Anthrax: CDC and AAP Preferred Regimens (*continued*)

Adapted from *Emerg Infect Dis* [Internet]. 2014 Feb. http://dx.doi.org/10.3201/eid2002.130687 and *Pediatrics* 2014;133(5):e1411 at http://pediatrics.aappublications.org/content/133/5/940.

[a] For women who are pregnant or breastfeeding, refer to *Emerg Infect Dis* [Internet]. 2014 Feb. http://dx.doi.org/10.3201/eid2002.130611.

[b] Refer to AAP report cited above for dosage regimens to treat infants younger than 1 mo.

[c] Alternatives for penicillin-susceptible strains. Post-exposure prophylaxis or cutaneous anthrax. Adults: amoxicillin 1000 mg PO q 8 h OR penicillin 500 mg PO q 6 h. Children: amoxicillin 75 mg/kg/day PO divided q 8 h (max 1 g/dose) OR penicillin 50 to 75 mg/kg/day divided q 6 to 8 h. Systemic anthrax. Adults: penicillin G 4 million units IV q 4 h OR ampicillin 3 g IV q 6 h. Children: penicillin G 400,000 units/kg/day IV divided q 4 h (max 4 million units/dose).

[d] Systemic anthrax is inhalation, injection, or GI anthrax; cutaneous anthrax with systemic involvement, extensive edema, or head or neck lesions; or meningitis. In addition to antibiotics, patients with suspected systemic anthrax should receive an antitoxin from the US Strategic National Stockpile. Three antitoxins bind the protective antigen on *B. anthracis* lethal and edema toxins. Obiltoxaximab (Anthim) and raxibacumab are monoclonal antibodies; anthrax immune globulin intravenous (AIGIV; Anthrasil) is human IgG polyclonal antibodies. Recommendations for prioritizing antitoxin use are available at: www.cdc.gov/mmwr/pdf/rr/rr6404.pdf.

[e] For patients exposed to aerosolized spores, provide prophylaxis to complete 60 days of treatment from the onset of illness.

[f] Linezolid can cause myelosuppression; monitor CBC weekly esp. in patients with myelosuppression and for courses longer than 2 weeks.

[g] In children younger than 8 yo, the benefit of preventing anthrax outweighs the risk of permanent tooth staining with doxycycline.