Recommended dosage for standard unsupervised 6-month treatment	
Isoniazid	Child: 10 mg/kg once daily (max. per dose 300 mg) for 6 months (initial and continuation phases)
Rifampicin	Child: ▸ body-weight up to 50 kg 15 mg/kg once daily for 6 months (initial and continuation phases); maximum 450 mg per day ; ▸ body-weight 50 kg and above 15 mg/kg once daily for 6 months (initial and continuation phases); maximum 600 mg per day
Pyrazinamide	Child: ▸ body-weight up to 50 kg 35 mg/kg once daily for 2 months (initial phase); maximum 1.5 g per day ; ▸ body-weight 50 kg and above 35 mg/kg once daily for 2 months (initial phase); maximum 2 g per day
Ethambutol hydrochloride	Child: 20 mg/kg once daily for 2 months (initial phase)

In general, doses should be rounded up to facilitate administration of suitable volumes of liquid or an appropriate strength of tablet. The exception is ethambutol hydrochloride p. 398 due to the risk of toxicity. Doses may also need to be recalculated to allow for weight gain in younger children.
The fixed-dose combination preparations (*Rifater*®, *Rifinah*®) are unlicensed for use in children. Consideration may be given to use of these preparations in older children, provided the respective dose of each drug is appropriate for the weight of the child.

Recommended dosage for intermittent supervised 6-month treatment	
Isoniazid	Child: 15 mg/kg 3 times a week (max. per dose 900 mg) for 6 months (initial and continuation phases)
Rifampicin	Child: 15 mg/kg 3 times a week (max. per dose 900 mg) for 6 months (initial and continuation phases)
Pyrazinamide	Child: ▸ body-weight up to 50 kg 50 mg/kg 3 times a week (max. per dose 2 g 3 times a week) for 2 months (initial phase) ; ▸ body-weight 50 kg and above 50 mg/kg 3 times a week (max. per dose 2.5 g 3 times a week) for 2 months (initial phase)
Ethambutol hydrochloride	Child: 30 mg/kg 3 times a week for 2 months (initial phase)

In general, doses should be rounded up to facilitate administration of suitable volumes of liquid or an appropriate strength of tablet. The exception is ethambutol hydrochloride due to the risk of toxicity. Doses may also need to be recalculated to allow for weight gain in younger children.
The fixed-dose combination preparations (*Rifater*®, *Rifinah*®) are unlicensed for use in children. Consideration may be given to use of these preparations in older children, provided the respective dose of each drug is appropriate for the weight of the child.

Immunocompromised

EvGr Children who are anticipated to be, or who are currently immunocompromised should be referred to a specialist if latent tuberculosis is suspected (for example if they are from a high incidence country or have been in close contact with people with *suspected infectious* or *confirmed* pulmonary or laryngeal tuberculosis). A

Treatment of latent tuberculosis

EvGr **Neonates** who have been in close contact with a person with tuberculosis which has not yet been treated for at least two weeks, should start treatment with isoniazid p. 399 (with pyridoxine hydrochloride p. 678) followed by a Mantoux test after 6 weeks of treatment.

If the Mantoux test is positive (and active tuberculosis is not present) treatment should be continued for 6 months; if negative (and confirmed by a negative interferon-gamma release assay), the treatment should be stopped and a BCG vaccination given. If the interferon-gamma release assay result is positive (and active tuberculosis is not present) treatment should be continued for 6 months.

Childrenaged 4 weeks to 2 years who have been in close contact with a person with tuberculosis which has not been treated for at least two weeks, should start treatment for latent tuberculosis and have a Mantoux test. Treatment is either isoniazid (with pyridoxine hydrochloride) alone for 6 months (preferred regimen if interactions with rifamycins are a concern) or rifampicin p. 396 and isoniazid (with pyridoxine hydrochloride) for 3 months (recommended when hepatotoxicity is a concern).

If the Mantoux test is positive (and active tuberculosis is not present), the treatment course should be completed. If the test is negative, treatment should be continued and the child should be re-assessed for active tuberculosis after 6 weeks. If the results are then negative (and confirmed by a negative interferon-gamma release assay), the treatment should be stopped and a BCG vaccination given (if the child has not already had one). If the result is positive (and active tuberculosis is not present), the course of treatment should be continued.

Childrenaged over 2 years should be offered a Mantoux test, and if positive (and active tuberculosis is not present), then treat as above for children aged 4 weeks to 2 years. If the test is negative, then offer an interferon-gamma release assay after 6 weeks and repeat the Mantoux test. A

The choice of regimen is dependent on clinical factors, including age, risk of hepatotoxicity and possible drug interactions. EvGr Testing for HIV, hepatitis B and hepatitis C should be offered before starting antituberculosis treatment as this may affect choice of therapy.

Children with severe liver disease should be treated under the care of a specialist team. Careful monitoring of liver function is necessary in children with non-severe liver disease, abnormal liver function, or who misuse alcohol or drugs. A

For advice on tuberculin testing and immunisation against tuberculosis, see Bacillus Calmette-Guérin vaccine p. 831.

Treatment failure

Major causes of treatment failure include incorrect prescribing by the clinician and inadequate compliance by the child or carer. EvGr All children diagnosed with tuberculosis should have an allocated case manager to help with the development of a health and social care plan, supervision of treatment, and support with the completion of treatment. Multidisciplinary tuberculosis teams should implement strategies (such as random urine tests, pill counts, home visits, health education counselling, and language appropriate reminder services) to help with adherence to, and successful completion of treatment. A

Treatment interruptions

A break in antituberculosis treatment of at least 2 weeks (during the initial phase) or missing more than 20% of prescribed doses is classified as treatment interruption. Re-establishing treatment appropriately following interruptions