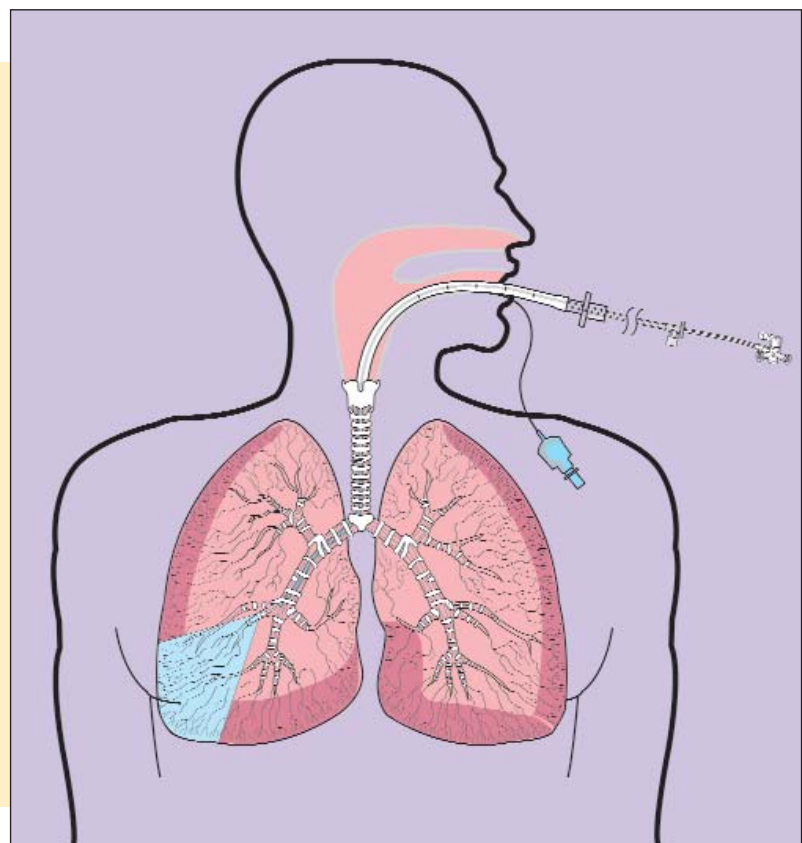




Ventilator-Associated Pneumonia (VAP)

Strategies for the Diagnosis of Ventilator-Associated Pneumonia with expanded description of blind bronchoalveolar lavage (mini-BAL) methods



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An Accredited Independent Study Guide

Strategies for the Diagnosis of Ventilator-Associated Pneumonia with Expanded Description of Blind Bronchoalveolar Lavage (Mini-BAL) Methods

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OVERVIEW

The major goals of any management strategy for patients with true Ventilator-Associated Pneumonia (VAP) are early diagnosis, then adequate doses of the correct antibiotic while avoiding overuse. The use of the wrong antibiotic can have dire consequences. Excessive use or overuse of antibiotics may allow multiple drug resistant strains of pathogens to evolve. According to Chastre, the only way to accomplish these goals is to follow these three steps:^[1]

1. Obtain a lower respiratory tract sample for culture and microscopy before introduction of new antibiotics.
2. Immediately start broad spectrum empiric antimicrobial treatment unless signs of sepsis are absent and microscopy is negative.
3. Re-evaluate treatment on day 2 or 3 based upon pathogen identification and clinical outcomes.

This document will discuss the various methods used in the diagnosis of VAP identifying the advantages and disadvantages of each approach. In addition, the recently introduced Blind Bronchoalveolar Lavage (mini-BAL) method will be described in detail.

INTRODUCTION

Hospital-associated pneumonia (HAP) accounts for up to 25% of all ICU-associated infections and for more than 50% of the antibiotics used there. Approximately 9-27% of all intubated patients acquire VAP.^[2] Diagnosis of VAP is complicated by the lack of a precise diagnostic test. Autopsy data have documented other causes of abnormal clinical findings in cases misdiagnosed as VAP. For instance, one autopsy study showed 9% of ICU patients had undiagnosed, untreated VAP.^[3] These studies highlight the importance of early, accurate VAP diagnostics to:

- decide if the patient has pneumonia
- determine the pathogen to ensure that the appropriate antibiotic can be given as soon as possible^[2]

LEARNING OBJECTIVES

At the completion of this study guide, the reader should be able to:

1. Discuss why no “gold standard” for the diagnosis of VAP has been agreed upon.
2. Identify three of the classical diagnostic procedures.
3. Discuss the advantages and disadvantages of the various sample collection methods for clinical diagnosis.
4. Describe the procedure for performing mini-BAL with the BAL catheter device.

WHY IS THERE NO GOLD STANDARD?

After more than 10 years of trying multiple invasive and non-invasive diagnostic techniques, the procedure which is specific, sensitive, rapid and inexpensive is yet to be developed. No studies have shown the superiority of any specific diagnostic method currently in use,^[4] thus, medical community still has no gold standard for the diagnosis of VAP.^[2,5] Invasive tests such as bronchoscopic BAL or protected specimen brush (PSB) may avoid the extended use of antibiotics for clinically insignificant organisms, but no direct consensus or evidence suggests that one test is superior to the other;^[6] all have their advantages and disadvantages.

