The following entries were unintentionally omitted from the original printing of 2014 Nelson’s Pediatric Antimicrobial Therapy, 20th Edition. All subsequent printings, the eBook, and the app have been updated.

On page 44, Chapter 6, Table C, the following entry (to be placed before Cellulitis, periorbital) was omitted:

| Cellulitis, orbital<sup>1–10</sup> (usually secondary to sinus infection; caused by respiratory tract flora and S aureus, including CA-MRSA) | Cefotaxime 150 mg/kg/day div q8h or ceftriaxone 50 mg/kg/day q24h; ADD (for S aureus, including CA-MRSA): clindamycin 30 mg/kg/day IV div q8h OR vancomycin 40 mg/kg/day IV q8h (AllI). If MSSA isolated, use: oxacillin/nafcillin IV OR cefazolin IV | Surgical drainage of larger collections of pus, if present by CT scan in orbit or subperiosteal tissue. Try medical therapy alone for small abscesses (BII).<sup>14</sup> Treatment course for 10–14 days after surgical drainage, up to 21 days. CT scan to confirm cure (BIII). |

On page 48, Chapter 6, Table D, the following entry (to be placed after Mastoiditis, acute) was omitted:

| Mastoiditis, chronic (see also Otitis, chronic suppurative) anaerobes, Pseudomonas, S aureus (including CA-MRSA)<sup>11</sup> | Antibiotics only for acute superinfections (according to culture of drainage); for Pseudomonas: meropenem 60 mg/kg/day IV div q8h, OR piperacillin/tazobactam 240 mg/kg/day IV div q4–6h for 1 wk after drainage stops (BIII) | Daily cleansing of ear important; if no response to antibiotics, surgery. Alternative:cefazolin IV (poor anaerobic coverage). Be alert for CA-MRSA. |

On page 63, Chapter 6, Table G, the following entry (to be placed after Staphylococci: S aureus) was omitted:

| Endocarditis Prophylaxis<sup>11–18</sup>: Given that (1) endocarditis is rarely caused by dental/GI procedures and (2) prophylaxis for procedures prevents an exceedingly small number of cases, the risks of antibiotics outweigh the benefits. Highest risk conditions currently recommended for prophylaxis: (1) prosthetic heart valve (or prosthetic material used to repair a valve); (2) previous endocarditis; (3) cyanotic congenital heart disease that is unrepaired (or palliatively repaired with shunts and conduits); (4) congenital heart disease that is repaired but with defects at the site of repair adjacent to prosthetic material; (5) completely repaired congenital heart disease using prosthetic material, for the first 6 mo after repair; or (6) cardiac transplant patients with valvulopathy. Routine prophylaxis no longer is required for children with native valve abnormalities. Long-term assessment of new prophylaxis guidelines documents no significant increase in endocarditis.<sup>11</sup> |

On page 63, Chapter 6, Table G, the following entry (to be placed after Genitourinary and gastrointestinal procedures) was omitted:

| Lemierre syndrome (Fusobacterium necrophorum)<sup>95,103,14,15</sup> postanginal sepsis, pharyngitis with internal jugular vein septic thrombosis | Empiric: meropenem 60 mg/kg/day div q8h (or 120 mg/kg/day div q8h for CNS metastatic foci) (AllI) OR ceftriaxone 100 mg/kg/day q24h AND metronidazole 40 mg/kg/day div q8h or clindamycin 40 mg/kg/day div q6h (BIII) | Anecdotal reports suggest metronidazole may be effective for apparent failures with other agents. Metastatic and recurrent abscesses often develop while on active, appropriate therapy, requiring multiple debridements and prolonged antibiotic therapy. |

On page 65, Chapter 6, Table H, the following entry (to be placed after Traveler’s diarrhea: prophylaxis) was omitted:

| – Aeromonas hydrophila<sup>204</sup> | Ciprofloxacin 30 mg/kg/day PO div bid for 5 days OR azithromycin 10 mg/kg qd for 3 days OR ceftizoxime 8 mg/kg/day PO qd (BIII) | Not all strains produce enterotoxins and diarrhea; role in diarrhea questioned.<sup>205</sup> Resistance to TMP/SMX about 10%–15%. Choose most narrow spectrum agent based on in vitro susceptibilities. |

