Corrigendum: Guideline on the management of occupational and non-occupational exposure to the human immunodeficiency virus and recommendations for post-exposure prophylaxis: 2015 Update

Authors:
Michelle Moorhouse[1]
Linda G. Bekker[2]
Vivian Black[1]
Francesca Conradie[3]
Beth Harley[4]
Pauline Howell[5]
Gary Maartens[6]
Tari Papavarnavas[7]
Kevin Rebe[8]
Gillian Sorour[9,10]
Francois Venter[1]
Carole L. Wallis[11,12]

Affiliations:
[1]Wits Reproductive Health and HIV Institute, Johannesburg, South Africa

[2]The Desmond Tutu HIV Centre, University of Cape Town, South Africa

[3]Right to Care and Clinical HIV Research Unit, University of Witwatersrand, South Africa

[4]City Health, City of Cape Town, South Africa

[5]Wits Health Consortium, University of Witwatersrand, South Africa

[6]Department of Medicine, University of Cape Town, South Africa

[7]Helen Joseph Hospital, Right to Care, South Africa

[8]Anova Health Institute, Johannesburg, South Africa

[9]Gauteng Department of Health, Gauteng, South Africa

[10]President's Emergency Plan for AIDS Relief, Wits Reproductive Health & HIV Institute, South Africa

Read online:
Scan this QR code with your smart phone or mobile device to read online.

The authors apologise for two oversights in Table 1: One was due to an incorrect recommendation; the other was an omission.

Table 1 states that, 'RAL is recommended as preferred third drug where available for HIV PEP in children. If RAL unavailable, then ATV/r is recommended.' This has been deleted and the correct recommendation made.

Please see below the revised Table 1.

Additionally, information about dosing was omitted. This information has now been added in Appendix 1 below.

TABLE 1: Summary of guidelines on post-exposure prophylaxis for HIV in adults, adolescents and children.

Guideline	Recommendation
Number of antiretroviral drugs	HIV PEP regimens should contain three drugs
Preferred PEP regimen for adults and adolescents	TDF + 3TC/FTC (preferably as fixed-dose combination) is recommended as preferred PEP backbone
	RAL is recommended as preferred third drug for PEP (except in pregnant women, where ATV/r is the recommended third drug)
	Alternative third drugs include ATV/r, LPV/r, DRV/r or EFV
Preferred PEP regimen for children ≤ 35 kg or unable to swallow tablets	AZT + 3TC is recommended as preferred backbone for HIV PEP in children ≤ 35 kg (substitute with d4T if AZT poorly tolerated)
	LPV/r is recommended as the third drug for HIV PEP in children. Where RAL is available, then it can be used in children over 2 years of age in preference to LPV/r due to better tolerability. In children over 6 years of age who can swallow tablets, ATV/r is another better tolerated alternative to LPV/r where available.†
Prescribing frequency	A full one-month course of antiretroviral drugs should be provided for HIV PEP at initial assessment
	Starter packs should not be used
Frequency of follow-up	Exposed individual should be seen at 2 weeks, 6 weeks and 3 months after exposure occurred
Adherence support	Enhanced adherence counselling is recommended for all individuals initiating PEP

PEP, post exposure prophylaxis; TDF, tenofovir; 3TC, lamivudine; FTC, emtricitabine; RAL, raltegravir; ATV/r, atazanavir/ritonavir; LPV/r, lopinavir/ritonavir; DRV/r, darunavir + ritonavir; EFV, efavirenz; AZT, zidovudine.
†, See dosing tables in Appendix 1 for dosages.

[11]BARC, Johannesburg, South Africa
[12]Lancet Laboratories, Johannesburg, South Africa
Correspondence to: Michelle Moorhouse
Email: mmoorhouse@wrhi.ac.za
Postal address: 22 Esselen Street, Hillbrow, Johannesburg 2001, South Africa

Dates: Published: 15 Dec. 2015
How to cite this article: Moorhouse M, Bekker LG, Black V, et al. Corrigendum: Guideline on the management of occupational and non-occupational exposure to the human immunodeficiency virus and recommendations for post-exposure prophylaxis: 2015 Update. S Afr J HIV Med. 2015;16(1), Art. #399, 3 pages. http://dx.doi.org/10.4102/sajhivmed.v16i1.399-1
Note: Doi of original article: http://dx.doi.org/10.4102/sajhivmed.v16i1.399

Appendix 1
Dosing tables

FIGURE 1-A1: Stavudine (d4T); Lopinavir/Ritonavir (LPV/r); Zidovudine (AZT).[1]

