

Acute meningitis and meningococcal sepsis – AT A GLANCE

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DEFINITION	Meningitis is an inflammation of the protective membranes (meninges) covering the brain and spinal cord. It is most commonly caused by an infection. More rarely, inflammatory non-infectious meningitis can be caused by injury, cancer, certain drugs, and prosthetic devices/foreign bodies. It is important to know the specific cause of meningitis because the treatment and management differs depending on the cause. This AT A GLANCE focuses on acute bacterial meningitis and meningococcal sepsis: Common causes of bacterial meningitis vary by age group: -New-borns: Group B <i>Streptococcus</i>, <i>Streptococcus pneumoniae</i>, <i>Listeria monocytogenes</i>, <i>Escherichia coli</i> -Babies and Children: <i>Streptococcus pneumoniae</i>, <i>Neisseria meningitidis</i>, <i>Haemophilus influenzae type b (Hib)</i>, Group B <i>streptococcus</i> -Teens and young adults: <i>Neisseria meningitidis</i>, <i>Streptococcus pneumoniae</i> -Older adults: <i>Streptococcus pneumoniae</i>, <i>Neisseria meningitidis</i>, <i>Haemophilus influenzae type b (Hib)</i>, Group B <i>streptococcus</i>, <i>Listeria monocytogenes</i> The incubation period is usually 1-7 days. The onset of the disease can vary from fulminant with acute and overwhelming symptoms to mild prodromal symptoms. The risk of infection to staff is generally very low and is only before the patient has been treated with appropriate antibiotics for 24 hours or more. Transmission is through direct contact with patient respiratory secretions or aerosols such as during intubation, suctioning or face-to-face contact i.e. being coughed on directly by the patient. <i>Listeria monocytogenes</i> can spread through food. Mothers can pass Group B <i>Streptococcus</i> and <i>E. coli</i> to their babies during labour and birth.
MANAGEMENT	Patients with suspected/confirmed meningitis who have not completed treatment for the first 24 hours of admission should be isolated in a side room with droplet precautions. Staff should use correctly fitted FFP3 mask, when intubating or suctioning a patient or performing other care and procedures which are likely to produce direct contact with respiratory secretions. Chemoprophylaxis is only recommended for staff whose mouth and nose are directly exposed to large particle droplets/secretions from the respiratory tract of a probable or confirmed case of meningococcal disease during acute illness before the patient has completed 24 hours of systemic antibiotics. If appropriate PPE (correctly fitted FFP3 mask) was worn chemoprophylaxis is not required. If staff have been exposed, contact Occupational Health and Wellbeing during normal working hours or Microbiology if out of hours via switchboard for a risk assessment. COHWB/Microbiology will risk assess staff and decide who requires antibiotic prophylaxis. Patients should be informed that they have been diagnosed with meningitis. If the patient requires transfer, the diagnosis needs to be communicated to the transferring team and the receiving ward/department/hospital must be informed of confirmed or probable or possible meningitis prior to transfer.
CLEANING	Any re-usable equipment should be decontaminated with GREEN Clinell wipes. A terminal clean is required (including curtain change) when the patient is discharged or transferred.

WHEN TO STOP ISOLATION	Isolation and droplet precautions are no longer required once the patient has completed 24 hours of appropriate antibiotics. <u>For further information or advice please contact Infection Prevention and Control on Bleep 1747</u>
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