mucoid, purulent, or blood-tinged sputum. Gross hemoptysis is suggestive of necrotizing pneumonia (e.g., that due to CA-MRSA). Depending on severity, the patient may be able to speak in full sentences or may be short of breath. With pleural involvement, the patient may experience pleuritic chest pain. Up to 20% of patients may have gastrointestinal symptoms such as nausea, vomiting, or diarrhea. Other symptoms may include fatigue, headache, myalgias, and arthralgias.

Findings on physical examination vary with the degree of pulmonary consolidation and the presence or absence of a significant pleural effusion. An increased respiratory rate and use of accessory muscles of respiration are common. Palpation may reveal increased or decreased tactile fremitus, and the percussion note can vary from dull to flat, reflecting underlying consolidated lung and pleural fluid, respectively. Crackles, bronchial breath sounds, and possibly a pleural friction rub may be heard. The clinical presentation may be less obvious in the elderly, who may initially display new-onset or worsening confusion but few other manifestations. Severely ill patients may have septic shock and evidence of organ failure. In cases of CAP, symptoms can range from almost nonexistent to severe, and chest radiographic findings are often in gravity-dependent parts of the lung.

■ DIAGNOSIS

When confronted with possible CAP, the physician must ask two questions: is this pneumonia, and, if so, what is the likely pathogen? The former question is answered by clinical and radiographic methods, whereas the latter requires laboratory techniques.

Clinical Diagnosis The differential diagnosis includes infectious and noninfectious entities, including acute bronchitis, exacerbations of chronic bronchitis, heart failure, and pulmonary embolism. The importance of a careful history cannot be overemphasized. The diagnosis of CAP requires a compatible history, such as cough, sputum production, fever and dyspnea, and a new infiltrate on chest radiography.