gressively increased during the first 2 weeks, going from the initial 25 cc/h up to the maximum tolerated speed (about 250 cc/h).[18]

Inhalation pneumonia is frequent in community dwellings and its incidence increases in geriatric acute settings and even more in institutionalized patients. In fact, its incidence is associated with the presence of dysphagia.[19] As with every pneumonia, the best management is based on a rapid diagnosis and the right choice of treatment. The complexity of the diagnosis derives from the absence of specific symptoms, being caught in half of them. Moreover, even if EN increases the risk of inhalation, it is possible to prevent it only to a limited extent (by reducing administration speed or using prokinetics).[17] For the choice of treatment, a good knowledge of common etiology is important (*Staphylococcus aureus*, *Haemophilus influenzae*, and *Streptococcus pneumoniae* in the community; gram-negative germs in hospital and long-term residence settings).

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