

Martin W. Dünser
Emir Festic
Arjen Dondorp
Niranjana Kissoon
Tsenddorj Ganbat
Arthur Kwizera
Rashan Haniffa
Tim Baker
Marcus J. Schultz
Global Intensive Care Working
Group of the European Society
of Intensive Care Medicine

Erratum to: Recommendations for sepsis management in resource-limited settings

Published online: 10 March 2012
© Copyright jointly held by Springer and ESICM 2012

The online version of the original article can be found under doi:[10.1007/s00134-012-2468-5](https://doi.org/10.1007/s00134-012-2468-5).

M. W. Dünser (✉)
Department of Anesthesiology, Perioperative and General Critical Care Medicine, Salzburg General Hospital and Paracelsus Private Medical University, Müllner Hauptstrasse 48, 5020 Salzburg, Austria
e-mail: M.Duenser@salk.at
Tel.: +43-662-448257780

E. Festic
Department of Critical Care Medicine,
Mayo Clinic, Jacksonville, FL, USA

A. Dondorp
Mahidol Oxford Research Unit, Faculty of Tropical Medicine,
Mahidol University, Bangkok, Thailand

N. Kissoon
Department of Paediatrics and Emergency Medicine,
BCCH and UBC Global Child Health, University of British Columbia and the Child and Family Research Institute,
Vancouver, Canada

T. Ganbat
Department of Anesthesiology and Critical Care Medicine,
Central State University Hospital, Ulaanbaatar, Mongolia

A. Kwizera
Department of Anaesthesia, Intensive Care Unit,
Makerere University College of Health Sciences, Mulago Hospital,
Kampala, Uganda

R. Haniffa
Department of Anaesthesia and Intensive Care,
University College London Hospitals, London, UK

T. Baker
Department of Physiology and Pharmacology,
Section for Anaesthesia and Intensive Care,
Karolinska Institute, Karolinska University Hospital,
Stockholm, Sweden

M. J. Schultz
Department of Intensive Care Medicine,
Laboratory of Experimental Intensive Care and Anesthesiology,
Academic Medical Center, University of Amsterdam,
Amsterdam, The Netherlands

Erratum to: Intensive Care Med **DOI 10.1007/s00134-012-2468-5**

The recommendation to use artesunate by suppositories (8–16 mg/kg at 0 and 12 h and then daily) if injectable artesunate is unavailable should not have been included in Table 8. The corrected table is given here.

Table 8 Management of sepsis due to specific causes

Malaria	<p>Prompt start of parenteral artesunate in adults and children (2.4 mg/kg STAT followed by the same dose at 12 h, 24 h, and then daily until oral medication can be taken) (LoE: A)</p> <p>If injectable artesunate is unavailable intramuscular artemether (3.2 mg/kg on admission followed by 1.6 mg/kg daily), or intravenous quinine (20 mg/kg loading dose over 4 h followed by 10 mg/kg over 4 h 8 hourly until oral medication is possible) can be used (LoE: A)</p> <p>In children, parenteral antibiotics should be given in addition to antimalarial treatment (LoE: A)</p> <p>Parenteral antibiotics should be given to adults with slide proven malaria and who present with a clinical syndrome requiring parenteral antibiotics (meningitis/encephalopathy, malnutrition, very severe or severe pneumonia) (LoE: A)</p> <p>Seizures should be treated with rectal or intravenous diazepam, intravenous lorazepam, paraldehyde or other standard anticonvulsants (LoE: B)</p> <p>In the absence of shock, fluid management should be performed judiciously and more restrictively than in patients with bacterial sepsis (LoE: B)</p> <p>In case of severe anemia (e.g., hemoglobin level <6 g/dL), blood transfusion should be considered (LoE: A)</p> <p>Empirical antibiotic therapy needs to cover Gram-positive, Gram-negative and anaerobic bacteria (LoE: B)</p>
Puerperal sepsis	<p>Treatment of tuberculosis infection in resource-limited settings is best performed by timely initiation of the combination of isoniazid, rifampicin, pyrazinamide and ethambutol for 2 months followed by isoniazid and rifampicin alone for another 4 months (LoE: A)</p>
Septic patients with HIV/AIDS	<p>Patients with open mycobacterial infections require isolation/cohorting (LoE: A)</p> <p>In <i>Pneumocystis jiroveci</i> pneumonia, the therapy of choice is trimethoprim/sulfamethoxazole administered for 3 weeks. In patients with hypoxemia, prednisolone (40 mg bid for 5 days followed by 40 mg/day for 5 days and then 20 mg/day for 11 days) should be added (LoE: B)</p> <p>In malnourished patients, energy supply should be re-started slowly with a stepwise increase of daily caloric intake and avoidance of large amounts of carbohydrates to prevent the re-feeding syndrome (LoE: B)</p>

LoE level of evidence