VARIOUS PROCEDURES FOR DIAGNOSING VAP

Clinical Diagnosis Procedure

Using general “clinical criteria” or the Clinical Pulmonary Infection Score (CPIS) results alone to diagnose VAP may have limited value.^[7] The CPIS alone is not entirely accurate and may indicate VAP when the symptoms are related to other causes.^[8] Furthermore, this assessment approach is controversial because the clinical definition of pneumonia is not definitive without isolation of the causative pathogen. The approach is sensitive, indicating that something is clinically occurring, but not very specific. Many clinical findings which mimic VAP may have other etiologies.^[9]

Using the modified CPIS^[10] alone to diagnose VAP can cause an overuse or inappropriate use of antibiotic. Treating patients with a CPIS of 6 or less with broad range antibiotics can lead to increased costs (for the antibiotics not needed) and the development of antibiotic-resistant strains of bacteria.^[10] Patients with a CPIS of 6 or greater are usually treated empirically; however, the treatment cannot be specific to the target pathogen as it is not isolated by the CPIS. Table 1 shows an example of the CPIS regimen.^[12]

Component	Value	Points
Temperature °C	≥ 36.5 and ≤ 38.4	0
	≥ 38.5 and ≤ 38.9	1
	≥ 39.0 and ≤ 36.0	2
Blood leukocytes per mm ²	≥ 4000 and ≤ 11,000	0
	< 4000 and > 11,000	1
Tracheal secretions	Few	0
	Moderate	1
	Large	2
	Purulent	+1
Oxygenation PaO ₂ /FIO ₂ mm Hg	> 240 or presence of ARDS	0
	≤ 240 and absence of ARDS	2
Chest radiograph	No infiltrate	0
	Patchy or diffuse infiltrate	1
	Localized infiltrate	2

Table 1. Modified CPIS regimen used by Luna

As compared to histology performed at autopsy, CPIS alone has a sensitivity of 72% to 85% and specificity of only 44% in identifying patients with pneumonia. If BAL is also used, the sensitivity increases to 42-93% and the specificity to 45-100%.^[2]

Symptoms of fever (>38.3C), leukocytosis (> 10,000), leukopenia (<5,000), purulent secretions and new or changing infiltrates seen on chest films, when considered separately, do not make the diagnosis of VAP, as the densities may be explained by other causes. However, most clinicians upon observing all four values at the same time in the same patient, would most certainly consider pneumonia^[7] and begin treatment with a broad range antibiotic while awaiting culture results.

Chest radiographs have long been the benchmark for diagnosing pneumonia even though many patients have abnormal chest films from other causes, and there is poor inter-observer agreement on specific findings. Because ventilator-assisted patients may have other radiographic abnormalities, the likelihood of VAP diagnosis is not increased by chest radiography.^[3,13]

Combining knowledge gained from microbiologic examination of bronchoalveolar fluids or tissues in the infected area with the CPIS and good clinical judgment give the best road map for patient treatment. A discussion of the advantages and disadvantages of using bronchoscopic bronchoalveolar lavage, protected specimen brush and blind bronchoalveolar lavage for obtaining those specimens follows.

Advantages and Disadvantages of Clinical Diagnosis Procedure

Advantages

- Can easily be calculated at the bedside
- No special equipment needed
- May be performed by nursing or respiratory therapy staff
- May be done quickly

Disadvantages

- All components of the CPIS can be caused by other conditions
- Can lead to erroneous or overuse of antibiotics
- Not as sensitive or specific as other diagnostic measures
- Specific or targeted antibiotics cannot be used because the causative pathogen is unknown
- Use of broad spectrum antibiotics adds the resistant strain problem such as Methicillin-Resistant Staphylococcus aureus (MRSA) and Vancomycin-Resistant Enterococci (VRE)

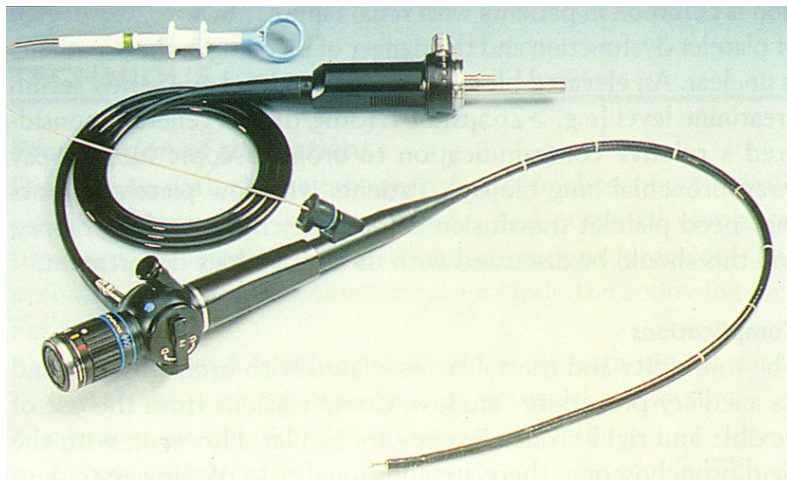
Bronchoscopic BAL

Concern about the inaccuracy of the “clinical diagnosis” approach as previously discussed and the likely possibility of overuse of antibiotics has led numerous investigators to conclude that a “specialized” diagnostic procedure is needed which includes quantitative culture of the specimens obtained from the lower airways. Using this strategy, bronchoscopic BAL was developed to obtain distal lung samples by wedging the bronchoscope in the distal third of the lung and lavaging with saline to obtain microbiologic samples for quantitative analysis.^[14]

Bronchoscopic BAL has been in use since 1988 (See Figure 1); however, the BAL technique is still not completely standardized. The amount of liquid instilled into the lung for specimen retrieval varies from 130 to 150 ml, with the first sample being discarded.

