère sud** Saison Mars-septembre 2025
Épidémie précoce, longue et intense 29 000 H, 14000 décès,	**466 000 patients** 233000 HD vs 233000 SD EIG identique (≈16000)	Inf ambu 2122 patients Inf hosp 42752 patients (61%exclus) **Couverture 15-29%**
EV 47%[26-63] EV (<65 ans) 59% [28-73] EV (>65 ans) 38% [3-60]	↓8,8% hospitalisations pour grippe ou pneumonie **-31,9%** H pour grippe confirmée **Pas de ≠ mortalité** toute cause,	Circulation AH1N1 pdm09 59% A H2N2 27% EV ambu 50%, **H 49%** (H1>H3) EV âgés 38%, comorbides 52%
Santé publique France	**SANOFI**	Réseau surveillance GISAID, OMS, CDC

Efficacité vaccinale

SPECIAL ARTICLE

Updated Evidence for Covid-19, RSV, and Influenza Vaccines for 2025–2026

J. Scott,[1] M.S. Abers,[2] H.K. Marwah,[3] N.C. McCann,[4] E.A. Meyerowitz,[2] A. Richterman,[5] D.F. Fleming,[6] E.J. Holmes,[6] L.E. Moat,[6] S.G. Redepenning,[6] E.A. Smith,[6] C.J. Stoddart,[6] M.E. Sundaram,[7] A.K. Ulrich,[6] C. Alba,[8] C.J. Anderson,[6] M.K. Arpey,[6] E. Borre,[9] J. Ladines-Lim,[5] A.J. Mehr,[6] K. Rich,[9] C. Watts,[5] N.E. Basta,[10] J. Jarolimova,[11] R.P. Walensky,[12] and C.M. Dugdale[13]

ABSTRACT

BACKGROUND

Changes in the vaccine advisory process in the United States have disrupted immunization guidance, which reinforces the need for independent evidence review to inform decisions regarding immunization for respiratory viruses during the 2025–2026 season.

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We conducted a systematic review of U.S.-licensed immunizations against coronavirus disease 2019 (Covid-19), respiratory syncytial virus (RSV), and influenza. We searched databases on PubMed/MEDLINE, Embase, and Web of Science for updates of the most recent review by the Advisory Committee on Immunization Practices (ACIP) Evidence-to-Recommendations for each disease, which was performed during the 2023–2024 period. Outcomes included vaccine efficacy and effectiveness against hospitalization, other clinical end points, and safety.

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Ongoing peer-reviewed evidence supports the safety and effectiveness of immunizations against Covid-19, RSV, and influenza during the 2025–2026 season. (Funded by the Center for Infectious Disease Research and Policy and the Alumbra Innovations Foundation.)

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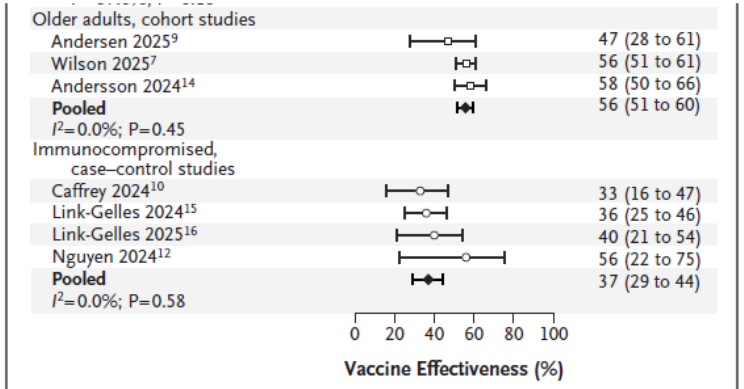

Figure 1. Meta-Analysis of Vaccine Effectiveness against Hospitalization for Covid-19.[7-16]

Forest plots show population-specific vaccine effectiveness against hospitalization for coronavirus disease 2019 (Covid-19) on the basis of case–control and cohort studies. Circles indicate case–control studies, and squares indicate cohort studies; diamonds represent pooled estimates. Heterogeneity (I^2 and P value) are displayed for pooled data at the bottom of each population analysis. In sensitivity analyses, studies that were deemed to have a moderate or high risk of bias were excluded; findings were similar to the primary results (Fig. S7 in the Supplementary Appendix).

