

# Early Management of Suspected Bacterial Meningitis and Meningococcal Septicaemia in Adults\*

## Early Recognition

- Petechial/purpuric non-blanching rash or signs of meningitis
- A rash may be absent or atypical at presentation
- Neck stiffness may be absent in up to 30% of cases of meningitis
- Prior antibiotics may mask the severity of the illness



typical meningococcal rash

## Assess Severity & Immediate Intervention<sup>a</sup>

- **Airway**
- **Breathing** - Respiratory Rate & O<sub>2</sub> Saturation
- **Circulation** - Pulse; Capillary Refill Time (hypotension late); Urine output
- **Mental status** (deterioration may be a sign of shock or meningitis)
- **Neurology** - Focal neurological signs; Persistent seizures; Papilloedema

Secure Airway  
High Flow O<sub>2</sub>  
Large bore IV Cannula ± fluid resuscitation

## Priority Investigations:

- FBC; U+Es; Blood sugar, LFTs; CRP
- Clotting profile
- Blood gases

## Microbiology:

- Blood culture
- Throat swab
- Clotted blood
- EDTA blood for PCR

## Additional Information

### **a Warning Signs** (see refs)

The following warn of impending/worsening shock, respiratory failure or raised intracranial pressure and require urgent senior review and intervention (see algorithm):

- Rapidly progressive rash
- Poor peripheral perfusion, CRT > 4 secs, oliguria and systolic BP < 90 (hypotension often a late sign)
- RR < 8 or > 30
- Pulse rate < 40 or > 140
- Acidosis pH < 7.3 or BE worse than - 5
- WBC < 4
- Marked depressed conscious level (GCS < 12) or a fluctuating conscious level (fall in GCS > 2)
- Focal neurology
- Persistent seizures
- Bradycardia and hypertension
- Papilloedema

### **b CT scan and meningitis** (see refs)

This investigation should only be used when appropriate:

- A normal CT scan does not exclude raised intracranial pressure
- If there are no clinical contraindications to LP, a CT scan is not necessary beforehand
- Subsequently a CT scan may be useful in identifying dural defects predisposing to meningitis

### **c Appropriate antibiotics for bacterial meningitis** (see refs)

Review with microbiology:

- Ampicillin IV 2g qds should be added for individuals >55 years to cover Listeria
- Vancomycin ± rifampicin if pneumococcal penicillin resistance suspected
- Amend antibiotics on the basis of microbiology results

### **d Steroids for bacterial meningitis** (see refs)

Steroid therapy in adults remains contentious:

- Consider dexamethasone 0.15mg/kg qds for 4 days started with or just before the first dose of antibiotics, particularly where pneumococcal meningitis is suspected
- Do not give unless you are confident you are using the correct antimicrobials

#### Bibliography

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## Predominantly Meningococcal Septicaemia

- Do not attempt LP
- IV 2g Cefotaxime or Ceftriaxone
- Call critical care team for review

## Predominantly Meningitis<sup>b,c,d</sup>

- Assess patient carefully before performing LP
- Call critical care team if any features of raised intracranial pressure, shock or respiratory failure
- If uncertain ask for senior review
- Monitor and stabilise circulation

### Signs of Shock<sup>a</sup>

YES NO

## Priorities

- Secure airway + High flow O<sub>2</sub>
- Volume resuscitation
- Senior review
- Management in critical care unit

Poor response Good response

## Further interventions

- Pre-emptive Intubation + Ventilation
- Volume support
- Inotropic/ Vasopressor Support

### No Raised ICP No Shock No Respiratory Failure<sup>a,b</sup>

## Lumbar puncture<sup>a,b</sup>

- IV 2g Cefotaxime/ Ceftriaxone immediately after LP
- if LP will be delayed for more than 30 minutes give IV antibiotics first

### Signs of Raised ICP<sup>a,b</sup>

## Priorities

- Secure airway + High flow O<sub>2</sub>
- Defer lumbar puncture
- IV 2g Cefotaxime/Ceftriaxone
- Careful volume resuscitation
- 30° head elevation
- Management in critical care unit
- Low threshold for elective Intubation + Ventilation (cerebral protection)

## Careful Monitoring<sup>a</sup> Repeated Review

## Public Health

- Notify CCDC
- If probable or confirmed meningococcal disease, contact CCDC urgently regarding prophylaxis to contacts
- Notify microbiology
- Isolate patient for first 24 hours

\* Community acquired meningitis in the immunocompetent host. In the immunocompromised seek additional expert advice