The sensitivity of quantitative BAL is 42 to 93% with a mean of 73%. Specificity is 45 to 100% with a mean of 82%. This procedure is relatively safe with a major risk of desaturation for several hours after the procedure.^[6]

Figure 1. Bronchoscope



Advantages and Disadvantages of Bronchoscopic BAL^[16]

Advantages

- Specific affected area of the lung can be visualized and sampled
- More accurate than sputum or tracheal aspirates
- May enable physician to identify non-infectious lesions
- Detects intracellular organisms in BAL cultures quickly and specifically with highly positive predictive value

Disadvantages

- More aggressively invasive than some of the other methods
- Reduced positive end expiratory pressure (PEEP) during procedure and for a short time thereafter
- Limited to larger sizes of endotracheal tubes because of the diameter of the bronchoscope
- Additional personnel needed to assist during procedure
- Must be performed by physician (usually a pulmonologist)
- Probable delay because of unavailability of pulmonologist and bronchoscope
- Sterilization of the scope is costly, technically difficult, and time consuming (spread of infection due to inadequate sterilization may occur)
- Desaturation, cardiac arrhythmias, bronchospasm are not unusual^[14]
- Bronchoscopic BAL cultures are specific about 75% and give false positives in about 20% of the cases
- Expensive (labor and device) estimated at >\$1,092 per procedure

Protected Specimen Brush (PSB)

The protected specimen brush technique for the diagnosis of pneumonia has been used for 20 years.^[17] This bronchoscopic technique uses a sample collection brush (protected by a sheath) inside the scope channel until the suspect portion of the lower airway has been reached. The brush is then extended into the desired specimen and withdrawn. This technique was first described in 1979 by Wimberly, et al.^[14]

An example of PSB is shown below in Figure 2. Note that only a small tissue specimen is procured thus reducing the sample area compared with lavage methods (BAL) and with it the sensitivity of the PSB.



Figure 2. ProBAL© PSB by Mill-Rose
Image provided by Millrose.com

Sensitivity of the PSB is from 36 to 95% and specificity 50 to 100%. Because the sample is small, sampling is often delayed to increase the probability of obtaining infected tissues. For this reason, it is often necessary to repeat the procedure.

However, reproducibility is poor with discordant results found 25% of the time. No studies have shown BAL or PSB being superior to the other as BAL is more sensitive and PSB is generally more specific.^[17]

Advantages and Disadvantages of Bronchoscopic Protected Specimen Brush (PSB)^[16]

Advantages

- Specific area of the lung can be visualized and sampled
- May enable physician to identify non-infectious lesions
- Highly specific
- More accurate than sputum or tracheal aspirates

Disadvantages

- More aggressively invasive than other pulmonary specimen collection methods discussed in this document
- Limited to larger endotracheal tubes due to the diameter of the bronchoscope
- Additional personnel needed
- Additional supplies needed (PSB)
- Pneumothorax may result if brush is mishandled
- Reduced PEEP during procedure
- Must be performed by pulmonologist
- Probable delay because of unavailability of pulmonologist, bronchoscope and assistance
- Sterilization of the scope is costly and technically difficult with failure reported
- PSB cultures are not specific about 25% of the time and give false positives in about 20% of the cases
- To improve accuracy, PSB is often performed later in the patient's clinical course, potentially delaying appropriate treatment
- Expensive (labor and device) estimated at >\$1,092 per procedure

Tracheal Aspirates

Niederman and others have recommended the use of tracheal aspirates before subsequent growth of the specimen, or as soon as VAP is suspected by CPIS.^[9,18] Gram stain can be used to make early decisions concerning which broad range antibiotic to use for treatment. Sensitivity and specificity vary widely when analyzed quantitatively. However, tracheal aspirates can easily be contaminated with colonizing pathogens rather than the culprit causing the VAP.^[19] Bacteria from the biofilm on the

inside of the endotracheal tube may contaminate the sample. Studies by both Neiderman and Wu recommend confirmation with an invasive BAL or PSB.

Niederman and Fabrice opine that all clinical information should be used to guide clinical decisions (i.e., CPIS, tracheal aspirates, Gram stain, BAL or PSB) without the extended necessity of using broad spectrum antibiotics.^[9,20] However, others feel that tracheal aspirates should not be included in this list of methods used to confirm VAP diagnosis or to adjust antimicrobial therapy due to its unreliable sensitivity and specificity.^[21]

Advantages and Disadvantages of Tracheal Aspirates

Advantages

- Easily performed at the bedside in the ICU
- Maybe performed by Respiratory Therapists or Nurses
- Inexpensive

Disadvantages

- Specimen easily contaminated
- Low specificity (38 to 100%)
- Low sensitivity (14 to 100%)^[19]
- Can cause incorrect selection of antibiotic treatment

Mini-BAL

Sometimes referred to as blind BAL or non-bronchoscopic BAL, this newer technique is performed with either a telescoping catheter such as the one illustrated in Figure 3 below, or