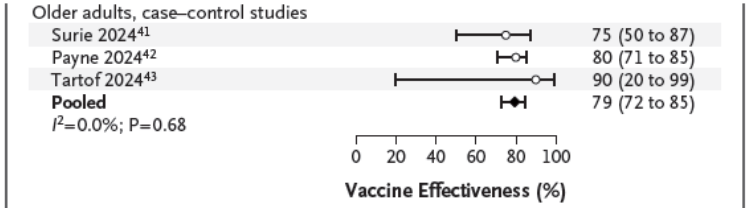

Figure 2. Meta-Analysis of Vaccine Effectiveness against Hospitalization for RSV.[26-43]

Forest plots show population-specific vaccine effectiveness against hospitalization for respiratory syncytial virus (RSV) on the basis of case–control and cohort studies.

<u>Vaccin ARN COVID Sujet âgé</u>
-56% hospitalisations
-58% décès (65-79 ans)
- 48% décès (80 ans)

<u>Vaccins VRS Sujet âgé</u>
-79% hospitalisation

Efficacité vaccinale

SPECIAL ARTICLE

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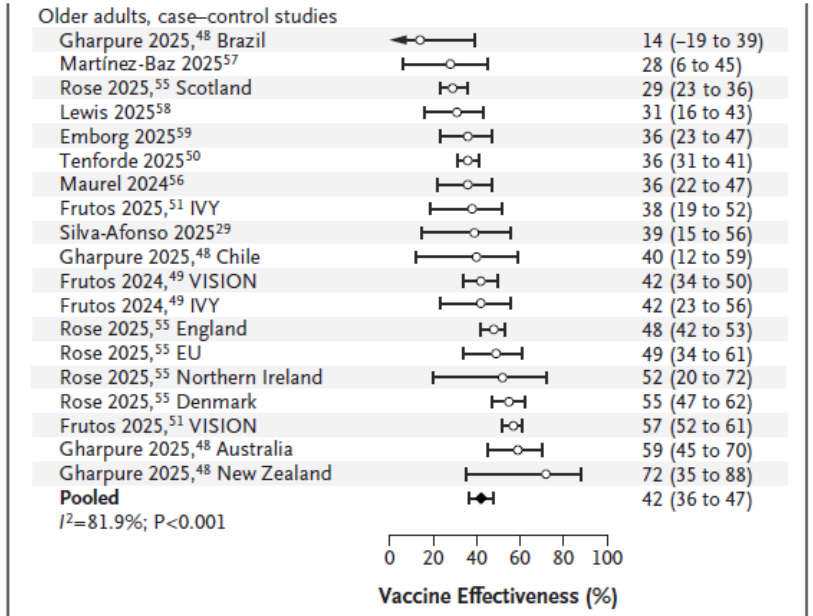

Figure 3. Meta-Analysis of Vaccine Effectiveness against Hospitalization for Influenza.[48-59]

Forest plots show population-specific vaccine effectiveness against hospitalization for influenza on the basis of case–control and cohort studies.

Vaccin grippe Sujet âgé
-42% hospitalisations

Sécurité vaccinale

SPECIAL ARTICLE

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J. Scott,[1] M.S. Abers,[2] H.K. Marwah,[3] N.C. McCann,[4] E.A. Meyerowitz,[2] A. Richterman,[5] D.F. Fleming,[6] E.J. Holmes,[6] L.E. Moat,[6] S.G. Redepenning,[6] E.A. Smith,[6] C.J. Stoddart,[6] M.E. Sundaram,[7] A.K. Ulrich,[6] C. Alba,[8] C.J. Anderson,[6] M.K. Arpey,[6] E. Borre,[9] J. Ladines-Lim,[5] A.J. Mehr,[6] K. Rich,[9] C. Watts,[5] N.E. Basta,[10] J. Jarolimova,[11] R.P. Walensky,[12] and C.M. Dugdale[13]

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Vaccin COVID pas de signal spécifique en particulier sur les myocardites

Vaccin VRS

RSV			
Myocardial infarction			
Older adults			
RSVpreF	1	Walsh 2025[116]	OR, 1.11 (0.72–1.71)
Guillain–Barré syndrome			
Older adults			
RSVpreF	1	Fry 2025[46]	IRR, 2.4 (1.5–4.0)
RSVPreF3	1	Fry 2025[46]	IRR, 1.5 (0.9–2.2)

Incidence absolue : **18,2 cas / million**

Vaccin grippes: pas de signal SGB, AVC, IDM

Pour conclure

across populations. These findings underscore the enduring value of immunization against respiratory viruses as a cornerstone of preventive care and support the feasibility of maintaining rigorous, evidence-based guidance during periods of institutional disruption.