On page 68, Chapter 6, Table H, the following heading (to be placed before Appendicitis; bowel-associated) was omitted:

| Intra-abdominal Infection (abscess, peritonitis secondary to bowel/appendix contents) |

On page 70, Chapter 6, Table I, the following entry (to be placed before Herpes simplex virus, genital infection) was omitted:

| Granuloma inguinale (donovanosis, Klebsiella granulomatis, formerly Calymmatobacterium)<sup>14</sup> | Doxycycline 4 mg/kg/day div bid (max 200 mg/day), PO for 21 days until lesions completely healed | Primarily in tropical regions of India, Pacific, and Africa. Option: azithromycin 1 g PO once weekly for 3 wk |
On page 72, Chapter 6, Table I, the following heading (to be placed before Bacterial vaginosis) was omitted:

Vaginitis

On page 77, Chapter 6, Table L, the following entry (to be placed after Brucellosis) was omitted:

Cat-scratch disease
(Bartonella henselae) Supportive (incision and drainage of infected lymph node); azithromycin 12 mg/kg/day PO qd for 5 days shortens the duration of adenopathy (AII)
This dosage of azithromycin has been documented to be safe and effective for streptococcal pharyngitis and may offer greater deep tissue exposure than the dosage studied by Bass et al and used for otitis media.
No prospective data exist for invasive infections: gentamicin (for 14 days) AND TMP/SMX AND rifampin for hepatosplenic disease and osteomyelitis (AII). For CNS infection, use cefotaxime AND gentamicin ± TMP/SMX (AII). Alternatives: ciprofloxacin, doxycycline.

On page 105, Chapter 8, Table B, the following entry (to be placed after Peritonitis) was omitted:

Urinary tract infection
– Cystitis: Fluconazole 6 mg/kg once daily IV or PO for 2 wk (AII)
– Pyelonephritis: Fluconazole 6 mg/kg once daily IV or PO for 2 wk (AII)
Removing Foley catheter, if present, may lead to a spontaneous cure in the normal host; check for additional upper urinary tract disease.
For fluconazole-resistant organisms, AmB-D is an alternative. AmB-D bladder irrigation is not generally recommended due to high relapse rate (an exception may be in fluconazole-resistant Candida). For renal collecting system fungus balls, surgical debridement may be required in non-neonates (BIII). Echinocandins have poor urinary concentrations.

On page 107, Chapter 8, Table B, the following entry (to be placed after Paracoccidioidomycosis) was omitted:

Phaeohyphomycosis
(dematious, pigmented fungi) Voriconazole 18 mg/kg/day IV div q12h for a loading dose on the first day, then 16 mg/kg/day IV div q12h as a maintenance dose for children 2–12 y. In children >12 y, use adult dosage (load 12 mg/kg/day IV div q12h on first day, then 8 mg/kg/day div q12h as a maintenance dose) (AII).
When stable, may switch from voriconazole IV to voriconazole PO at a dose of 18 mg/kg/day div bid for children 2–12 y and 400 mg/day div bid for children >12 y (AIII).
Alternatives could include posaconazole (trough concentrations >0.7 µg/ml), combination therapy with an echinocandin and an azole or an echinocandin and AmB (AIII).
Surgery is essential; susceptibilities are variable. Optimal voriconazole trough concentrations (generally thought to be >1–2 µg/mL) are important.

On page 173, Chapter 14, Table A, the following 2 entries (to be placed after Genitourinary and gastrointestinal procedures) were omitted:

Meningococcus
(Neisseria meningitidis) For prophylaxis of close family contacts or child care contacts, or for those having contact with respiratory secretions from an infected patient, in the 7 days before symptom onset in the index case:
Rifampin
Children <1 mo: 5 mg/kg PO q12h for 4 doses
Children >1 mo: 10 mg/kg PO q12h for 4 doses (max 600 mg/dose)
OR
Ceftriaxone
Children <15 y: 125 mg IM once
Children ≥16 y: 250 mg IM once
OR
Ciprofloxacin 500 mg PO once (adolescents and adults)
A few cipro-resistant strains have now been reported. Insufficient data to recommend azithromycin at this time.

Pertussis Prophylaxis to family members and close contacts.
Azithromycin and clarithromycin are better tolerated than erythromycin (see Chapter 5); azithromycin is preferred in exposed young infants to reduce pyloric stenosis risk.