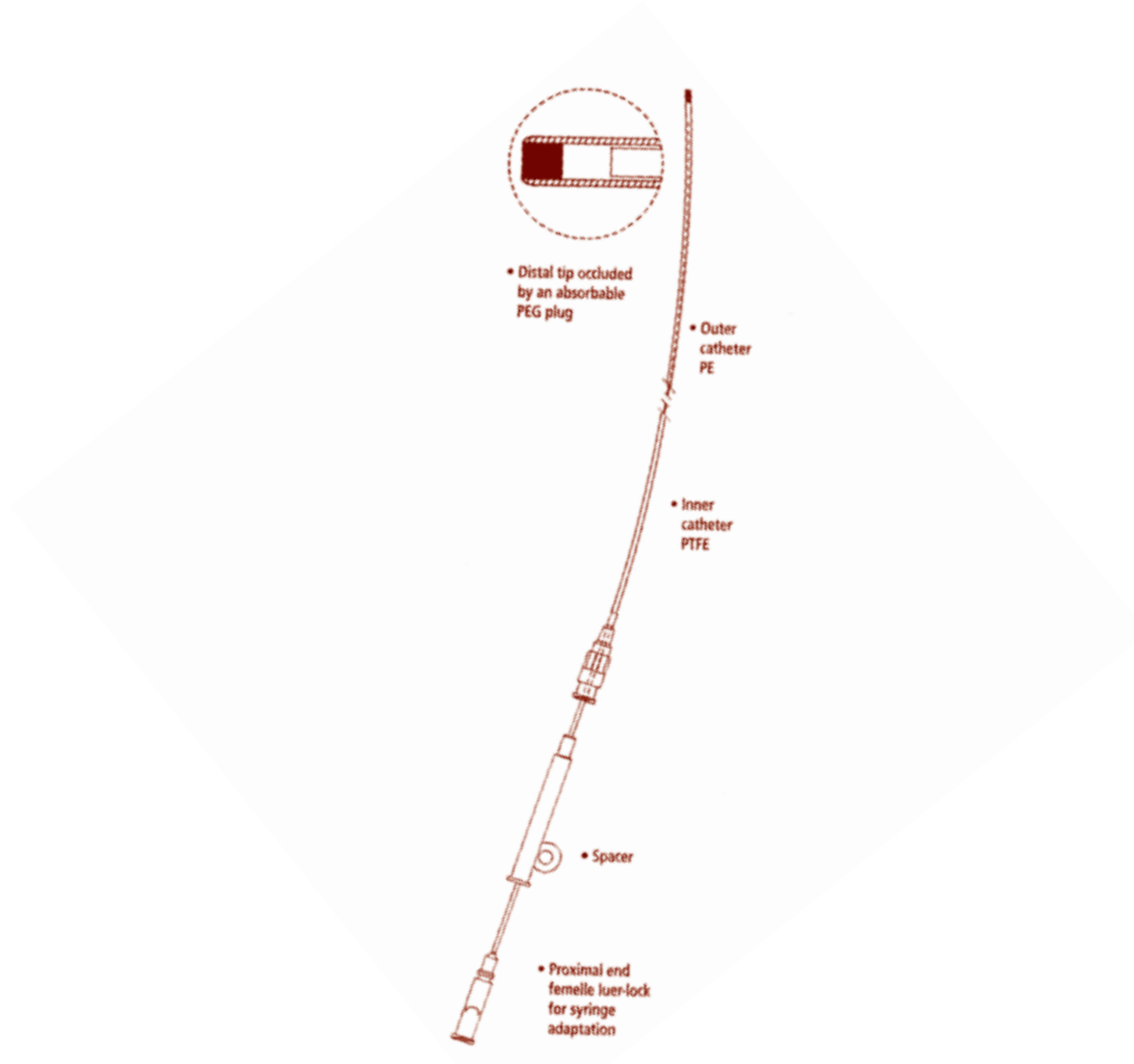


Figure 3. CombiCath® by PlastiMed
Image provided by Keomed.com

the mini-BAL illustrated in Figure 4 on the next page. Quantitative specimens from the blind BAL can successfully be used to guide the therapeutic approach^[22] and may be safer and have less adverse effects than the bronchoscopic BAL.^[23] Mini-BAL is technically simple, and the quantitative culture results are similar to those obtained by other lavage methods.^[24] The descriptors *blind* or *non-bronchoscopic* refer to the

manually guided positioning of the catheter into the congested lung section rather than the optical guidance of a bronchoscope.

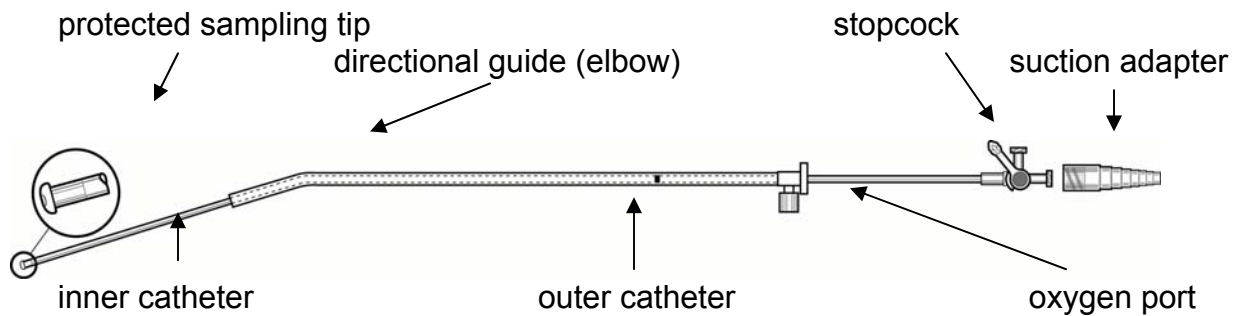


Figure 4. Kimberly-Clark* BAL CATH* catheter by Ballard Medical Products Division of Kimberly-Clark Health Care

Mini-BAL catheter procedures can be performed in 20 minutes or less. Mechanical ventilation and PEEP is maintained throughout the procedure. The specificity and sensitivity of the Mini-BAL catheter is very similar to that of the bronchoscopic BAL.

