MENINGITIS

Transfer all patients to hospital as an emergency by telephoning 999.

For suspected meningococcal disease (meningitis with non-blanching rash or meningococcal septicaemia), parenteral antibiotics (intramuscular or intravenous benzylpenicillin or IM ceftriaxone) should be given at the earliest opportunity, either in primary or secondary care, but urgent transfer to hospital should not be delayed, for the parenteral antibiotics to be given.

It is the statutory duty of the registered medical practitioner (RMP) to report all suspected meningitis or meningococcal septicaemia cases to the UKHSA. The UKHSA will determine the household and kissing contacts of the index case and will advise the RMP to initiate the appropriate prophylaxis or vaccination if necessary.

- The local health protection team (HPT) should be contacted via telephone at 03442254524, followed by option 1. This number can also be used out of hours and at weekends.

Guidance on notifiable diseases

Clinical features: may include fever, headache, neck stiffness, photophobia, nausea and vomiting, non-blanching rash (petechial or purpuric), and the presence of an altered mental state (there is often a degree of overlap with encephalitis).

Empirical Treatment

Medicine	Dose	Frequency & Duration of Treatment
Empirical treatment for suspected meningococcal disease: Administer **a single dose** at the earliest opportunity, but do not delay urgent transfer to hospital.		
Do not give IV antibiotics if there is a definite history of anaphylaxis to penicillin or cephalosporins; rash is not a contraindication. Transfer to a hospital immediately.		
Benzylpenicillin IV or IM	Child <1 year: **300mg** Child 1–9 years: **600mg** Child 10+ years: **1.2g** Adult: **1.2g**	Single STAT dose **IV or,** if a vein cannot be found, give **IM**
OR Local guidance for **non-severe** penicillin allergy **OR** if benzylpenicillin not available:		
Ceftriaxone[1] IM	Child 1 month: **250mg** Child 2-11 months: **500mg** Child 1-4 years: **1g** Child 5-8 years: **1.5g** Child 9-17years: **2g** Adult: **2g** (local guidance)	Single STAT dose by **IM**
[1] Avoid if there is a history of immediate hypersensitivity to penicillin and use with caution if there is a non-severe allergy.		

Prophylaxis should be considered for the following close contacts, regardless of meningococcal vaccination status:

- Close contact is defined as prolonged close contact with the case in a household-type setting during the **7 days before onset of illness**. It also includes kissing contacts of the index case. Household and kissing contacts include those who have slept in the same house or dormitory e.g. university students sharing a kitchen in a hall of residence before the onset, boy/girlfriend, childminders, and anybody who has performed mouth-to-mouth resuscitation or intubation of the index case.
- For confirmed serogroup A, C, W or Y infections, close contacts of any age should be offered the MenACWY conjugate vaccine, unless they are confirmed to have been immunised against the relevant meningococcal serogroup within the preceding 12 months (2 doses 4 weeks apart if aged less than 1 year; 1 dose if after first birthday). For close contacts of MenC IMD cases, another MenC-containing conjugate vaccine would be a suitable alternative
- After a single case of confirmed or probable serogroup B infection, vaccination against MenB is not recommended for close contacts, even if the strain is identified as vaccine preventable.
- Eligible at-risk close contacts (for example asplenia, complement-deficiency) who are unimmunised or partially immunised should be immunised appropriately for their age.

Antibiotic prophylaxis should be given as soon as possible (ideally within 24 hours) after the diagnosis of the index case.

Prophylaxis:		
Medicine	**Dose**	**Frequency & Duration of Treatment**
Ciprofloxacin ^ (Recommended for use in all age groups and in pregnancy, unless contraindicated) **OR**	Child <5years: **30mg/kg** (Max 125mg) Child 5 to <12 years: **250mg** Adult & Child ≥12 years: **500mg**	Single STAT dose **by mouth** * Ciprofloxacin suspension contains 250mg/5mL
Rifampicin – see below (Suitable alternative when ciprofloxacin is contraindicated. **NOT** recommended in pregnancy)	Child <12 months: **5mg/kg** Child 1 to <12 years: **10mg/kg** (Max 600mg per dose) Adult & Child ≥12years: **600mg**	TWICE daily (every 12 hours) for TWO days **by mouth** * Rifampicin suspension contains 100mg/5mL
^Note fluoroquinolones can cause long-lasting (up to months or years), disabling, and potentially irreversible side effects, sometimes affecting multiple systems, organ classes, and senses. Please refer here for further information on MHRA alerts.		
Alternatives during rifampicin shortage CAS alert July 2025. There will be intermittent supplies of rifampicin available until at least the end of 2025, and these must be prioritised to treat tuberculosis (TB). Rifampicin should not be prescribed in primary care until the shortage is resolved. If a patient is not able to use ciprofloxacin for prophylaxis the locally agreed alternatives are: • Azithromycin Adults: 500mg single STAT dose (suitable in pregnancy) • Ceftriaxone. Adults: 250mg single STAT dose by IM.		

Chemoprophylaxis agents:

- Ciprofloxacin (unlicensed) is now recommended by UKHSA for use in all age groups and in pregnancy as a single prophylactic dose.
- Rifampicin causes orange-red stains to tears, soft contact lenses and urine. It may also cause skin rashes and itching. Rifampicin is contraindicated in the presence of jaundice or known hypersensitivity to rifampicin. Interactions with other drugs, such as anticoagulants, phenytoin, and hormonal contraceptives, should be considered. It reduces the effectiveness of most oral contraceptives (and some contraceptive patches), so additional contraceptive precautions should be taken whilst taking

rifampicin and for at least 4 weeks after stopping it, the next new packet being started immediately without a break. It is licensed for use in prophylaxis.

Patient information and support:

- Ensure that appropriate hospital follow-up has been arranged. All children should have a review with a paediatrician 4-6 weeks after hospital discharge to assess their recovery.
- Be alert for possible late-onset complications.
- Meningitis NHS A-Z
- The Meningitis Now (Trust) – offers free services, providing emotional, practical, and financial support for people who have been affected by meningitis—free 24-hour UK helpline: 0808 8010388.
- Brain and Spine Foundation – Free telephone number: 0808 808 1000.
- The National Deaf Children's Society (NDCS) – Free telephone number: 0808 800 8880.
- Give advice on driving if appropriate – Assessing fitness to drive: a guide for medical professionals for recommendations on driving restrictions after recovery.