Vaccins et troubles cognitifs

Démence et vaccin contre le zona

Vaccin recombinant antizosterien

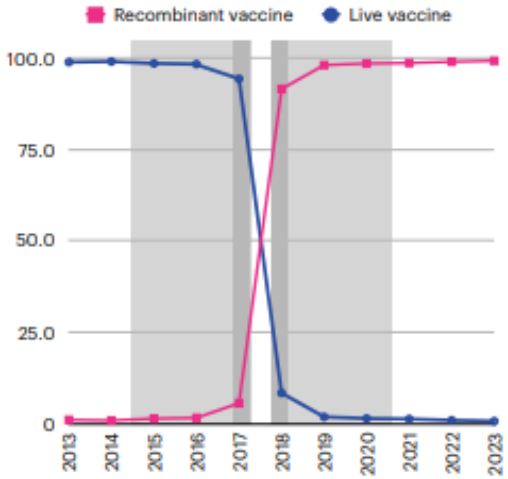
Analyse des dossiers électroniques US

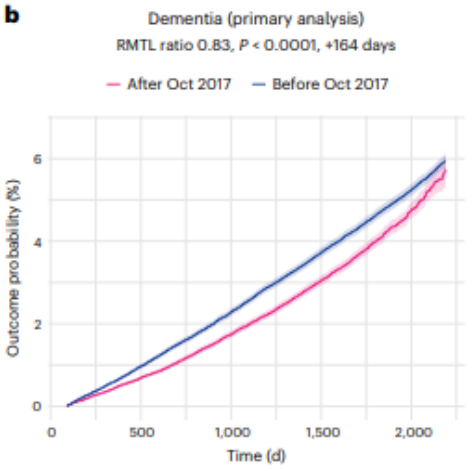
Transition rapide vaccin vivant/recombinant

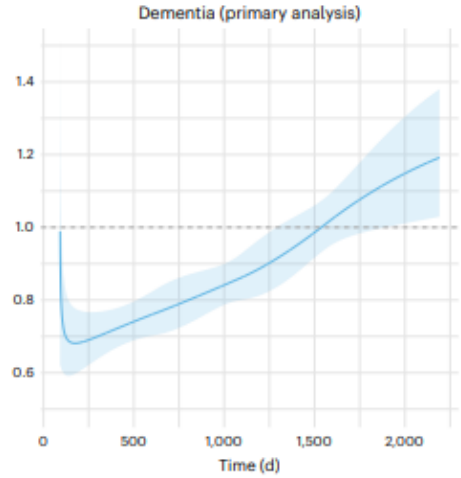
103000 vaccinés avec vaccin recombinant (95%) et 103000 avec score de propension vacciné avec vaccin vivant (95%)

Comparaison incidence de la démence

- Diminution du risque de démence de 17% avec vaccin recombinant à 6 ans IC [0,8-0,87] vs vaccin vivant
- Augmentation du temps de vie sans démence (+164j)
- Effet protecteur pour Homme et femme (> chez femmes)
- Les 2 vaccins contre le zona sont associés à un moindre risque de démence que le vaccin antigrippal et DTP,