Advantages and Disadvantages of Mini-BAL Catheter

Advantages

- Allows collection and examination of lower airway secretions quickly and rapidly
- May be performed by a Nurse or Respiratory Therapist reducing delays and cost
- No assistants or extra equipment are required
- Sensitivity and specificity is comparable with bronchoscopic BAL and PSB
- Sensitivity and specificity are significantly better than tracheal aspirates
- No cost or potential safety concerns of re-sterilization of equipment
- Repeated samples can be used to “de-escalate” use of empirical broad range antibiotics^[25]
- Much less expensive than bronchoscopic BAL or PSB
- Narrower diameter of mini-BAL catheters as compared to the traditional bronchoscope enables use in a greater variety of sizes of endotracheal tubes

Disadvantages

- Blind procedure (although selection of which lung is sampled is possible)
- Requires training for Respiratory Therapists and Nurses to perform

Some authors have advocated using mini-BAL as soon as VAP is first suspected as it has comparable sensitivity and specificity with bronchoscopic BAL and PSB^[18,20,22,24] (See Table 2 below). Others feel that tracheal aspirates and/or the clinical approach is just as effective.^[9,20]

Comparison of Techniques

	Aspirate	BAL (Bronch or Mini)	PSB
Sampling area	Proximal	Distal	Distal
	Small	Large	Small
Sample amount	Variable	>5 ml	.01-.001ml
Contamination	Maximal	Moderate	Minimal
Timing of diagnosis	Unknown	Early/Late	Late

Clinics in Chest Medicine 1993; 10: 61-69

Table 2.

Step By Step Procedure for Performing Mini-BAL

1. Obtain, from patient and staff, information regarding the pneumonia (location, etc.) and any other pertinent patient information (e.g., physical abnormalities).
2. Gather and prepare necessary equipment prior to performing the procedure:
 - BAL catheter
 - Premarked laboratory specimen slip
 - Specimen trap
 - Sterile saline
 - Drape
 - SpO₂ monitor
4. Increase the FIO₂ to 1.00 (i.e., 100% oxygen).
5. Closely monitor patient throughout procedure for evidence of desaturation. If desaturation occurs (SpO₂ < 90%), the procedure should be terminated immediately.
6. Wash and dry hands thoroughly.
7. Open BAL catheter package in a sterile manner and lay on sterile field.

8. Put on sterile gloves and mask.
9. Fill 30 ml syringe with 20 ml sterile saline.
10. Pass catheter through access port elbow extending to 1½ inches (See Figure 5). Attach access port elbow between the endotracheal tube and ventilator circuit (See Figure 6). Once the adapter is secured onto the ET tube, extend the BAL catheter to the end of the ET tube. Align the numbers on the ET tube with the numbers on the BAL catheter to show when this has been achieved.

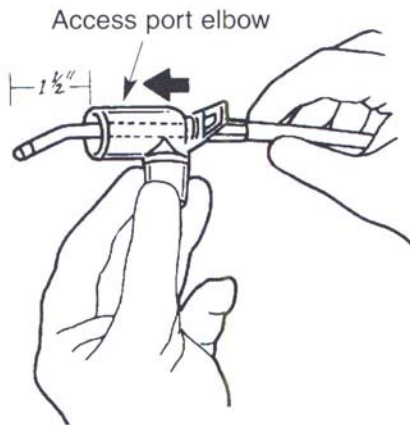


Figure 5.

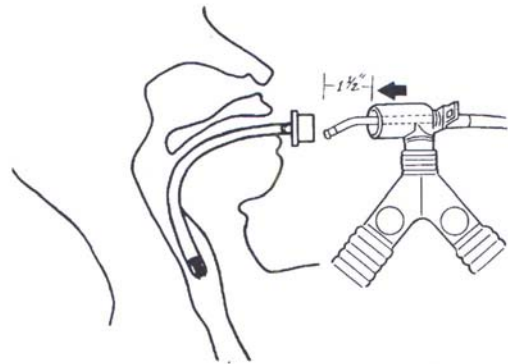


Figure 6.

11. Extend the BAL catheter 2-4 cm (depending on the ET tube position and patient size) beyond the end of the ET tube and flush the catheter with 2 ml sterile saline.
12. Direct the catheter tip to the chosen lung by orienting the O₂ port to the side of the chosen lung.
13. Advance the catheter until about 10 cm of BAL catheter protrudes beyond the access port elbow, (See Figures 5 and 7) then advance the inner catheter from the outer catheter until resistance is met. The inner catheter should now be in a wedge position (See Figure 8).
14. Lock the catheter in place. Note: For patients with untrimmed endotracheal tubes, the catheter should protrude no more than 15 cm from the patient's mouth or nose.

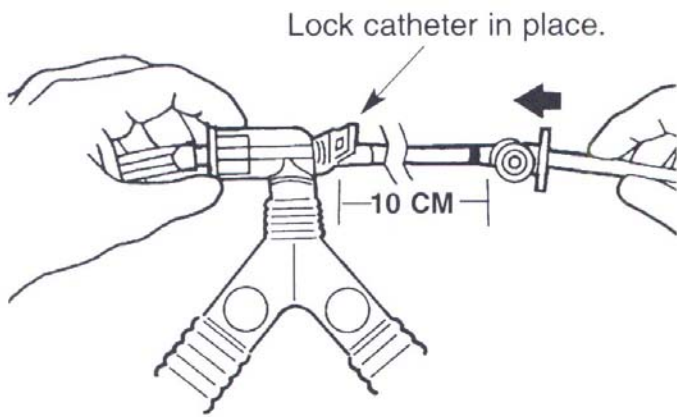


Figure 7.