Weight	Stavudine (d4T) Solution 1 mg/mL Caps 15 mg, 20 mg, 30 mg	Lopinavir/ Ritonavir (LPV/r) Solution 80/20/mL Adult tabs 200/50 mg† Paeds Tabs 100/25†	Zidovudine (AZT) Solution 10 mg/mL Capsules 100 mg Tablets 100 mg, 300 mg	Weight
3 kg – 4.9 kg	6 mL bd	1 mL bd	6 mL bd	3 kg – 4.9 kg
5 kg – 5.9 kg	**7.5 mg bd:** open 15 mg capsule into 5 mL water: give 2.5 mL	1.5 mL bd		5 kg – 5.9 kg
6 kg – 6.9 kg			9 mL bd	6 kg – 6.9 kg
7 kg – 9.9 kg	**10 mg bd:** open 20 mg capsule into 5 mL water: give 2.5 mL			7 kg – 7.9 kg
8 kg – 9.9 kg			100 mg bd (1 x 100 mg tab or cap) OR 12 mL bd	8 kg – 9.9 kg
10 kg – 13.9 kg	**15 mg bd:** open 15 mg capsule into 5 mL water	2 mL bd		10 kg – 13.9 kg
14 kg – 19.9 kg	**20 mg bd:** open 20 mg capsule into 5 mL water (If the child is unable to swallow a capsule)	Choose one option: -2.5 mL bd -100/25 mg **paeds tabs:** 2 bd -200/50 mg **adult tabs:** 1 bd	200 mg am and 100 mg pm OR 15 mL bd	14 kg – 19.9 kg
20 kg – 24.9 kg		Choose one option: -3 mL bd -100/25 mg **paeds tabs:** 2 bd -200/50 mg **adult tabs:** 1 bd	200 mg bd (2 x 100 mg cap or tab) OR 20 mL bd	20 kg – 24.9 kg
25 kg – 29.9 kg	**30 mg bd**	Choose one option: -3.5 mL bd -100/25 mg **paeds tabs:** 3 bd -200/50 mg **adult tabs:** 1 bd + 100/25 mg **paeds tabs:** 1 bd	1 x 300 mg tab bd	25 kg – 29.9 kg
30 kg – 34.9 kg		Choose one option: -4 mL bd -100/25 mg **paeds tabs:** 3 bd -200/50 mg **adult tabs:** 1 bd + 100/25 mg **paeds tabs:** 1 bd		30 kg – 34.9 kg
> 35kg		Choose one option: -5 mL bd -200/50 mg **adult tabs:** 2 bd		> 35kg

†, Do not crush or break lopinavir/ritonavir tablets.

Raltegravir[2]

- Chewable tablets and film-coated tablets are not equivalent.

Children aged 2 to < 12 years:
- < 25 kg: Chewable tablet twice daily (see dosing chart below)
- ≥ 25 kg and can swallow tablets: one 400 mg film-coated tablet twice a day
- ≥ 25 kg and can't swallow tablets: chewable tablets twice daily (see dosing chart below – maximum of 300 mg twice daily).

TABLE 1-A1: Raltegravir chewable tablets.

Weight (kg)	Number of chewable tablets (100 mg scored or 25 mg)
11 kg to < 14 kg	75 mg (3 x 25 mg) twice daily
14 kg to < 20 kg	1 x 100 mg twice daily
20 kg to < 28 kg	150 mg twice daily (1.5 x 100 mg)
28 kg to < 40 kg	200 mg (2 x 100 mg) twice daily
≥ 40 kg	300 mg (3 x 100 mg) twice daily

Atazanavir[2]

- Children ≥ 6 years and ≥ 15 kg.

TABLE 2-A1: Atazanavir capsules.

Weight (kg)	Once daily dose
< 15 kg	Capsules not recommended
15 kg to < 20 kg	Atazanavir 150 mg plus ritonavir† 100 mg, both once daily with food
20 kg to < 40 kg‡	Atazanavir 200 mg plus ritonavir† 100 mg both once daily with food
≥ 40 kg	Atazanavir 300 mg plus ritonavir 100 mg† both once daily with food

†, Either ritonavir capsules or ritonavir oral solution can be used
‡, Some experts would increase atazanavir to 300mg at ≥35kg especially when administered with tenofovir

References

1. Practice Guidelines SA-HIV Clinicians Society: 2013 ARV Dosing Chart for Children and Adolescents. [cited 2013 Aug 19] Available from: http://www.sahivsoc.org/upload/documents/ARV%20dosing%20chart%20for%20children%202013.pdf
2. Guidelines for the Use of Antiretroviral Agents in HIV-1-Infected Adults and Adolescents. [cited 2015 Nov 25] Available from: http://aidsinfo.nih.gov/guidelines