

## EMPIRIC CHOICE

- + ceftriaxone 2 g iv q12h + vancomycin 25mg/kg iv loading dose x1 followed by 15 mg/kg iv q8h
- + if over age 50, add ampicillin 2g iv q4h or TMP-SMX 5 mg/kg iv q6h

## DURATION

- + *S. pneumoniae*: 10 days
- + *N. meningitidis*: 7 days
- + *L. monocytogenes*: 21 days

## ALTERNATIVES FOR ALLERGIES

- + For non-anaphylactic penicillin allergy, ceftriaxone may be used.
- + For severe  $\beta$ -lactam allergy, use moxifloxacin 400 mg iv q24h + vancomycin 15 mg/kg iv q8h (add agent for *Listeria* if over age 50 or immunocompromised (see below)).

## TOP FIVE ORGANISMS (what we expect for common organisms)

- + *S. pneumonia*
- + *N. meningitidis*
- + *L. monocytogenes* (esp. in those over age 50)
- + aerobic Gram-negative bacilli

## CURRENT RESISTANCE ISSUES

- + The rate of ceftriaxone-resistant pneumococci in Toronto is <1%. Recommendations for treating with vancomycin are based, primarily, from jurisdictions with higher resistance than we are currently encountering in Toronto.

## IMMUNOCOMPROMISED HOST CONSIDERATION (INCLUDING THOSE WITH ADVANCED LIVER/KIDNEY DISEASE)

- + Add ampicillin 2 g iv q4h or TMP-SMX 5 mg/kg iv q6h for *Listeria* coverage.
- + Fungal meningitis (esp. cryptococcal) is relatively common in those with severe cell-mediated immunocompromised (eg. steroids, transplantation).

## ADDITIONAL DIAGNOSTIC AND THERAPEUTIC COMMENTS

- + Dexamethasone 10mg iv q6h for 4 days (started as soon as possible prior to initiating antimicrobial therapy) is currently recommended. The current evidence demonstrates that this neither provides benefit nor harm in patients with bacterial meningitis (*vis a vis* mortality, neurologic sequelae), but a single study from the Netherlands suggested benefit and the recommendation remains controversial.
- + Consideration for repeat lumbar puncture should be given for patients failing to improve after 24-48h of therapy.

## References:

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