

Table VII. Pneumocystis Pneumonia Prophylaxis

Intervention	Indication	Dose and Administration		Comments
		First Choice	Alternative	
Primary PCP Prophylaxis	All recipients after day +14	<p>Adults: TMP/SMX* DS: TMP 160 mg + SMX 800 mg PO daily, 3 days/week^a</p> <p>Peds: TMP/SMX* 75 mg/m² PO BID 3 days/week to a maximum dose that does not exceed an individual dose given to an adult. (trimethoprim 40 mg + sulfamethoxazole 200 mg/5 mL)</p>	<p>Adults: Aerosolized pentamidine 300 mg by inhalation q4 weeks^b</p> <p>Peds: same dose & schedule OR Adults: Dapsone* 100 mg PO daily^c</p> <p>Peds: Dapsone* 2 mg/kg PO daily, up to a maximum dose of 100 mg daily OR Adults: Atovaquone 1500 mg PO daily</p> <p>Peds – age > 2 yrs: Atovaquone 30 mg/kg PO daily, to a maximum dose of 1500 mg daily</p>	<p>Continue until patients are off all immune suppressive agents in the absence of C-GVHD</p> <p>In patients who have received T-cell depleted grafts or who are receiving in-vivo T-cell depleting agents, continue prophylaxis until CD4 count is ≥ 200.^d</p> <p>Minimum duration of prophylaxis is 6 months post transplant.</p> <p>TMP/SMX DS PO BID twice daily on Saturdays and Sundays may be acceptable in selected patients.</p>

^a Cotrimoxazole (TMP/SMX) is the prophylactic agent of choice and confers prophylaxis against toxoplasmosis. The second-line agent selection is controversial (Souza et al., 1999; Vasconcelles et al., 2000), but we find that the convenience and track record of aerosolized pentamidine make it the preferred agent when TMP/SMX cannot be used (Marras et al., 2002).

^b Patients receiving aerosolized pentamidine remain at risk for toxoplasmosis therefore, see table IX for prophylaxis recommendations.

^c Prior to instituting Dapsone therapy, rule out G6PD deficiency.

^d There are no conclusive data on the value of CD4 count to define risk for PCP in patients who have received a T-cell-depleted transplant. We recommend continuing prophylaxis in this setting until the CD4 count has been documented to be > 200 for three months. The recommendations come from the CDC guidelines for HIV disease, <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5108a1.htm>, Table 13. CD4 determinations are not recommended for this purpose in HSCT recipients who have not received *in vivo* T-cell depletion.

* Requires dose or schedule modification in renally impaired patients.