Pneumonia in children

Dear bpac,

In the article "Antibiotic choices for common infections" (BPJ 21 June 2009), I was interested to read that your recommended antibiotic for childhood pneumonia is amoxycillin. In "Rational use of antibiotics" (August 2006) you list erythromycin 40 mg/kg/day for 5–12 year olds as best for home treatment of lower respiratory tract infection. Can you clarify this?

GP, Bay of Plenty

Well spotted and a very good question.

Amoxycillin is the antibiotic of choice in children aged less than five years because it is effective against the majority of pathogens causing community-acquired pneumonia in this age group. It is also well tolerated and inexpensive. In children aged over five years, amoxycillin is the antibiotic of choice for *S. pneumoniae* infection and a macrolide antibiotic is the choice for atypical infections. However there is no simple way to distinguish between these infections therefore it is reasonable to use amoxycillin initially as macrolides are often less well tolerated than amoxycillin.

For simplicity, we recommend amoxycillin as the initial empiric choice for pneumonia in children. For amoxycillin failure or when atypical infections are circulating in the community, a macrolide (e.g. erythromycin) may be used for children aged over five years.[1]

References:

1. Clinical Knowledge Summaries. Cough – acute with chest signs in children. Community-acquired pneumonia 2007. Available from: http://cks.library.nhs.uk (Accessed June 2009).

Alternative to amizide

Dear bpac,

I have read Tim Maling's comments in regards to the potential hazards of Amizide (BPJ 16, September 2008).

I have a 65-year-old patient whose blood pressure has been perfectly well controlled on amizide for many years. Specifically, what would you suggest I switch him to?

Dr Bill Daniels, GP, Auckland

Amizide is a combination of a thiazide diuretic (hydrochlorothiazide 50 mg) and a potassium sparing agent (amiloride 5 mg). It is now well recognised that the dose of thiazide in this preparation is unnecessarily high for the treatment of hypertension and confers an increased risk of electrolyte and metabolic disturbances. Amizide has been associated with reports of hyponatraemia and hypokalaemia especially in the elderly (See BPJ 16).

It is particularly important that elderly patients are reviewed and the drug combination discontinued if possible. Where there is a clear indication for ongoing use of a thiazide, low dose bendrofluazide 2.5 mg is appropriate. If the Amizide has been prescribed with potassium sparing in mind it should be withdrawn as the hydrochlorothiazide dose is too high for efficient potassium sparing action. In this situation it is important to confirm persistent hypokalaemia with further investigation to exclude hyperaldosteronism. Non-oedematous patients including those with mild heart failure, who are taking thiazides, generally do not require potassium supplements.

(bpac consulted with Dr Tim Maling in providing this response)

We value your feedback. Write to us at: Correspondence, PO Box 6032, Dunedin or email: editor@bpac.org.nz