[from Dave Portelli, 1/9/2017 – *get better screen shot of CDC page 16 & 17 from this url:* (https://www.cdc.gov/mmwr/pdf/rr/rr5407.pdf)]

[edited version loaded into knowledge base – see original below – edited for clarity and better screenshot]

[text to add above email: *Email response to a question concerning: "who contacts EMS and traces close contacts?" due to an exposure. See below:*

[use this bigger screenshot in lieu of the one sent by L. Mermel] bottom of page 16,

TABLE 7. Schedule for administering chemoprophylaxis against meningococcal disease

Drug	Age group	Dosage	Duration and route of administration*
Rifampin[†]	Children aged <1 mo	5 mg/kg body weight every 12 hrs	2 days
	Children aged ≥1 mo	10 mg/kg body weight every 12 hrs	2 days
	Adults	600 mg every 12 hrs	2 days
Ciprofloxacin[§]	Adults	500 mg	Single dose
Ceftriaxone	Children aged <15 yrs	125 mg	Single IM[¶] dose
Ceftriaxone	Adults	250 mg	Single IM dose

* Oral administration unless indicated otherwise.
† Not recommended for pregnant women because it is teratogenic in laboratory animals. Because the reliability of oral contraceptives might be affected by rifampin therapy, consideration should be given to using alternative contraceptive measures while rifampin is being administered.
§ Not usually recommended for persons aged <18 years or for pregnant and lactating women because it causes cartilage damage in immature laboratory animals. Can be used for chemoprophylaxis of children when no acceptable alternative therapy is available. Recent literature review identified no reports of irreversible cartilage toxicity or age-associated adverse events among children and adolescents (**Source:** Burstein GR, Berman SM, Blumer JL, Moran JS. Ciprofloxacin for the treatment of uncomplicated gonorrhea infection in adolescents: does the benefit outweigh the risk? Clin Infect Dis 2002;35:S191–9).
¶ Intramuscular.

from "MMWR, Morbidity and Mortality Weekly Report, Recommendations and Reports, May 27, 2005/Vol. 54 /No. RR-7, pg 16, "Prevention and Control of Meningococcal Disease: Recommendations of the Advisory Committee on Immunization Practices (ACIP)", Dept of Health and Human Services, Center for Disease Control and Prevention.

[Original email from Dave Portelli, with instructions]
===

Can you post Mermels reply including the date line up to the "image" on the knowledge base with

Tags: post exposure prophylaxis, meningitis, prophylaxis, meningococcal, neissieria, bacterial meningitis

From: Mermel, Leonard A. DO
Sent: Monday, January 09, 2017 2:09 PM
To: Portelli, David <DPortelli@Lifespan.org>; Sparhawk, Dana P MD <dsparhawk@Lifespan.org>; Larkin, Jerome <JLarkin@Lifespan.org>; Jefferson, Julie W <JJefferson@Lifespan.org>; Smit, Michael A <msmit@Lifespan.org>
Subject: RE: meningitis prophylaxis for exposures

Basically, this simply involves an LIP reading CDC guidelines re: meningococcal meningitis prophylaxis. Prophylaxis is not recommended for other microbial etiologies of meningitis. Antibiotic prophylaxis of exposed individuals is as follows from CDC website(https://www.cdc.gov/mmwr/pdf/rr/rr5407.pdf) and should be initiated based on CSF gram stain showing gram-negative diplococci or upon culture confirmation of meningococcus.

Prophylaxis is recommended if someone is a ‘close contact’ as defined by CDC by any of the following:
1) household members or
2) child-care center contacts or
3) anyone directly exposed to the patient’s oral secretions (e.g., through kissing, mouth-to-mouth resuscitation, endotracheal intubation, or endotracheal tube management).

Use table below re: antibiotic dosage.

So, the question is, how to post this information in a user-friendly place frequented by the ED LIPs (ED website?). If after reviewing this, the LIP still has a question re: antibiotic prophylaxis of staff, I think discussing with the ID team on call is the next stop in my opinion as we are talking about antibiotic management, not isolation precaution question. Re: antibiotic prophylaxis of non-staff members, I believe this is orchestrated by DOH, Julie, is this correct? If so, then Julie [Jefferson] can you confirm that the ED staff should alert infection control office during the day, on call phone after hours. The infection control person would contact DOH re: potential community exposures, correct?
Len

rr5407.pdf

Secure | https://www.cdc.gov/mmwr/pdf/rr/rr5407.pdf

cating adolescents and their parents about the benefits of receiving MCV4 is key to preventing a substantial number of cases of meningococcal disease. Finally, educating policy makers and the general public about the benefits of receiving

index patient). Conversely, chemoprophylaxis administered >14 days after onset of illness in the index patient is probably of limited or no value. Oropharyngeal or nasopharyngeal cultures are not helpful in determining the need for chemoprophylaxis and might unnecessarily delay institution of this preventive measure.

TABLE 7. Schedule for administering chemoprophylaxis against meningococcal disease

Drug	Age group	Dosage	Duration and route of administration*
Rifampin†	Children aged <1 mo	5 mg/kg body weight every 12 hrs	2 days
	Children aged ≥1 mo	10 mg/kg body weight every 12 hrs	2 days
	Adults	600 mg every 12 hrs	2 days
Ciprofloxacin§	Adults	500 mg	Single dose
Ceftriaxone	Children aged <15 yrs	125 mg	Single IM¶ dose
Ceftriaxone	Adults	250 mg	Single IM dose

* Oral administration unless indicated otherwise.
† Not recommended for pregnant women because it is teratogenic in laboratory animals. Because the reliability of oral contraceptives might be affected by rifampin therapy, consideration should be given to using alternative contraceptive measures while rifampin is being administered.
§ Not usually recommended for persons aged <18 years or for pregnant and lactating women because it causes cartilage damage in immature laboratory animals. Can be used for chemoprophylaxis of children when no acceptable alternative therapy is available. Recent literature review identified no reports of irreversible cartilage toxicity or age-associated adverse events among children and adolescents (**Source:** Burstein GR, Berman SM, Blumer JL, Moran JS. Ciprofloxacin for the treatment of uncomplicated gonorrhea infection in adolescents: does the benefit outweigh the risk? Clin Infect Dis 2002;35:S191–9).
¶ Intramuscular.

