

Galway: GAPP - Galway Antimicrobial Prescribing Policy / Guidelines (GAPP): Suspected Bacterial Meningitis

Suspected Bacterial Meningitis

1. The **most important** aspect of treatment of suspected or confirmed bacterial meningitis is to **commence antibacterial therapy IMMEDIATELY** .
2. Consult with Microbiology or Infectious Diseases is recommended.
3. **Chloramphenicol** is available in the Emergency Department and in the Pharmacy Department. **Meropenem** may be an alternative to chloramphenicol in patients with a history of penicillin anaphylaxis, as recommended in Irish guidelines, with close monitoring for cross-sensitivity e.g. in ICU. Consult with immunology strongly advised.
4. See footnote on use of **Dexamethasone**** .
5. **Consult with Microbiology or Infectious Diseases essential** if risk factors for ***M. tuberculosis*** (alcohol, homelessness, immunocompromised host, recent immigration from area of high incidence, recent contact with tuberculosis) or if history of neurosurgery or head trauma or if device-related infection e.g central nervous system shunt, ventricular drain or other.
6. Risk factors for ***Listeria monocytogenes*** meningitis in adults include underlying neoplasm, immunosuppressive treatment, age over 50, pregnancy and excessive alcohol use.
7. Viral meningitis (as distinct from encephalitis) generally does **NOT** require anti-viral treatment. Discuss with Microbiology or Infectious Diseases.
8. See [Appendix 3](#) for management of contacts.

Empiric Antibiotics for Suspected Bacterial Meningitis				
Infection	1 st Line Antibiotics	Penicillin allergy:		Comment
		delayed onset non-severe reaction	immediate or severe delayed reaction	
		See penicillin hypersensitivity section for further information		
Suspected Bacterial Meningitis	CefTRIAxone IV 2g every 12 hours	CefTRIAxone IV 2g every 12 hours	Chloramphenicol IV 25mg/kg	Minimum duration of treatment:
	Consider adding Vancomycin IV infusion, dose per GAPP App calculator, if Pneumococcal meningitis is likely/suspected. See footnote* re vancomycin review and monitoring. See footnote ** re Dexamethasone. Consider adding Amoxicillin IV 2g every 4 hours if at risk for <i>L. monocytogenes</i> (See point 6 above)	Consider adding Vancomycin IV infusion, dose per GAPP App calculator, if Pneumococcal meningitis is likely/suspected. See footnote* re vancomycin review and monitoring. See footnote ** re Dexamethasone. Consider adding Co-trimoxazole IV 60mg/kg every 12 hours (round dose to nearest multiple of 480mg) if at risk for <i>L. monocytogenes</i> (See point 6 above)	+ Vancomycin IV infusion, dose per GAPP App calculator. See footnote* re vancomycin review and monitoring. Give first dose, THEN IMMEDIATELY consult Microbiology or Infectious Diseases regarding further therapy. See footnote ** re Dexamethasone. Consider adding Co-trimoxazole IV 60mg/kg every 12 hours (round dose to nearest multiple of 480mg) if at risk for <i>L. monocytogenes</i> (See point 6 above) Discuss need for nasopharyngeal eradication for the patient with Microbiology or Infectious Diseases	Meningococcal meningitis: 7 days Haemophilus meningitis: 10 days Pneumococcal meningitis: 14 days Listeria meningitis: 21 days

* Review need for ongoing vancomycin on a daily basis. For advice on monitoring see [Vancomycin Dosing & Monitoring](#) section.

****Dexamethasone**

Consider adjunctive treatment with dexamethasone IV 10mg every 6 hours, particularly if *Pneumococcal* or *Haemophilus influenzae* meningitis suspected, **preferably starting before or with first dose of antibiotic** , but no later than 24 hours after starting antibiotic. Discontinue dexamethasone if a diagnosis other than bacterial meningitis is subsequently made. Discontinue dexamethasone if bacterial meningitis with an organism other than *pneumococcus* or *H.influenzae* is confirmed.

Avoid dexamethasone in septic shock, meningococcal septicaemia, or if immunocompromised, or in meningitis following surgery.

Some experts add **Rifampicin** PO 600mg every 12 hours to the antimicrobial regimen if Dexamethasone is given.

Refs:

1. [HPSC Guidelines for the Early Clinical and Public Health Management of Bacterial Meningitis \(including meningococcal disease\) November 2016](#)
2. ESCMID guideline: diagnosis and treatment of acute bacterial meningitis. *Clinical Microbiology and Infection*. 2016; 22 (3); S37-S62
3. BNF 86 March 2024
4. IDSA Guidelines for the Management of Bacterial Meningitis. [Clin Infect Dis 2004;39:1267-84](#)