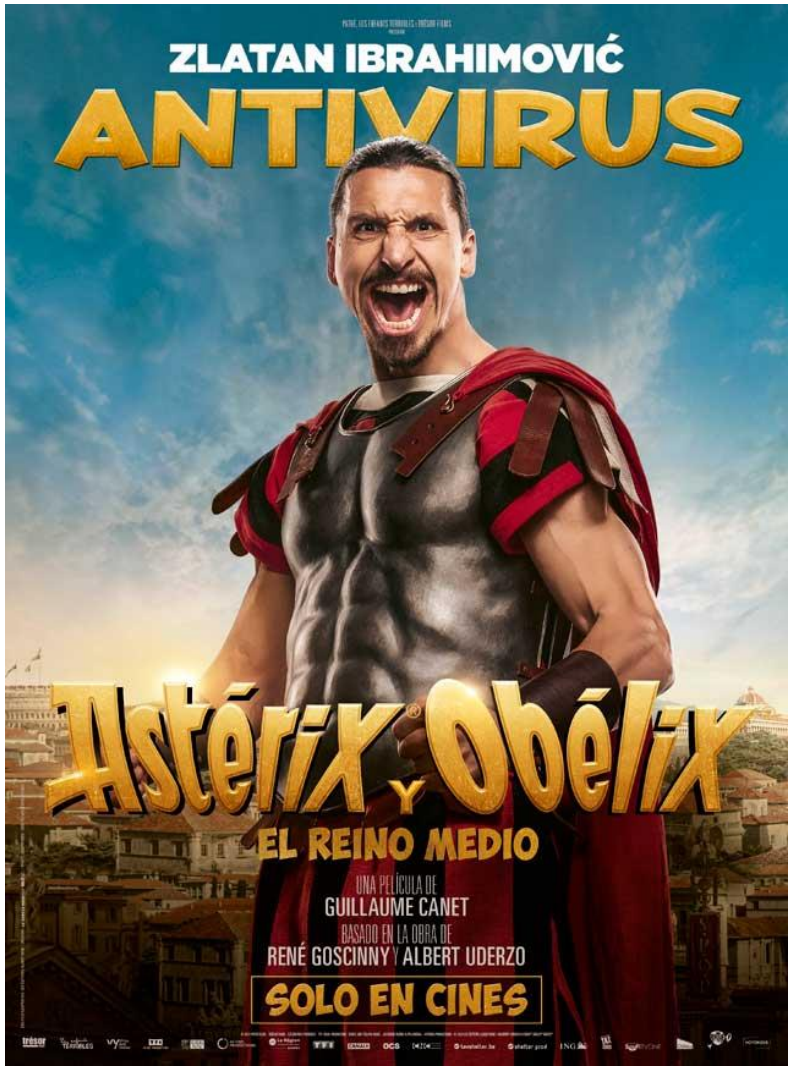






M. Taquet et al Nature Medicine 2024

antivirus


ZLATAN IBRAHIMOVIĆ
ANTIVIRUS
Astérix y Obélix
EL REINO MEDIO
UNA PELÍCULA DE
GUILLAUME CANET
BASADO EN LA OBRA DE
RENÉ GOSCINNY Y ALBERT UDERZO
SOLO EN CINES

Grippe délai de début antiviral

Clinical Infectious Diseases

MAJOR ARTICLE

Timing of Influenza Antiviral Therapy and Risk of Death in Adults Hospitalized With Influenza-Associated Pneumonia, Influenza Hospitalization Surveillance Network (FluSurv-NET), 2012–2019

Mark W. Tenforde,[1,©] Kameela P. Noah,[1] Alissa C. O'Halloran,[1] Pam Daily Kirley,[2] Cora Hoover,[3] Nisha B. Alden,[4] Isaac Armistead,[4] James Meek,[5] Kimberly Yousey-Hindes,[5] Kyle P. Openo,[6,7,8] Lucy S. Witt,[6,7] Maya L. Monroe,[9] Patricia A. Ryan,[9] Anna Falkowski,[10] Libby Reeg,[10] Ruth Lynfield,[11] Melissa McMahon,[11] Emily B. Hancock,[12] Marisa R. Hoffman,[12] Suzanne McGuire,[13] Nancy L. Spina,[13] Christina B. Felsen,[14] Maria A. Gaitan,[14] Krista Lung,[15] Eli Shiltz,[15] Ann Thomas,[16] William Schaffner,[17] H. Keipp Talbot,[17] Melanie T. Crossland,[18] Andrea Price,[18] Svetlana Masalovich,[1] Katherine Adams,[1] Rachel Holstein,[1] Devi Sundaresan,[1] Timothy M. Uyeki,[1] Carrie Reed,[1] Catherine H. Bozio,[1] and Shikha Garg[1]

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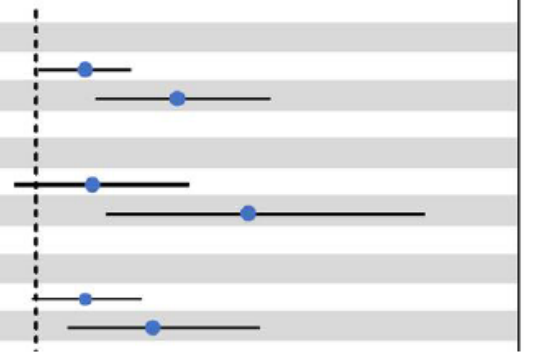
Group	No. / Total (%)	Unadjusted OR	(95% CI)	Adjusted OR	(95% CI)
Overall					
Treatment initiated day 0	15 806/26 233 (60.9)	Ref		Ref	
Treatment initiated day 1	7810/26 233 (29.5)	1.16	(1.03, 1.31)	1.14	(1.01, 1.27)
Treatment initiated **days 2–5**	2617/26 233 (9.7)	1.41	(1.21, 1.64)	1.40	(1.17, 1.66)
18-64 years					
Treatment initiated day 0	6498/10 812 (60.3)	Ref		Ref	
Treatment initiated day 1	3153/10 812 (29.1)	1.16	(.95, 1.42)	1.16	(.94, 1.43)
Treatment initiated **days 2–5**	1161/10 812 (10.7)	1.64	(1.25, 2.18)	1.60	(1.20, 2.13)
≥65 years					
Treatment initiated day 0	9308/15 421 (61.2)	Ref		Ref	
Treatment initiated day 1	4657/15 421 (29.7)	1.16	(1.00, 1.34)	1.14	(.99, 1.30)
Treatment initiated **days 2–5**	1456/15 421 (9.1)	1.40	(1.17, 1.68)	1.33	(1.09, 1.63)



