Has the patient trialled TMP-SMX previously?

Yes

TMP-SMX ADR history

Test all patients for G6PD prior

Type B or unknown TMP-SMX ADR

Rash (no mucosal involvement or fever)\( ^{a} \) OR OR unknown

OR

SCAR OR rash with mucosal involvement OR Other\( ^{b} \)

Refer allergy services or consult Infectious Diseases

TMP-SMX rechallenge\( ^{c} \)

2 hour observation

ADR (Type B)

No ADR

Wait for rash to resolve

ADR (Type B)

No ADR

Continue TMP-SMX as per unit protocol\( ^{d} \)

ADR (Type B)

Continue TMP-SMX (daily)

Dapsone\( ^{f,g} \)

ADR (Type B)

If no adverse event continue chosen antimicrobial

Legend: SCAR – Severe cutaneous adverse reaction (e.g. Stevens-Johnson syndrome, toxic epidermal necrolysis, drug reaction with eosinophilia and systemic symptoms, acute generalised) Type A – Non-immune mediated adverse drug reactions Type B – Immune mediated adverse drug reaction\( ^{e} \) If TMP-SMX-associated rash within last two years, can consider dapsone rather than rechallenge\( ^{b} \) Drug fever, acute interstitial nephritis, fixed drug eruption\( ^{c} \) Oral single dose challenge and observe for two hours (TMP-SMX 80mg-400mg).\( ^{d} \) Preferred prophylaxis strategy generally TMP-SMX 160mg-800mg daily or 3 times weekly.\( ^{e} \) For all patients proceed with TMP-SMX desensitization or alternatively, dapsone therapy may be employed.\( ^{f} \) Prescribe dapsone 100mg orally daily. Ensure G6PD deficiency screen negative prior to use.\( ^{g} \) Only if required for PJP prophylaxis. If for alternative reason seek infectious diseases advice