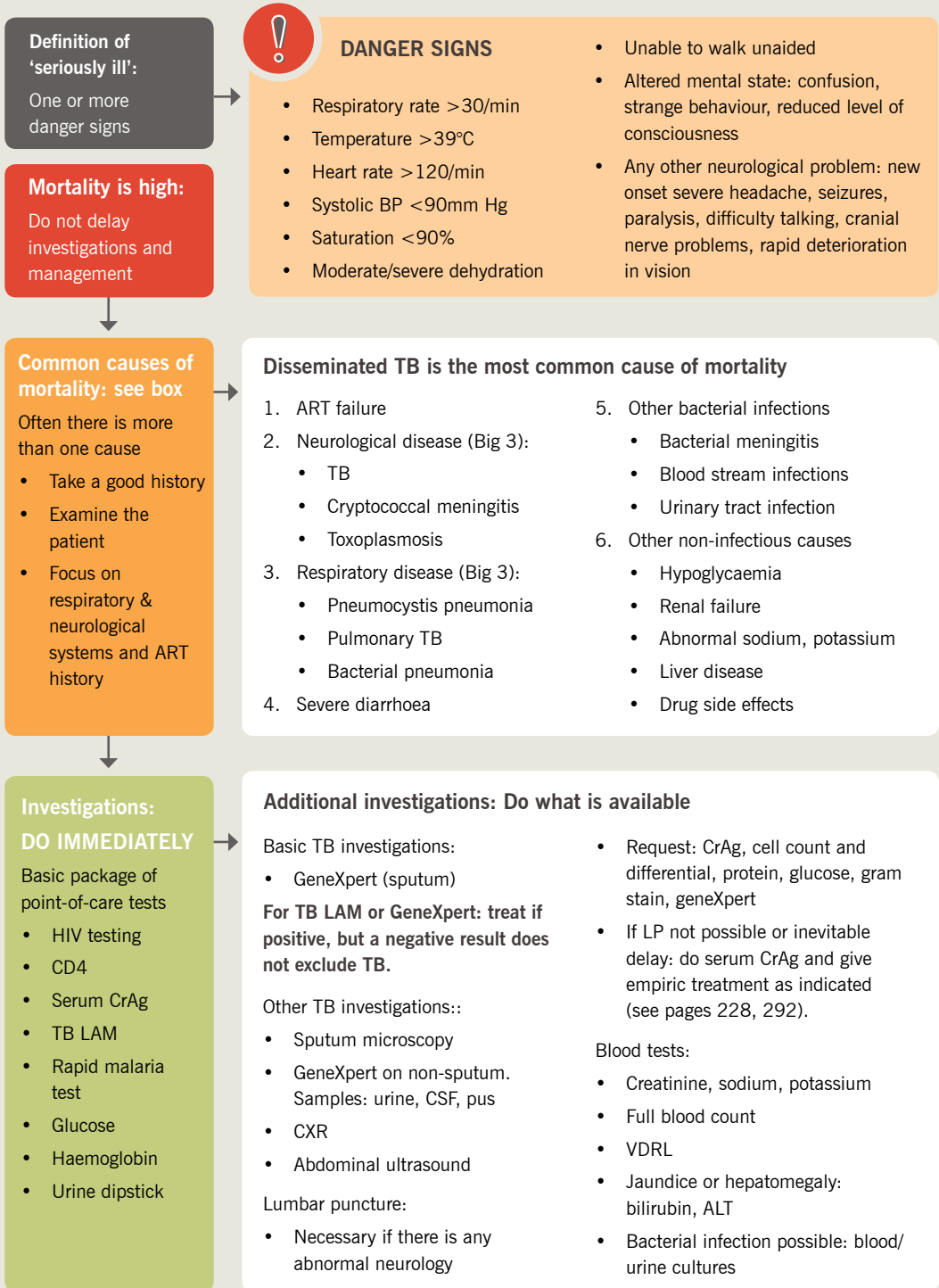


Figure 11.6 Management if transfer to hospital is delayed



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Management:
Initiate without delay

Start empiric treatment for diseases where clinical suspicion is high, but where there is no diagnostic test available or where diagnostic tests cannot exclude the disease.

Emergency management

Hypoglycaemia: 50 mls of 50% dextrose

Dehydration, renal impairment (see Chapter 17):

- IV fluids, electrolytes
- Chronic watery diarrhoea: empiric treatment for *Isospora belli* (cotrimoxazole)
- Beware nephrotoxic drugs

Liver failure: Beware hepatotoxic drugs (see Chapter 16)

Severe anaemia (Hb <5g/dL): Transfuse, oxygen (see Figure 18.1 in Chapter 18)

Bloodstream infection: If fever and other danger signs or other evidence suggesting bacterial infection, give empiric antibiotics

Neurological disease

Treat for cryptococcal meningitis if:

- CSF CrAg positive
- Abnormal neurology, serum CrAg positive and LP not possible (or CSF CrAg unavailable)

Give fluconazole prevention regimen if:

Serum CrAg positive and CSF CrAg negative

Treat for CNS TB if:

Neurology signs AND:

- Proven TB (LAM/GXP) or strongly suspected clinically
- CSF CrAg negative

Treat for toxoplasmosis if:

CD4 <200; new focal neurology; or other abnormal neurology and no other diagnosis

Respiratory disease

Respiratory danger signs: RR >30 or saturation <90%

- Give oxygen
- Empiric treatment for pneumocystis and bacterial pneumonia
- Empiric treatment for TB if indicated

No danger signs:

- CXR – treat accordingly
- CXR not available, consider empiric treatment: pneumocystis, bacterial pneumonia, TB

Clinical indications for immediate empiric TB treatment:

Do available investigations while starting treatment.

- CNS TB likely
- Miliary TB or other CXR evidence of TB
- Clinical presentation strongly suggests TB; investigations not available or unable to exclude TB
- Clinical condition life-threatening, patient deteriorating, or not improving after 3 days of hospitalisation