Early Recognition

- Petechial/purpuric non-blanching rash or signs of meningitis
- A rash may be absent or atypical at presentation
- Neck stiffness may be absent in up to 30% of cases of meningitis
- Prior antibiotics may mask the severity of the illness

Assess Severity & Immediate Intervention

- Airway
- Breathing - Respiratory Rate & O₂, Saturation
- Circulation - Pulse; Capillary Refill Time (hypotension late);
  Urine output
- Mental status (deterioration may be a sign of shock or meningitis)
- Neurology – Focal neurological signs; Persistent seizures;
  Papilloedema

Priorities

- Secure Airway
- High Flow O₂
- Large bore IV Cannula ± fluid resuscitation

Preponderantly Meningococcal Septicaemia

- Do not attempt LP
- IV 2g Cefotaxime or Ceftriaxone
- Call critical care team for review

Signs of Shock

- YES
- NO

No Raised ICP

- No Respiratory Failure

- Signs of Raised ICP

Further interventions

- Pre-emptive Intubation
- Ventilation
- Volume support
- Inotropic/ Vasoconstrictor Support
- Consider activated protein C₁²
- Good glycemic control
- In refractory circulatory failure, physiological replacement corticosteroid therapy may be beneficial

Public Health/Infection Control

- Notify CDC/Trust
- If probable or confirmed meningococcal disease, contact CDC/Trust urgently regarding prophylaxis to contacts
- Notify microbiology
- Isolate patient for first 24 hours

* Community acquired meningitis in the immunocompetent host.
In the immunocompromised seek additional expert advice

CPFM in Scotland

References: