PAEDIATRIC HOSPITAL LEVEL ESSENTIAL MEDICINES LIST
CHAPTER 25: DRUG ALLERGIES
NEMLC 31 MARCH 2022

MEDICINE AMENDMENTS

SECTION	MEDICINE	ADDED/DELETED/NOT ADDED
25.4.1 Allergies to penicillins		
Milder infections	Azithromycin, oral	Specified for infections such as respiratory tract infections
	Clindamycin, oral	Added, specified for skin infections
25.4.2 Allergies to Sulphonamides		
Medicine Treatment	Dapsone, oral	Removed for treatment of *P. jirovecii* pneumonia
	Dapsone, oral	Specified for prophylaxis of *P. jirovecii* pneumonia

25.4.1 Allergies to Penicillins

Following external comment, it was recommended that clindamycin be added as an alternative for skin infections. [1,2] This was added and specified in the text.

The text was amended as follows:

~~Milder infections e.g. upper respiratory tract infections, impetigo, mild cellulitis:~~
~~Macrolide, e.g. Azithromycin, oral, 10 mg/kg/day for 3 days.~~
Milder infections
e.g. upper respiratory tract infections:
- Azithromycin, oral, 10 mg/kg/day for 3 days.

OR
e.g. impetigo, mild cellulitis:
- Clindamycin, oral, 6 mg/kg/dose 6 hourly for 3 days.

25.4.2 Allergies to sulphonamides

An external comment was received outlining that dapsone is an alternative option to cotrimoxazole for prophylaxis but not for treatment (on its own) of *P. jiroveccii*.[3] The Committee agreed with this recommendation and amended the text accordingly.

The text was amended as follows:

[1] Stevens DL, et.al. Practice Guidelines for the Diagnosis and Management of skin and soft tissue infections: 2014 Update by Infectious Diseases Society of America. Clinical Infectious Diseases. 2014, 59 (2): e10-e52.
[2] Miller LG, et.al. Clindamycin versus Trimethoprim-sulfamethoxazole for uncomplicated skin infections. NEJM. 2015, 372 (12): 1093-1103.
[3] Nuttall J. Review – Current antimicrobial management of community-acquired pneumonia in HIV-infected children. Expert Opinion on Pharmacotherapy. 2019.

Options for HIV-infected patients requiring treatment for *P. jirovecii* pneumonia with history of mild reaction, e.g. rash to prior co-trimoxazole exposure:

- ~~Dapsone, oral, 2 mg/kg daily.~~
  - ~~Maximum dose: 100 mg (1 tablet) daily.~~
  - ~~Note: Dapsone is a sulphone, not a sulphonamide, but there are cases of cross-reactivity with sulphonamide allergy but reactions are usually mild. Avoid dapsone if there is a history of anaphylaxis, SJS/TEN, or rash with systemic involvement.~~

» Consult specialist for guidance on management options.

P. jirovecii pneumonia prophylaxis

- Dapsone, oral, 2 mg/kg daily.
  - Maximum dose: 100 mg (1 tablet) daily.
  - Note: Dapsone is a sulphone, not a sulphonamide; but there are cases of cross-reactivity with sulphonamide allergy however reactions are usually mild. Avoid dapsone if there is a history of anaphylaxis, SJS/TEN, or rash with systemic involvement.

PAEDIATRIC HOSPITAL LEVEL ESSENTIAL MEDICINES LIST
CHAPTER 25: DRUG ALLERGIES
NEMLC 9 DECEMBER 2021

MEDICINE AMENDMENTS

No medicine amendments proposed.

25.1 Drug Allergies

Description
It was recommended and agreed by the Paediatric Hospital Level Expert Review Committee, that additional agents such as anticonvulsants and chemotherapeutic agents be added to the description as common medicines that may be involved in an allergic reaction.

The text was amended as follows:

DESCRIPTION
Drug allergy is an immune-mediated reaction to the drug. Reactions are idiosyncratic and, unlike side-effects, cannot be predicted by physiological action of the pharmaceutical agent. Common drugs involved include penicillin, sulphonamides, ~~and~~ non-steroidal anti-inflammatory drugs, anticonvulsants, and chemotherapeutic agents.

25.3 Delayed Hypersensitivity Reactions

Medicine Treatment
A higher proposed dose of chlorphenamine was discussed. It was agreed that the dose should remain consistent across the Standard Treatment Guidelines which is aligned with the South African Medicine Formulary and thus be retained at 0.1mg/kg/dose. The addition of cetirizine was proposed, however the Paediatric Hospital Level Expert Review Committee agreed that in the case of a mild reaction, a non-sedating antihistamine would not be required.

It was recommended that if a child is asthmatic, a preventative dose of a salbutamol inhaler and prednisolone (2mg/kg) be given to prevent a late phase reaction. This approach is in line with the conditions with predominant wheeze section within the Respiratory System chapter and a cross-referral to the chapter was included.

The text was amended as follows:

MEDICINE TREATMENT
Mild reactions without systemic or mucosal involvement may be treated symptomatically:
Chlorphenamine, oral, 0.1mg/kg/dose 6 hourly.

If a child is asthmatic, see Chapter 15: Respiratory System, section 15.4: Conditions with predominant wheeze.