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Reference: 2026/03/31EDP/02

ERRATUM TO THE PAEDIATRIC HOSPITAL LEVEL STANDARD TREATMENT GUIDELINES AND ESSENTIAL MEDICINE LIST

Please note the following update has been made to the Paediatric Hospital Level Standard Treatment Guidelines (STGs) and Essential Medicine List (EML) - Review Cycle 2025-2029.

Chapter 18: POISONING

Organophosphate poisoning

An update to the Paediatric Standard Treatment Guidelines (STGs) and Essential Medicines List (EML) atropine dilution in Chapter 23 Paediatric Intensive Care, and Chapter 18 Poisoning Chapters was published in November 2025. A query however arose around the proposed atropine dilution for organophosphate poison and its potential for fluid accumulation from the large cumulative atropine doses required for this condition.

The dilution recommendations for organophosphate were thus updated together with guidance from the University of Cape Town Poisons Information Centre, considering the following principles:

- Use of the least fluid possible to deliver the calculated atropine dose.
- Atropine typically delivered undiluted with the use of a syringe driver.
- When starting atropine infusion, regular clinical assessments (hourly) are needed, with dose adjustments based on clinical findings.
- Weaning off should be done actively, based on clinical assessment (patient specific).
- In settings where there are no syringe drivers, atropine bolus dosing should continue.

The guidance was updated as follows:

MEDICINE TREATMENT

For bradycardia, bronchorrhoea or bronchospasm:

- Atropine bolus, IV, 0.05 mg/kg over 1 minute.
  - Assess after 3 - 5 minutes for evidence of atropinisation as indicated by reduced bronchial secretions, dry skin, increasing heart rate and blood pressure, and dilating pupils (note: pupil dilatation may be delayed).
  - If no evidence of atropinisation after initial bolus, give repeated atropine boluses every 3 - 5 minutes, incrementally doubling the dose of atropine until atropinisation is achieved, e.g.:
    - For a 10 kg child: 0.5 mg, 1 mg, 2 mg, 4 mg, 8 mg, (no maximum dose).
  - If there is some evidence of atropinisation after ~~initial~~ bolus, give the same or reduced dose.

- Once atropinisation achieved, follow with atropine infusion. Calculate the total dose of atropine required to achieve atropinisation (as described above). Give 10-20% of this dose per hour.

  Undiluted infusion:
  - Prepare 20 mL of undiluted atropine (0.5 mg/ml).
  - Calculate infusion rate to deliver 10-20% of the total bolus dose per hour.
  - Example: If the patient required 15 mg of atropine bolus dose to clear respiratory secretions, then start infusion at 1,5 mg – 3 mg per hour = 3-6 mL/hour of atropine [0.5 mg/mL].

  Undiluted atropine infusion must be given via a syringe driver. If not available, continue with bolus dosing.

  ~~Mix to a concentration of 0.01 mg/mL~~

  ~~i.e.~~
  - ~~remove 1 mL from a 100 mL bag of normal saline; add atropine, 1 mg/mL, 1 mL~~

  ~~OR~~
  - ~~remove 1 mL from a 50 mL bag of normal saline; add atropine, 500 mcg/mL, 1 mL~~

  ~~Administer calculated dose.~~

  If high dose of atropine is required, use undiluted atropine 1mg/mL. Calculate infusion rate accordingly.

- Reassess frequently and adjust atropine infusion/bolus dosing as follows:
  - Bronchial secretions, bronchospasm or bradycardia recur—increase dose.
  - Good control of bronchial secretions and signs of atropine toxicity ~~overdose~~ (tachycardia, dilated pupils, agitation, pyrexia, reduced bowel sounds and urinary retention): decrease dose rapidly or stop infusion.
  - No recurrence of bronchial secretions and no signs of atropine overdose: reduce dose slowly.
  - Note: Atropine will not improve focal areas of chest crackles that are due to aspiration.

Note: Do not stop atropine infusion abruptly but wean over at least 24 hours. Tachycardia and dilated pupils are not contraindications for giving atropine in the acute resuscitation setting.

Annexure 1: AMOXICILIN/CLAVULANIC ACID – WEIGHT BAND DOSING TABLE

A query was received around the amoxicillin/clavulanic acid oral weight band dosing table; for the > 30kg weight band. The published recommendation was to administer two of the amoxicillin/clavulanic acid 875/125 mg capsules 12 hourly. This would result in a 500 mg/day clavulanic dose, a 16mg/kg/day dose of clavulanic acid for a 30kg child (advisable to dose clavulanic acid not more than 10mg/kg/day to prevent gastrointestinal adverse events).

In adults the recommended oral amoxicillin/clavulanic acid dose is one 875/125mg capsule 12 hourly. It was recommended that the paediatric dosing table align the >30kg weight band with adult dosing.

Following discussion with NEMLC, it was proposed that the recommendations for > 30 kg be removed, as it would be the same as those > 25 kg. Additionally, it was recommended that the maximum dosing recommendations be removed.

ERRATUM TO THE PAEDIATRIC HOSPITAL LEVEL STANDARD TREATMENT GUIDELINES AND ESSENTIAL MEDICINE LIST

The table was updated as follows:

Amoxicillin/Clavulanic Acid (14:1 Ratio) 600mg/42.9mg/5 ml

- Amoxicillin/clavulanic acid, oral, 45 mg/kg/dose of amoxicillin component, 12 hourly.
  - ~~Maximum dose of amoxicillin component: 1.5 g 12 hourly.~~

Weight *kg*	Dose (amoxicillin component) *mg*	600mg/42.9/5ml Solution (14:1)		875mg/125mg Capsule	Age
>2–2.5 kg	96 mg	**0.8**	**mL**	–	>34–36 weeks
>2.5–3.5 kg	120 mg	**1**	**mL**	–	>36 weeks–1 month
>3.5–5 kg	180 mg	**1.5**	**mL**	–	>1–3 months
>5–7 kg	240 mg	**2**	**mL**	–	>3–6 months
>7–11 kg	360 mg	**3**	**mL**	–	>6–18 months
>11–14 kg	480 mg	**4**	**mL**	–	>18 months–3 years
>14-17.5 kg	720 mg	**6**	**mL**	**1**	>3–5 years
>17.5–25 kg	900 mg	**7.5**	**mL**	**1**	>5–7 years
~~>25–30 kg~~	1200 mg	**10**	**mL**	**1**	~~>7–10 years~~
~~>30 kg~~	~~1500 mg~~	**~~12.5~~**	**~~mL~~**	**~~2~~ 1**	~~>10 years~~

The updated Paediatric Hospital Level STGs and EML has been uploaded to the National Health Insurance webpage and can be downloaded using the following URL: https://www.health.gov.za/wp-content/uploads/2026/03/Paediatric-STGs-and-EML-2025-2029-Review-Cycle_Updated-March-2026.pdf

Circular dissemination

Provinces and Healthcare Facilities are requested to distribute and communicate this information in consultation with the Pharmaceutical and Therapeutics Committees and all other relevant stakeholders.

Comments may be submitted *via* e-mail: SAEDP@health.gov.za

Kind regards

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DATE: 08 April 2026