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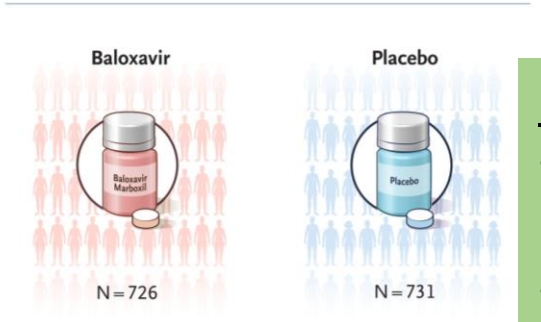
Limites:

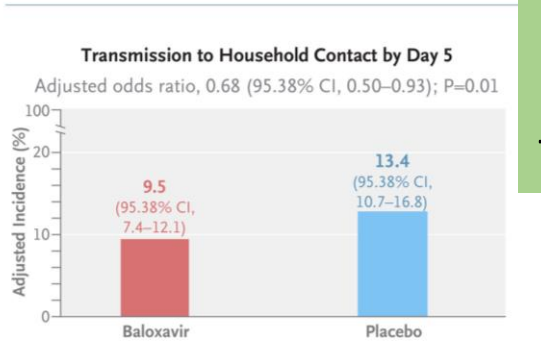
- Pas de distinction précise pneumonie virale et bactérienne
- Sous déclaration possible du ttt préhospitalier
- Pas d'horaire d'administration
- Pas d'étude des autres traitements (antibiotiques, corticoïdes)
- Délai par rapport à l'admission mais pas début des symptomes

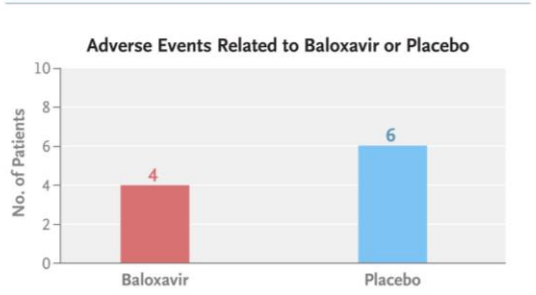
Si on décide de traiter il faut traiter précocement les pneumonies associées à la grippe

Grippe Baloxavir

Efficacité du Baloxavir pour prévenir la transmission de la grippe (CENTERSTONE study)







Rationnel:

Baloxavir = inhibiteur de l'endonucléase cap dependante du virus de la grippe

« Efficace » pour traiter la grippe et surtout réduction rapide de la charge virale (vs oseltamivir)

Méthodologie

- Etude de phase IIIb RCT double aveugle
- Multicentrique 15 pays 2019-2024
  - 1457 cas index randomisés
  - suivi de 2681 contacts (famille)
  - Surveillance à J5 (J9)

Résultats

- Réduction 29 % du nombre de cas Ilaires (p=0,01)
- Réduction des cas symptomatiques 24% (p=0,16)

Manque de puissance car taux de transmission < celui attendu (effet COVID)

Intérêts potentiels?

- dans les EHPAD pour arrêter une épidémie?
- en cas de pandémie pour gagner le temps de produire les vaccins?




- Le bon usage concerne tous les médicaments
- Savoir dépister et prendre en charge le sepsis (PNDS) y compris atypique (mesurer la FR)
- Les vaccins pour les virus respiratoires (VRS, COVID, grippe) sont efficaces en vie réelle et bien tolérés
- La couverture vaccinale est faible pour le COVID et la grippe et surtout chez les professionnels
- Les vaccins ont des bénéfices secondaires (troubles cognitifs)
- La recherche sur les antiviraux se poursuit, ils doivent être utilisés le plus tôt possible dans l’infection

GInGer
Groupe Infectio-Gériatrie