Louth: Antimicrobial Guidelines - Louth Hospitals: Antimicrobial Guidelines: Malaria in Pregnancy

Indication

Obstetrics - Severe Malaria in Pregnancy [26-29]

> 2% of red blood cells parasitised or end organ damage

Likely organisms

P. falciparum

Antimalarial Treatment

First Line Therapy for Severe Malaria – All Trimesters:

Artesunate IV 2.4mg/kg at 0h, 12h, 24h, then daily

Please note Quinine IV is no longer available (Jul 2019)

Switch to oral therapy after at least 24 hours of IV therapy, once patient improving and can tolerate oral medication:

Artemether-Lumefantrine (Riamet®) 20mg/120mg, 4 tablets at 0h, 8h, 24h, 36h, 48h and 60h

N.B. Please note the timing of Riamet® doses relates to time from time zero – see worked example below:

- Time Zero = 18.00 on 12/8/19
- Next dose due at 8 hours from time zero = 02.00 on 13/8/19
- Next dose due at 24 hours from time zero = 18.00 on 13/8/19
- Next dose due at 36 hours from time zero = 06.00 on 14/8/19
- Next dose due at 48 hours from time zero = 18.00 on 14/8/19
- Next dose due at 60 hours from time zero = 06.00 on 15/8/19
- It will take 60 hours total (2.5 days) for administration of full course.

N.B. Contact Pharmacy Department prior to discharge to ensure continuity of supply as Riamet® is not readily available in the community.

OR

Quinine Sulphate 600mg TDS PO to complete total of 7 days **PLUS** start Clindamycin 450mg TDS PO for 7 days.

Comments

Malaria is a medical emergency. Always discuss with ID Consultant or Consultant Microbiologist.

Diagnostic tests:

Blood for stained thick *and* thin films – three samples at least 12 hours apart

Request percentage parasitaemia on thin blood film.

Admit patient medically if *P. falciparum* suspected or confirmed. Start treatment after laboratory confirmation except in severe disease with strong clinical suspicion. Patients who have taken malaria chemoprophylaxis should not receive the same drug for treatment.

Please see HPSC Clinical Guidelines on the Management of Suspected Malaria for further information, available at www.hpsc.ie .

Always document travel history for the past 12 months – countries and locations visited, travel dates, prophylaxis taken, prior history of malaria and co-morbidities. Malaria prophylaxis is not 100% effective and having taken prophylaxis does not rule out the possibility of malaria infection. The incubation period may be from 8 days up to 1 year.

Indication

Obstetrics - Uncomplicated Malaria in Pregnancy [26-29]

Likely organisms

P. falciparum or "species not identified" initially

Antimalarial Treatment

1st Trimester of Pregnancy:

Quinine Sulphate 600mg TDS PO **PLUS** Clindamycin 450mg TDS PO for 7 days

[If patient cannot tolerate PO due to vomiting, consider IV therapy. Please note Quinine IV is no longer available (Jul 2019). There is limited evidence for the use of artemisinin derivatives in pregnancy: data for > 250 pregnant women in the first trimester did not show evidence of teratogenic risk and data for > 1,500 pregnant women in the second and third trimester did not find an increased risk of miscarriages, stillbirths or malformations. The WHO recommends using artemisinin derivatives as medications of choice for malaria in the second and third trimester. During the first trimester, due to lack of experience, the WHO views artemisinin derivatives as reserve medications that should not be withheld in an individual case where needed. (Reference: Schaeffer C, Peters P, Miller RK. Drugs during pregnancy and lactation, 3rd Edition. UK: Academic Press; 2014). If IV therapy required in the first trimester for uncomplicated malaria, consider Artesunate IV 2.4mg/kg at 0h, 12h, 24h, then daily and switch to PO therapy as above (Quinine/Clindamycin) as soon as the patient can tolerate PO.]

2nd or 3rd Trimester of Pregnancy:

Artemether-Lumefantrine (Riamet®) PO 20mg/120mg, 4 tablets at 0h, 8h, 24h, 36h, 48h and 60h

N.B. Please note the timing of Riamet® doses relates to time from time zero – see worked example below:

- Time Zero = 18.00 on 12/8/19
- Next dose due at 8 hours from time zero = 02.00 on 13/8/19
- Next dose due at 24 hours from time zero = 18.00 on 13/8/19
- Next dose due at 36 hours from time zero = 06.00 on 14/8/19
- Next dose due at 48 hours from time zero = 18.00 on 14/8/19
- Next dose due at 60 hours from time zero = 06.00 on 15/8/19
- It will take 60 hours total (2.5 days) for administration of full course.

N.B. Contact Pharmacy Department prior to discharge to ensure continuity of supply as Riamet® is not readily available in the community.

[If patient cannot tolerate PO due to vomiting, start with Artesunate IV 2.4mg/kg at 0h, 12h, 24h, then daily and change to PO Artemether-Lumefantrine (Riamet®) as soon as patient can tolerate PO].

OR

Quinine Sulphate 600mg TDS PO **PLUS** Clindamycin 450mg TDS PO for 7 days

If cause of malaria subsequently diagnosed as *P. vivax* or *P. ovale* :

To prevent relapse, give chloroquine 310mg PO once weekly until delivery. Once baby delivered, contact ID Consultant for advice on how to complete required treatment to prevent relapse.

Comments

Malaria is a medical emergency. Always discuss with ID Consultant or Consultant Microbiologist.

Diagnostic tests:

Blood for stained thick *and* thin films – three samples at least 12 hours apart

Request percentage parasitaemia on thin blood film.

Admit patient medically if *P. falciparum* suspected or confirmed. Start treatment after laboratory confirmation except in severe disease with strong clinical suspicion. Patients who have taken malaria chemoprophylaxis should not receive the same drug for treatment.

Please see HPSC Clinical Guidelines on the Management of Suspected Malaria for further information, available at www.hpsc.ie .

Always document travel history for the past 12 months – countries and locations visited, travel dates, prophylaxis taken, prior history of malaria and co-morbidities. Malaria prophylaxis is not 100% effective and having taken prophylaxis does not rule out the possibility of malaria infection. The incubation period may be from 8 days up to 1 year.