

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

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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.

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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	9 mL bd	5 kg – 5.9 kg
6 kg – 6.9 kg				6 kg – 6.9 kg
7 kg – 9.9 kg				7 kg – 7.9 kg
8 kg – 9.9 kg	10 mg bd: open 20 mg capsule into 5 mL water: give 2.5 mL	2 mL bd	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			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.

Raltegravir²

- 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

Atazanavir²

- 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

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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>