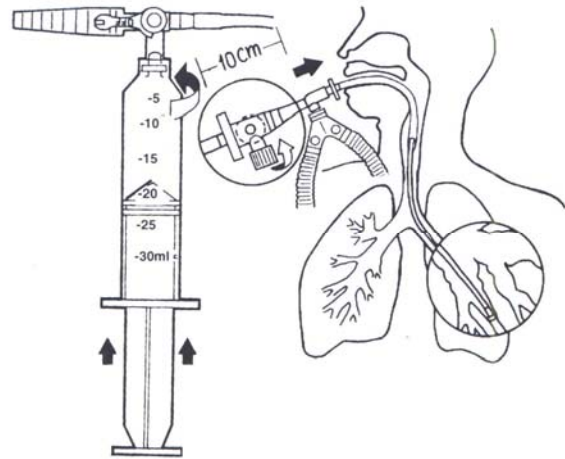


Figure 8.

15. Attach a 30 ml syringe to the BAL catheter stop-cock and instill 20 ml of saline (See Figure 9).

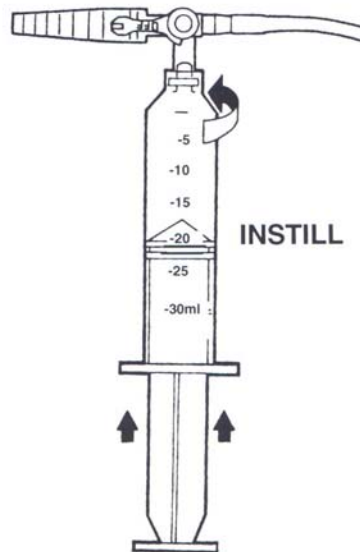


Figure 9.

16. Aspirate the sample into a specimen trap by reversing stop-cock and setting the wall vacuum regulator to 40-60 mm Hg or pull the sample back into the syringe according to hospital protocol (See Figure 10).

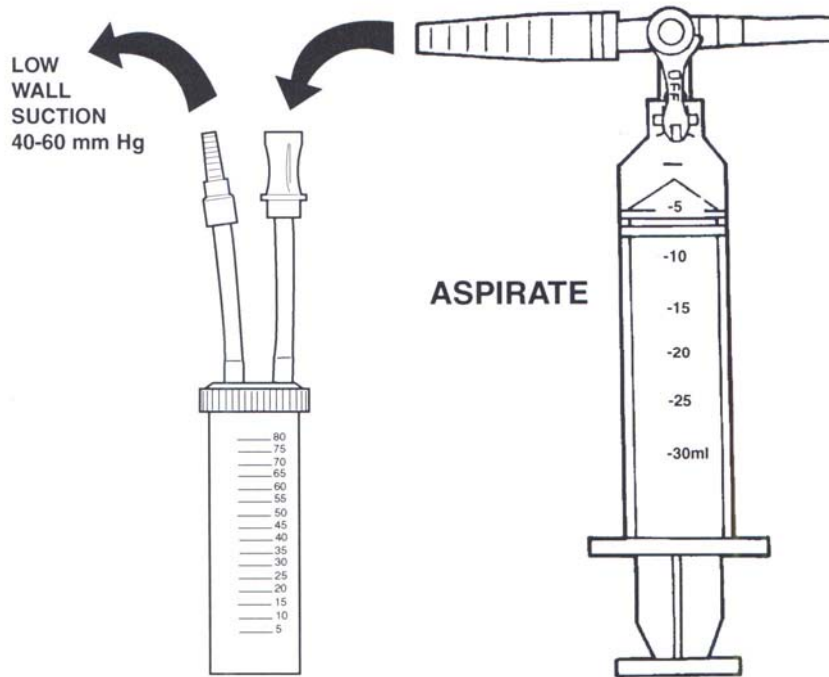


Figure 10.

17. Repeat until the total volume of BAL fluid has been infused and an adequate sample volume has been obtained (i.e., 5 x 20 ml = 100 ml).
18. Disconnect the specimen trap, unlock the catheter and retract the inner catheter. Then remove the BAL catheter and elbow access adapter from the endotracheal tube and ventilator circuit. Reconnect the ventilator tubing to the ET tube.
19. Attach the appropriate patient label and lab slip marked "BAL fluid".
20. Send the specimen to the lab for quantitative analysis

Wedge Information

Achievement of a proper wedge will ensure adequate lavage solution returns. If lavage return is inadequate, slight withdrawal of the inner catheter may be necessary. Inadequate wedge may result in the patient coughing up lavage solution or coughing lavage solution into the ET tube and ventilator circuit.

Post Procedure Care for Bronchoscopic BAL, PSB and Mini-BAL

Hypoxemia should be avoided during and immediately following the BAL procedure. Low flow oxygen therapy for 30 minutes post procedure may be helpful for some patients. Patients receiving mechanical ventilator support may benefit from increased FIO₂. Oxygen saturation and pulse rate monitoring with a pulse oximeter may be desirable. Slight hemoptysis (bleeding) may occur in some patients during the first 24 hours after a BAL procedure. Additional clinical assessment is indicated if hemoptysis is significant or prolonged. Mini-BAL may be expected to have complications similar to those seen in bronchoscopic BAL procedures, which may include: pneumonitis, post-procedure fever, bronchospasm and possible bleeding.

Oxygenation Support Precautions

In non-intubated patients, low flow oxygen administration (up to 5 LPM) prior to the sampling procedure, during the procedure and for 30 minutes after may be desirable. This should be delivered by nasal cannula prior to and following the procedure or may be delivered through the catheter oxygen port of the Mini-BAL catheter after confirmation of intratracheal position. Mechanically-ventilated patients may benefit from increased FIO₂. Pulse oximetry may be desirable to monitor oxygen saturation. Appropriate monitoring and emergency resuscitation equipment should be readily available.

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References

1. Chastre J. Conference Summary: Ventilator-Associated Pneumonia. *Respir Care*, 2005; 50(7): 975-983.
2. Guidelines for the Management of Adults with Hospital-Acquired, Ventilator-Associated, and Healthcare-Associated Pneumonia. *Am. J. Respir. Crit. Care Med.*, 2005; 171(4): 388-416.
3. Wunderink RG. Radiologic Diagnosis of Ventilator-Associated Pneumonia. *Chest*, 2000; 117(90042): 188S-190.
4. Rello J, et al. International Conference for the Development of Consensus on the Diagnosis and Treatment of Ventilator-Associated Pneumonia. *Chest*, 2001; 120(3): 955-970.
5. Craven DE. Epidemiology of Ventilator-Associated Pneumonia. *Chest*, 2000; 117(90042): 186S-187.
6. Grossman RF, Fein A. Evidence-Based Assessment of Diagnostic Tests for Ventilator-Associated Pneumonia: Executive Summary. *Chest*, 2000; 117(90042): 177S-181.
7. Hubmayr RD, Burchardi H, Elliot M, et al. Statement of the 4th International Consensus Conference in Critical Care on ICU-Acquired Pneumonia--Chicago, Illinois, May 2002. *Intensive Care Med.*, 2002; 28(11): 1521-1536.
8. Wunderink RG. Clinical Criteria in the Diagnosis of Ventilator-Associated Pneumonia. *Chest*, 2000; 117(90042): 191S-194.
9. Niederman MS. The Clinical Diagnosis of Ventilator-Associated Pneumonia. *Respir Care.*, 2005; 50(6): 788-96.
10. Singh N, Rogers P, Atwood CW, et al. Short-Course Empiric Antibiotic Therapy for Patients with Pulmonary Infiltrates in the Intensive Care Unit. A Proposed Solution for Indiscriminate Antibiotic Prescription. *Am J Respir Crit Care Med.*, 2000; 162(2 Pt 1): 505-11.
11. Fagon JY, Chastre J, Wolff M, et al. Invasive and Noninvasive Strategies for Management of Suspected Ventilator-Associated Pneumonia: A Randomized Trial. *Ann Intern Med*, 2000; 132(8): 621-630.
12. Luna CM, Blanzaco D, Niederman MS, et al. Resolution of Ventilator-Associated Pneumonia: Prospective Evaluation of the Clinical Pulmonary Infection Score as an Early Clinical Predictor of Outcome*. *Critical Care Medicine*, 2003; 31(3): 676-682.
13. Kollef MH, What Is Ventilator-Associated Pneumonia and Why Is It Important? *Respir Care.*, 2005; 50(6): 714-21.
14. Chastre J, Combes A, Luyt CE. The Invasive (Quantitative) Diagnosis of Ventilator-Associated Pneumonia. *Respir Care.*, 2005; 50(6): 797-807.
15. Torres A, El-Ebiary M. Bronchoscopic BAL in the Diagnosis of Ventilator-Associated Pneumonia. *Chest*, 2000; 117(90042): 198S-202.
16. Truscott W. Ventilator Associated Pneumonia: Strategies for Prevention and Diagnosis. Kimberly-Clark Knowledge Network, 2005 (Power Point Presentation).
17. Baughman RP. Protected-Specimen Brush Technique in the Diagnosis of Ventilator-Associated Pneumonia. *Chest*, 2000; 117(90042): 203S-206.

18. Wu CL. Quantitative Culture of Endotracheal Aspirates in the Diagnosis of Ventilator-Associated Pneumonia in Patients with Treatment Failure*. *Chest*, 2002; 122(2): 662-668.
19. Cook D, Mandell L. Endotracheal Aspiration in the Diagnosis of Ventilator-Associated Pneumonia. *Chest*, 2000; 117(90042): 195S-197.
20. Michel F, Franceschini B, Berger P, et al. Early Antibiotic Treatment for BAL-Confirmed Ventilator-Associated Pneumonia*: A Role for Routine Endotracheal Aspirate Cultures. *Chest*, 2005; 127: 589-597.
21. Camargo LF, De Marco FV, Barbas CS, et al. Ventilator Associated Pneumonia: Comparison Between Quantitative and Qualitative Cultures of Tracheal Aspirates. *Critical Care* 2004; 8(6): 422-430.
22. Brun-Buisson C, Fartoukh M, Lechapt E, et al. Contribution of Blinded, Protected Quantitative Specimens to the Diagnostic and Therapeutic Management of Ventilator-Associated Pneumonia. *Chest*, 2005; 128(2): 533-544.
23. Perkins GD, Chatterjee S, Giles S, et al. Safety and Tolerability of Nonbronchoscopic Lavage in ARDS. *Chest*, 2005; 127(4): 1358-1363.
24. Kollef MH, Bock KR, Richards RD, et al. The Safety and Diagnostic Accuracy of Minibronchoalveolar Lavage in Patients with Suspected Ventilator-Associated Pneumonia. *Ann Intern Med*, 1995; 122(10): 743-748.
25. Kollef MH, Micek ST. Strategies to Prevent Antimicrobial Resistance in the Intensive Care Unit. *Crit Care Med.*, 2005; 33(8): 1845-53.
26. Ballard, M.P., BAL CATH* Instructions for Use. Kimberly-Clark Health Care Publications, 2000. Z0376.

