

Letterkenny University Hospital - LUH Antimicrobial Prescribing Policy/Guidelines: 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. **IV Chloramphenicol** is available in the Emergency Department and in the Pharmacy Department (unlicensed room). **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. Please discuss with Microbiology.
3. See footnote on use of **Dexamethasone**.
4. **Discuss with Microbiology - 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, head trauma or if device-related infection e.g. central nervous system shunt, ventricular drain or other.
5. Risk factors for ***Listeria monocytogenes*** meningitis in adults include patients who are immunocompromised, have chronic illness such as alcohol dependency, diabetes, and malignancy or age over 60.
6. Viral meningitis (as distinct from encephalitis) generally does **NOT** require anti-viral treatment. Discuss with Microbiology.
7. See [Appendix 4](#) 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: Meningococcal meningitis: 5 to 7 days Haemophilus meningitis: 7 to 10 days Pneumococcal meningitis: 10 to 14 days Listeria meningitis: 21 days
	+ Consider adding Amoxicillin IV 2g every 4 hours if at risk for <i>L. monocytogenes</i> (See point 5 above) 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 5 above) See footnote ** re Dexamethasone.	• Give this first dose, THEN IMMEDIATELY discuss with Microbiology regarding further therapy. 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> Discuss need for nasopharyngeal eradication for the patient with Microbiology (See point 5 above) See footnote ** re Dexamethasone.	
	If patient has, within the last 6 months, been to a country where penicillin resistant pneumococci are prevalent, IV Vancomycin should be added , dose per LAPP App calculator. See footnote* re review and monitoring. Recommend discussion with Microbiology. Note: Up to date European and worldwide data on resistance can be found via the European Centre for Disease Prevention and Control website . Or please consider a discussion with Microbiology if recent travel.			

* 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 0.15mg/kg every 6 hours for four days (particularly if Pneumococcal or Haemophilus influenzae meningitis suspected in adults), **preferably starting before or with first dose of antibiotic**, but no later than 12 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 Streptococcus pneumoniae or H. Influenzae is confirmed.
- For haemodynamically unstable patients with sepsis, and unresponsive to fluid and inotrope resuscitation, give low dose hydrocortisone - 50mg IV 6 hourly

References:

1. [NICE guideline NG240](#) . Meningitis (bacterial) and meningococcal disease: recognition, diagnosis and management. Published 19 March 2024 [Accessed 19/3/2026]
2. [HPSC Guidelines for the Early Clinical and Public Health Management of Bacterial Meningitis \(including meningococcal disease\)](#) November 2016
3. *Mc Gill et al "The UK Joint specialist societies guidelines on the diagnosis and management of acute meningitis and meningococcal sepsis in immunocompetent adults" British Infection Society 2016*
4. *BNF 86 March 2024*