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Table 2. Clinical Efficacy for Isolates of *Streptococcus pneumoniae* and *Haemophilus influenzae* Subclassified by In Vitro Susceptibility*

Pathogen	Azithromycin		Cefuroxime/ Erythromycin	
	Cure	Failure	Cure	Failure
S pneumoniae†				
Penicillin sensitive (n=14)	80 (4/5)	20 (1/5)	100 (9/9)	0 (0/9)
Penicillin resistant (n=4)‡	100 (1/1)	0 (0/1)	67 (2/3)	33 (1/3)
Azithromycin sensitive (n=16)	80 (4/5)	20 (1/5)	91 (10/11)	9 (1/11)
Azithromycin resistant (n=2)§	100 (1/1)	0 (0/1)	100 (1/1)	0 (0/1)
H influenzae‖				
Penicillin sensitive (n=12)	89 (8/9)	11 (1/9)	100 (3/3)	0 (0/3)
Penicillin resistant (n=4)¶	50 (1/2)	50 (1/2)	100 (2/2)	0 (0/2)
Azithromycin sensitive (n=16)	82 (9/11)	18 (2/11)	100 (5/5)	0 (0/5)

**Data are given as percentage (number/total number).*
†Isolates from 18 of 28 patients were available for in vitro testing. Fourteen isolates were susceptible to both azithromycin and penicillin, 2 isolates were resistant to both azithromycin and penicillin, and 2 isolates were susceptible to azithromycin but resistant to penicillin.
‡Minimum inhibitory concentration range, 0.064 to 2 µg/mL.
§Minimum inhibitory concentration range, 8 to greater than 256 µg/mL.
‖Isolates from 16 of 19 patients were available for in vitro testing. Twelve isolates were susceptible to both azithromycin and penicillin, and 4 isolates were susceptible to azithromycin but resistant to penicillin.
¶Minimum inhibitory concentration range, 6 to greater than 32 µg/mL.

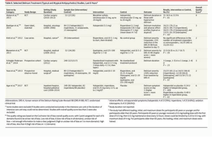
Nursing Care Plan

Patient's Name: Baby M
Medical Diagnosis: Pediatric Community Acquired Pneumonia
Nursing Diagnosis: Impaired gas exchange r/t collection of secretions affecting oxygen exchange across alveolar membrane.
Short-term Goal: at the end of my **duft, the patient's condition will lighten and minimal formation of** secretion will only occur
Long-term Goal: after hospital confinement patient will be free of secretion enabling condition of oxygen exchange normally.

ASSESSMENT	DIAGNOSIS	INFERENCE	PLANNING	INTERVENTION	RATIONALE	EVALUATION
>S: **"Nahihirapan** huminga ang baby ko dahil sa **ubo" ni** verbalized by the mother. >O: · Dyspnea · Tachycardia · V/S taken as follows: T: 36.7 °C P: 128 R: 40 BP: *none taken*	>Impaired gas exchange	>Pneumonia is an excess of fluid in the lungs resulting from an inflammatory process. The inflammation is triggered by many infectious organisms and by inhalation of irritating agents. Infectious pneumonias are categorized as community acquired (CAP) or hospital acquired (nosocomial) depending on where the patient was exposed to infectious agent.	>After 4 hours of nursing interventions, the patient will achieve timely resolution of current infection without complications.	>Assess respiratory rate, depth and ease. >Monitor body temperature. >Elevate head of the bed and change position frequently. >Limit visitors as indicated. >Institute isolation precaution.	>Manifestation of respiratory distress is dependent on indicative of the degree of lung involvement and underlying general status. >High fever greatly increases metabolic demands and oxygen consumption and alters cellular oxygenation. >Promotes expectoration, clearing or infection. >Reduces likelihood of exposure to other infectious pathogens. >Isolation technique may be desired to prevent spread and protect patient from other infectious process.	>After 4 hours of nursing interventions, the patient will achieve timely resolution of current infection without complications.
				>Suction as indicated. >Assist with nebulizer treatments. >Monitor effectiveness of antimicrobial therapy. >Administer antimicrobials as prescribed.	>Stimulates cough or mechanically clears airway in patient who is unable to cough effectively. >Facilitates liquefaction and removal of secretions. >Signs of improvement in condition should occur within 24- 48 hrs. >These drugs are used to combat most of the microbial pneumonias.	

Hypercapnic Respiratory Failure

- **Depressed drive: Drugs, Myxoedema,Brain stem lesions and sleep disordered breathing**
- **Impaired neuromuscular transmission: phrenic nerve injury, cord lesions, neuromuscular blokers, aminoglycosides, Gallian Barre syndrome, myasthenia gravis, amyotrophic lateral sclerosis, botulism**
- **Muscle weakness: fatigue, electrolyte Derangement ,malnutrition , hypoperfusion, myopathy, hypoxaemia**
- **Resistive loads: bronchospasm, airway edema ,secretions scarring ,upper airway obstruction, obstructive sleep apnea**
- **Lung elastic loads:PEEPi, alveolar edema, infection, atelectasis**
- **Chest wall elastic loads:pleural effusion, pneumothorax, flail chest, obesity,ascites,abdominal distension**



What is the pathophysiology of bronchopneumonia. What is the pathophysiology of community acquired pneumonia. What is childhood pneumonia. Pathophysiology of pneumonia in child pdf. Pathophysiology of bronchopneumonia in child. What is the pathophysiology of pneumonia.

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