GCHD
GRANT COUNTY HEALTH DISTRICT

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FOR IMMEDIATE RELEASE 02/07/2017	FOR INFORMATION CONTACT
TO: Grant County healthcare providers, infection control staff, supervisory nursing staff & clinic management	Kathleen Nelson, RN, Community Public Health Manager- 509-766-7960 ext. 28

Lab confirmed Neisseria Meningitidis Disease in an Infant

GCHD is currently recommending post-exposure prophylaxis for close contacts

The Grant County Health Officer, Dr. Alexander Brzezny, has issued the following alert to the Grant County healthcare community: lab confirmed diagnosis of a 5-month old child with invasive Neisseria Meningitidis disease has been made.

GCHD has identified and contacted all known non-healthcare close contacts of the child, advised on post-exposure prophylaxis (PEP), prescribed PEP or referred to their healthcare providers. The healthcare facility has been involved in providing PEP to appropriate staff members. You may be contacted to prescribe prophylaxis for your patients or you may be receiving calls regarding the exposure and need for prophylaxis.

Those considered for PEP should have a history of close contacts with the patient, i.e.: household contacts, healthcare, daycare and other intimate contacts that would share the same living, breathing, eating and sleeping space. Examples of close contact with meningococcal patients include:

1. **Direct face-to-face contact with a symptomatic case-patient during the contagious period.** (those who spend many hours together or sleep under the same roof)
2. **An obvious exposure that involves direct contact with respiratory, oral, or nasal secretions from a case-patient during the contagious period** (e.g., a cough or sneeze in the face, suctioning without a mask, etc.). Health care workers who have not had direct contact with the case's nasopharyngeal secretions are not at increased risk, and prophylaxis is not indicated.
3. **Close proximity for a prolonged period of time** (usually more than 1-4 hours) with a case-patient during the contagious period (some passengers during shared transportation, some contacts at community activities, some healthcare workers caring for a case without wearing a mask, children attending a daycare).

Individuals who are contacts to the above specified contacts (not a close contact to the index case) are not recommended for PEP.

The recommended course of prophylactic therapy:

- Adults:
  - Rifampin 600mg bid x 2 day or
  - Ceftriaxone 250mg IM given in a single dose or
  - Ciprofloxacin 500mg po given as a single dose
- Children:
  - < 1-month Rifampin 5mg/Kg (body weight every 12 hrs.) x 2 day;
  - > 1-month Rifampin 10mg/Kg (body weight every 12 hrs. [max 600 mg/dose]) x 2 day or
  - Ceftriaxone 125mg IM given as a single dose for under 15yr
  - Avoid ciprofloxacin
- Pregnant Women:
  - Avoid Rifampin, usually use ceftriaxone 250mg IM given in a single dose

Rifampin is the drug of choice for most children. Rifampin is not recommended for pregnant women. Those taking rifampin should be informed that the following side effects can occur: gastrointestinal upset, orange discoloration of urine and tears, discoloration of soft contact lenses, and decreased effectiveness of oral contraceptives.

Ciprofloxacin can be used for chemoprophylaxis of persons 18 years and older. Ciprofloxacin is not recommended for pregnant women.

Ceftriaxone can be used for children and adults (including pregnant women) to eradicate nasopharyngeal carriage if rifampin is contraindicated.

Treatment is best when given within 24 hours and unlikely to be effective if given more than 14 days following exposure.

CDC recommended vaccination schedule:
All 11 to 12 year olds should be vaccinated with a meningococcal conjugate vaccine (Menactra® or Menveo®). A booster dose is recommended at age 16 years. Teens and young adults (16 through 23 year olds) may also be vaccinated with a serogroup B meningococcal vaccine.

Vaccination is not generally recommended for post-exposure treatment, unless the patient is behind on their routine vaccination schedule.

Maintaining high suspicion of illness:
Continued close surveillance in your practice for the next several weeks for early signs of illness in patients is important to initiate appropriate tests and therapy without delay. Early symptoms may include:

- sudden onset of fever,
- intense headache,
- nausea,
- vomiting,
- often a stiff neck and
- frequently a petechial rash with pink macules.

- The rash may also present very rarely as vesicles. Photophobia, altered mental state, delirium and coma may appear. It can also present as pneumonia, arthritis and epiglottitis. Occasionally fulminant cases exhibit sudden prostration, ecchymosis and shock at onset.

Meningococcal Meningitis is immediately reportable to GCHD. If you suspect illness, please contact GCHD as soon as possible. Please see attached "Reporting and Surveillance Guidelines" from the state Department of Health for more in depth information.

Addition Resources and Report form:
Meningococcal Disease I DOH
Meningococcal Disease Reporting Form I DOH
Causes of Bacterial Meningitis I CDC

Consultation

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