Rifampin, ciprofloxacin, and ceftriaxone are 90%–95% effective in reducing nasopharyngeal carriage of *N. meningitdis* and are all acceptable antimicrobial agents for chemoprophylaxis (*141–144*). Systemic antimicrobial therapy of meningo-

12. Jackson LA, Wenger JD. Laboratory-based surveillance for meningococcal disease in selected areas, United States, 1989–1991. In: CDC Surveillance Summaries, June 4, 1993. MMWR 1993;42(No. SS-2): 21–30.

[only add up to this point to the knowledgebase]

==

From: Portelli, David
Sent: Monday, January 09, 2017 1:07 PM
To: Sparhawk, Dana P MD <dsparhawk@Lifespan.org>; Mermel, Leonard A. DO

<LMermel@Lifespan.org>
Cc: Larkin, Jerome <JLarkin@Lifespan.org>; Jefferson, Julie W <JJefferson@Lifespan.org>
Subject: RE: meningitis prophylaxis for exposures

This is a highly charged situation where a clear, concise and definitive answer is appreciated.

If this is involving whether a staff member should be registered and treated prophylactically, shouldn't this really go to EOSH (daytime) and the infection control attending (nights and weekends)?

From: Sparhawk, Dana P MD
Sent: Monday, January 09, 2017 12:11 PM
To: Mermel, Leonard A. DO <LMermel@Lifespan.org>; Portelli, David <DPortelli@Lifespan.org>
Cc: Larkin, Jerome <JLarkin@Lifespan.org>; Jefferson, Julie W <JJefferson@Lifespan.org>
Subject: RE: meningitis prophylaxis for exposures

Len and Dave,

Excellent questions and discussion Len.

No, unfortunately we are not adequately staffed to have a physician on call for EOHS. Any injured/exposed employee is directed to the ED on off hours. As far as antibiotic prophylaxis, the ID fellow on call makes most sense.

Happy to discuss more for protocols/policies

Dana

From: Mermel, Leonard A. DO
Sent: Monday, January 09, 2017 11:29 AM
To: Portelli, David <DPortelli@Lifespan.org>
Cc: Larkin, Jerome <JLarkin@Lifespan.org>; Sparhawk, Dana P MD <dsparhawk@Lifespan.org>; Jefferson, Julie W <JJefferson@Lifespan.org>
Subject: RE: meningitis prophylaxis for exposures

Dave,
Good questions. This is a good question re: contact tracing and antibiotic prophylaxis after hours. This has been a problematic issue that Julie and I have discussed with Latha and Barbara, the worst case scenario was the possible measles exposure as you remember. Re: antibiotic prophylaxis, Dana is there a physician on call for EOHS issues? If not, Jerry, would you agree that the ED doc should call the ID fellow on call re: prophylaxis and the fellow can discuss with the ID attending on call.

Re: contact tracing of EMS and close contacts, what has been done before in this regard? I believe infection control should be contacted and they will contact EMS. If the gram stain suggests meningococcus (or culture eventually grows out mening), infection control would contact DOH re: close contacts. If the gram stain suggested

mening, I don’t know if state law requires ED docs to write scripts for close contacts or not.

Since there’s uncertainty re: all this, I think we should have a written protocol for all involved for future reference and we could meet to discuss this and draft policy thereafter.
Len

From: Portelli, David
Sent: Monday, January 09, 2017 10:47 AM
To: Mermel, Leonard A. DO <LMermel@Lifespan.org>
Subject: FW: meningitis prophylaxis for exposures

Leonard,
We had a bacterial meningitis case over the weekend. In the end no prophylaxis was needed but can you comment on item 4 below?
Dave
From: Rybasack-Smith, Heather L
Sent: Monday, January 09, 2017 10:41 AM
To: Portelli, David <DPortelli@Lifespan.org>
Subject: meningitis prophylaxis for exposures

Dr. portelli:

We had a case in Anderson 2 days ago; woman critically ill w/ meningitis. Thankfully, gram stain came back with GPC and no prophylaxis needed; however prior to that when we wer 99% sure she had bacterial meningitis, I had a very hard time finding anyone that knew how to trigger employee/EMS/household contact prophylaxis. Specifically, I asked the charge nurse, the hospital nursing supervisor and several senior nurses and attendings. Everyone was unsure, noone knew who to contact and noone knew the procedure. If I needed to I would have paged the DOH on call doc and the infection control pager, but we got gram stain back before that. This was a saturday afternoon, no employee health to call.

Also, of note, it was VERY difficult to get staff to follow isolation; noone wanted to wear a mask!

My questions:
1) what is the correct procedure for notifications for possible meningitis exposure –infection control
2) whose responsibility is it in the ED – ED provider / attending
3) Who gets called – infection control
4) who contacts EMS and traces close contacts? (I'm guessing DOH but who reports it to them?) – Who reports cases to DOH? Who traces prehospital and home contacts?

Thanks!
Heather