

INFECTION CONTROL COMMITTEE  
ST. LUKE'S HOSPITAL  
MALTA

**MENINGOCOCCAL POLICY  
FOR ST. LUKE'S HOSPITAL**

Editor: Dr. M.A. Borg M.D., M.Sc.[Lond]  
*Infection Control Officer - SLH*

April 1996

## **Introduction**

Meningococcal infection is caused by *Neisseria meningitidis*. It may present as meningitis with septicaemia or, less commonly, as septicaemia alone both of which can be rapidly fatal. Infection is spread from person to person through droplets or intimate direct contact (mouth-to-mouth). The source of infection is an individual who is either ill with meningitis or septicaemia or, more commonly, an asymptomatic healthy carrier who has close domestic contact with the patient. Only those people who have had prolonged intimate contact with the infected person (practically members of the same household) are mainly at risk of acquiring the infection. It cannot be acquired from casual social contact, from buildings, water supplies or swimming pools. The incubation period between acquiring the organism and becoming ill is 2-10 days.

A provisional diagnosis of Meningococcal infection must be made on clinical grounds. Laboratory confirmation is by urgent microscopy of the cerebrospinal fluid (CSF) and by culture of the patient's blood or CSF. The diagnosis is almost certain if Gram-negative cocci in pairs are seen in the CSF. If organisms are not seen and laboratory examination of the CSF is that of acute bacterial meningitis (i.e. the presence of pus cells and/or lowered glucose) the treatment of the patient and prophylaxis for close contacts should be followed without delay.

## **Prevention of spread of Meningococcal disease in the hospital setting**

### **Isolation of the patient**

The patient should be isolated for 24 hours after starting effective treatment using Respiratory procedures:

1. Masks, *of the filtered type*, should be worn by all those coming close to the patient, particularly when performing tracheal suction or lumbar puncture.
2. Gowns are NOT indicated.
3. Gloves are indicated only for handling infective material.
4. Hands must be washed after handling the patient or potentially contaminated articles and before taking care of another patient.
5. Grossly soiled linen should be placed in water soluble bags and sent to the laundry in yellow bags.
6. Articles contaminated with infective material should be discarded or bagged and labelled before being sent for decontamination.
7. Visitors are to report to Nurses' Station prior before entering the room.
8. Specimens do NOT need to be sent in a biohazard format but the containers must be firmly capped in order to prevent leakage and sealed in a separate plastic bag.

## **0000 Notification**

Once a suspected diagnosis is made on clinical grounds, the clinician must IMMEDIATELY inform the Superintendent of Public Health by telephone via the hospital switchboard without waiting for bacteriological confirmation. An Infectious Disease Notification form must be also completed and forwarded to the Public Health Department.

The Infection Control Unit must also be notified in order to be in a position to arrange for proper isolation management.

## **Prophylaxis**

Antibiotic prophylaxis is ONLY for the following group of hospital contacts:

- staff who have performed mouth-to-mouth resuscitation or had prolonged close face to face contact with the patient (e.g. they performed intubation and tracheal suction or the patient coughed into their face).
- when a case has only been diagnosed after a period of hospitalisation, all other patients who were in the same cubicle or room with the patient for a period of more than 6 hours.

Members of staff who have had only brief contact with the patient should NOT be offered prophylaxis as in such cases the potential hazards of antibiotic therapy (i.e. side effects, the encouragement of resistance and the eradication of non-pathogenic protective organisms) far outweigh the possible risk of infection.

Nasal swabs from hospital contacts are unnecessary unless indicated by the Infection Control Officer for epidemiological purposes.

If the patient has been treated with penicillin, he should also be given the antibiotic prophylactic regimen. This is because penicillin treatment may not eradicate nasopharyngeal carriage of the meningococcus.

## **Responsibility for administering prophylaxis**

In the hospital setting, prophylaxis should ONLY be given after consultation with the Infection Control Officer. This is even more important when the possibility of pregnancy exists.

Prophylaxis for family, close domestic or school contacts is the responsibility of the Public Health Department. It is therefore essential in order to ensure correct management, that such individuals are immediately notified to the Medical Officer of Health in charge of the case and NOT treated by hospital personnel.

## Regimens

### RIFAMPICIN:

This is the drug of choice which, in the absence of contraindications, may be used in all age groups.

#### Dosage:

Adults & children over 12 years: 600mg orally twice daily x 2 days  
Children - 1 to 12 years: 10 mg/kg orally twice daily x 2 days  
Infants under 12 months: 5 mg/kg orally twice daily x 2 days

Rifampicin is contraindicated in the presence of jaundice, known hypersensitivity or concurrent anticoagulant use. The efficacy of hormonal contraceptives may be reduced during treatment. A side effect of rifampicin therapy is an orange discoloration of all body secretions; if worn, contact lenses may be irreversibly stained.

### CIPROFLOXACIN

Although still not licensed for this use, ciprofloxacin is a useful prophylactic agent particularly for management of outbreaks in colleges or military camps.

#### Dosage:

Adults only: 500mg orally as a single dose

### CEFTRIAZONE

Ceftriazone offers an alternative option especially for prophylaxis of pregnant women where both rifampicin and particularly ciprofloxacin may be potentially contraindicated. Treatment of pregnant women who are contacts should only be performed after proper counselling and full discussion with the Infection Control Officer, Microbiologist or Infectious Disease clinician.

#### Dosage:

Adults & children over 12 years: 250mg intramuscularly as a single dose  
Children under 12 years: 125mg intramuscularly as a single dose