Currently, in the practice of general practitioners a special urgency has community-acquired pneumonia (CAP), due to the high prevalence in the pediatric population. In practice, especially in the outpatient setting, serious problems are early diagnosis and rational therapy of pneumonia in children. According to the WHO, pneumonia is the leading cause of infant mortality worldwide. In particular, among the causes of mortality in children under 5 years, accounting for 17.5% annually in the world is about 1.1 million deaths [1, 3, 5]. The most common pathogens in VP are Streptococcus pneumoniae, Haemophilus influenzae and other microorganisms, including viruses and fungi. It should be clarified that the etiology of diseases of the lower respiratory tract is very different in different age groups. The most common cause of the EP (to50%) is Str.pneumoniae, rarely are such sticks as E. coli, Klebsiella spp., C. trachomatis, Mycoplasma, Ureoplasma [3, 4]. For children from 1 month of age, and up to 3 years, in the etiology of community-acquired pneumonia, the role of respiratory viruses, which can be as an separate cause of the disease, and create viral-bacterial association [5,11, 20]. The most common respiratory viruses as separate etiological factors in the development of diseases of the lower respiratory tract are observed in children aged up to 1 year. By age 5, their etiologic role is markedly reduced. Infections of the lower respiratory tract, and pneumonia in young children often cause rhino syncytial virus, parainfluenza virus 3 and 1st types. Mixed viral and bacterial infections is 30-50% in the etiology of CAP in children [5, 6, 10, 17].The widespread use of vaccination against pneumococcal disease reduced infectious morbidity (15). In children older than 5 years in the etiological structure of CAP, along with S. pneumonia increased importance of Mycoplasma pneumonia. Diagnostic procedure in the CAP consists of common clinical symptoms with the use of modern methods of laboratory and instrumental diagnosis [6]. WHO experts believe (25, 26), that in typical cases pneumonia characterized by: febrile lasting> 3 days; the presence of cyanosis and respiratory distress following
features: - shortness of breath> 60 in 1 min in children under 2 months,> 50 aged 2-12 months,> 40 children from one year to 5 years, and> 30 in children older than 5 years no signs of bronchial obstruction. Tachypnea is one of the best predictors of pneumonia in children of all ages. Counting the number of breaths the child, it is desirable to carry out during quiet breathing for 1 minute; cough. The physical examination of the patient the appearance of the following symptoms: a shortening of percussion sound in the affected area, the bronchial or breathing weakened, rhonchi, crackles or wheezing. [10]. Gold standard diagnosis of pneumonia is chest X-ray (23) in order to assess the following criteria indicating the severity of the disease: size of infiltrative changes in the lungs and their prevalence, presence or absence of pleural effusion, presence or absence of lung tissue destruction. No severe CAP treated in outpatient settings. Indications for hospitalization of children are: child age less than 2 months, regardless of the severity and prevalence of the process, children under 3 years with equity nature of lung disease, age of the child up to 5 years if damage more than one lobe of the lung, children with bad background, severe encephalopathy, of any origin, birth defects, chronic bronchopulmonary and cardiovascular systems, kidney disease, diabetes, tumors, immunodeficiency states, children from socially disadvantaged families with poor social conditions, children with complicated pneumonia, in the absence of positive dynamics within 48-72 hours after the empirical antibiotic therapy on an outpatient settings. The initial antibiotic therapy CAP conducted empirically, as the causative pathogen is known in rare cases at diagnosis (6, 17). Selecting ABP in each case the CAP is carried out individually, considering the natural activity of drugs against the pathogen and the possibility of acquiring resistance, the severity and course of the disease, the presence of patient contraindications to the use of certain antibiotics. The principles of empirical therapy: early use of the antibacterial preparations according to the most probable pathogen and its sensitivity in the region, age of the patient, the
presence of background diseases, toxicity and tolerability of ABP for a particular patient. (9, 20). In severe community-acquired pneumonia ABP administered parenterally or in the form of a two-stage step therapy antibiotics: the transition from parenteral to oral after the improvement of the patient (usually 2-3 days after initiation of treatment) (3, 7). This reduces the cost of treatment and reduce the length of stay in the hospital, with maintaining high efficiency [1, 4, 7]. The drugs of choice for patients with severe pneumonia requiring hospitalization, are amoxicillin + clavulanate (i/v) or II generation cephalosporins. The duration of antibiotic therapy depends on the severity and course of the disease, and the presence of background diseases (5, 20). In general, the duration of antibiotic therapy in the CAP caused by typical bacteria is 7-10 days, atypical bacteria - 10-14 days (1, 5, 20, 23). In the dynamics of 24-48 hours should be empirically evaluated the effectiveness of the prescribed therapy. (17). Current recommendations for the treatment of CAP suggest a number of measures to prevent the disease.