Strategies for the Diagnosis of Ventilator-Associated Pneumonia
with Expanded Description of Blind Bronchoalveolar Lavage
(Mini-BAL) Methods
Post Test

Name: _____

1. Why is there no gold standard for VAP diagnosis?
 - A.) Not all hospitals have access to bronchoscopes
 - B.) Regional differences in preference
 - C.) All present methods have variation in specificity and sensitivity.
 - D.) Most nurses find the CPIS too difficult to calculate
 - E.) The only real way to diagnose is lung biopsy following the patient's death

2. The CPIS method includes all but the following:
 - A.) Purulent sputum
 - B.) Chest X-Ray shows infiltrates
 - C.) Increased white blood cell count (leukocytes)
 - D.) Patient has a normal temperature
 - E.) Patient has signs of hypoxia

3. Bronchoscopic BAL is preferred because of all but which of the following:
 - A.) Specific portions of the lung can be visualized
 - B.) It is more accurate than tracheal aspirates or sputum induction
 - C.) May identify non-infectious lesions
 - D.) Detects intracellular organisms quickly and specifically
 - E.) It is very inexpensive

4. Why is the Protected Specimen Brush (PSB) preferred?
 - A.) It has been around a long time and is a well know protocol
 - B.) The tip is protected
 - C.) Only small specimen is obtained as compared to BAL
 - D.) The tip often becomes contaminated
 - E.) It is very reproducible

5. The acquisition of tracheal aspirates (from a suction catheter) has which of the following problems:
 - A.) It's a pleasant easy procedure to do
 - B.) May be performed by nurses or RT, and no MD is required
 - C.) It is inexpensive
 - D.) Specimen is easily contaminated with non-causative pathogens
 - E.) Can be performed at the bedside

6. The use of tracheal aspirates all can lead to the use of broad range antibiotics, thus allowing the development of potentially resistant strains.
- A.) True
 - B.) False
7. The CPIS diagnosis method is problematic due primarily to:
- A.) It can be quantified by a point system
 - B.) Anybody can do it
 - C.) All of the symptoms of the CPIS can come from other sources and must be eliminated by other testing
 - D.) It does not require separate technology (tests)
 - E.) It is simple
8. A physician must be in attendance when performing mini-BAL.
- A.) True
 - B.) False
9. Quantitative culture from mini-BAL is similar to other lavage methods.
- A.) True
 - B.) False
10. One disadvantage of the mini-BAL is that it requires:
- A.) Special training for the Nurse or RT
 - B.) Expensive lab equipment
 - C.) The equipment to be cleaned and sterilized immediately after the procedure
 - D.) Special lighting equipment
 - E.) Two people at the bedside to perform it
11. When performing the mini-BAL, the oxygen FIO_2 should not be increased.
- A.) True
 - B.) False
12. All but which is a common post-BAL procedure complication:
- A.) Pneumonitis
 - B.) Post procedure temperature increase
 - C.) Feeling of euphoria
 - D.) Bronchospasm
 - E.) Possible bleeding (Hemoptysis)

Please print clearly and fill in all data to ensure accurate record-keeping.

Name: _____ License State and #:* _____

Title: _____ SSN:* (if license # not available) _____

Facility Name: _____ AARC # _____

Home address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

(*) Either your Social Security Number or License number is required to obtain CE Credit.
 Please check appropriate box: RN/LPN Surg Tech Resp Therapist CS Sup/Mgr Other

Evaluation

Date: _____ Facilitator: _____

The evaluation process is important to determine the extent to which this program has met your learning needs and to measure its overall effectiveness. Circle the number that best reflects the extent of your agreement with each statement.

Rating Scale: 1=Poor to 5=Excellent

Objectives:

Indicate to what degree the objectives for this program were met.

- | | Poor ⇒ Excellent | | | | |
|--|------------------|---|---|---|---|
| 1. Discuss why no "gold standard" for the diagnosis of VAP has been agreed upon. | 1 | 2 | 3 | 4 | 5 |
| 2. Identify three of the classical diagnostic procedures. | 1 | 2 | 3 | 4 | 5 |
| 2. Discuss the advantages and disadvantages of the various sample collection Methods for clinical diagnosis. | 1 | 2 | 3 | 4 | 5 |
| 4. Describe the procedure for performing mini-BAL with the BAL catheter device. | 1 | 2 | 3 | 4 | 5 |

Overall Evaluation

- | | Poor ⇒ Excellent | | | | |
|------------------------------------|------------------|---|---|---|---|
| 6. Content | 1 | 2 | 3 | 4 | 5 |
| 7. Expertise of speaker | 1 | 2 | 3 | 4 | 5 |
| 8. Audiovisual materials | 1 | 2 | 3 | 4 | 5 |
| 9. Handout materials | 1 | 2 | 3 | 4 | 5 |
| 10. Overall quality of the program | 1 | 2 | 3 | 4 | 5 |

Program Integrity: Indicate your agreement with the following statement

- | | Disagree⇒Agree | | | | |
|--|----------------|---|---|---|---|
| 11. The content in this course was presented without bias of any commercial product or drug. | 1 | 2 | 3 | 4 | 5 |

12. How long did it take you to complete this program? _____

13. What other topics would be of benefit to you? _____

14. Additional comments.

Iowa Nurses Only: Please complete and leave evaluation form with conference coordinator at the conclusion of the conference in exchange for a Certificate of Completion, or you may submit the evaluation form to the Iowa Board of Nursing.
Florida registered nurses must provide your Florida RN license number.

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