Early recognition and prompt administration of empirical antibiotic therapy can be life saving.

1. Treatment

Commence empirical antibiotic therapy immediately (without waiting for test results):

- **Benzylpenicillin**
  2.4 g (children: 60 mg/kg up to 2.4 g) IV, every 4 hours (penicillin should only be withheld in cases who have a definite history of anaphylaxis).

PLUS either

- **Ceftriaxone**
  2 g (children: 50 mg/kg up to 2 g) IV, every 12 hours
- **Cefotaxime**
  2 g (children 50 mg/kg up to 2 g) IV, every 6 hours.

2. Laboratory Tests

Take blood cultures, (2 sets - 4 bottles) EDTA blood for PCR, and, if indicated, CSF for microscopy, culture and PCR.

3. Infection Control

Additional precautions (patient isolation; staff wearing surgical masks) – continue for 24 hours after the commencement of recommended antibiotics.

Surgical masks should be worn while intubating and during oropharyngeal suctioning.

The patient should wear a surgical mask during transport.

4. Notification (URGENT)

Notify immediately, by telephone, clinically suspected cases of meningococcal disease to the Communicable Disease Control Branch.

**Phone (08) 8226 7177**

24 hours/7 days

**IMMEDIATELY** on clinical suspicion of meningococcal infection, and REGARDLESS OF PRIOR ANTIBIOTIC THERAPY:

**Absence of rash does not exclude meningococcal infection**

In infants and children the following **may also** occur

- Irritability, dislike of being handled, refusal of food
- Tiredness, floppiness, drowsiness
- Twitching or convulsions
- Grunting or moaning
- Photophobia
- Leg pain, cold extremities, and abnormal skin colour are frequently seen in the first 12 hours of disease (before classic symptoms and signs develop) in children under 16 years.

**Signs and symptoms**

- Fever, sweats, rigors, pallor, vomiting and/or nausea (non-specific signs and symptoms of a systemic illness).
- Prostration, drowsiness, irritability, altered conscious state.
- Headache, neck stiffness, photophobia, cranial nerve palsies and seizures (if meningitis).
- Joint pain, myalgia, backache, difficulty walking.
- Classic non-blanching petechial or purpuric rash, often in clusters where pressure occurs from elastic. However, in early stages the rash may blanch and resemble a viral exanthem. Less commonly the rash may be non-blanching and maculopapular.

**Meningococcal septicaemia** is more common than meningococcal meningitis and has a greater mortality rate.

Patients with a **systemic febrile illness**, particularly children, must be assessed promptly and reassessed as frequently as necessary for meningococcal disease, whether or not a rash is present.

In early stages of infection the rash may be atypical or not present; during later stages of infection a petechial or purpuric rash may develop rapidly.

**May 2008**

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