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Re: Meningococcal disease information and prophylaxis guidelines in response to local case

Meningococcal disease has been reported in your area. As a result, you may receive questions from concerned patients about their risk of contracting this disease.

We want to alert you to this situation and provide information and guidelines regarding prophylaxis of contacts to the meningococcal disease in your area. These recommendations are consistent with those of the Wisconsin Division of Public Health, the Centers for Disease Control and Prevention (CDC), the National Foundation for Infectious Diseases, and the American Academy of Pediatrics for identifying and treating contacts of a suspect case patient.

As you know, meningococcal disease is caused by the bacterium *Neisseria meningitidis* and is spread only by **direct contact with saliva or respiratory secretions.** The incubation is 1-10 days, with 3-4 days being the average. As soon as a patient is identified with confirmed or suspected meningococcal disease, prophylactic antimicrobial treatment is recommended for "high-risk" contacts who had direct contact with saliva or respiratory droplets while the case patient was infectious. The case patient is considered infectious beginning 7 days prior to onset of illness and until 24 hours after antibiotics are initiated. Prophylactic treatment has not been shown to be useful if more than 14 days have elapsed since contact occurred.

High risk contacts include:

- household contacts/roommates, especially children younger than 2 years of age
- child care or pre-school contacts (both attendees and staff)
- intimate partners
- ambulance/EMS and other healthcare personnel exposed to respiratory secretions (e.g., during mouth-to-mouth resuscitation, endotracheal intubation, suctioning)
- passengers seated directly next to the index case during airline flights lasting > 8 hours

Intimate, direct contact includes the following exposures:

- kissing
- sharing eating utensils, drinking containers, toothbrushes, smoking materials, etc.
- sharing water bottles, cups (e.g., among athletes)
- providing direct medical procedures, such as CPR or airway management
- other direct contact with saliva or respiratory secretions

High-risk contacts should receive preventive antibiotic treatment ASAP as a precautionary measure. Casual contacts of a case are generally not at risk for developing the disease. Simply being in the same room does not qualify as intimate, direct contact. There is also no recommendation for treatment based on the distance from the suspect patient (i.e., "three-foot rule").

The following regimens are appropriate for chemoprophylaxis of contacts.

Agent*	Dose	Duration	Cautions
Rifampin			
	Adults: 600 mg, p.o., b.i.d.	2 days	Not recommended during pregnancy
	Children ≥ 1 month: 10 mg/kg, p.o., b.i.d.	2 days	Stains urine and tears; avoid contact lens use
	Children < 1 month: 5 mg/kg, p.o., b.i.d.	2 days	
Ciprofloxacin			
	Adults only: 500 mg, p.o.	1 dose	Not recommended during pregnancy or lactation
Ceftriaxone			
	Adults: 250 mg, i.m.	1 dose	May be mixed with 1% xylocaine to reduce injection pain
	Children < 15 years: 125 mg, i.m.	1 dose	

*Certain antibiotics could decrease the effectiveness of oral contraceptives.

N. meningitidis bacteria are commonly found in the nasopharynx. Nationally, the CDC estimates that 5-10% of the population may be carrying the bacteria asymptomatically in their throat at any given time. It is not well understood why only a few people develop invasive illness, but may be influenced by genetic, immune (e.g., antecedent viral illness, immunocompromising condition), societal (e.g., overcrowding, smoke exposure) or physical factors. Children under the age of 5 years have the highest incidence of disease.

Since 2000, Wisconsin has averaged 33 laboratory-confirmed cases per year (range: 23-53). The vast majority of cases are sporadic, and secondary transmission is rare. Only two cases of secondary transmission have occurred in Wisconsin since enhanced surveillance began in 1998.

Your assistance is appreciated with early diagnosis and rapid reporting to your local health department as soon as a case is suspected. (Please note that notification should not be delayed until the diagnosis is confirmed.) The local health department will coordinate chemoprophylaxis of appropriate community contacts.

If you have questions about this occurrence of meningococcal disease, please contact your local health department.

Sincerely,

References

American Academy of Pediatrics. Meningococcal infections. In: Pickering LK et al. *2009 Red Book: Report of the Committee on Infectious Diseases*. 28th ed. Elk Grove Village, IL: American Academy of Pediatrics, 2009:455-463.

American Public Health Association. Meningococcal infection. In: Heymann DL, ed. *Control of Communicable Diseases Manual*. 19th ed. Washington, DC: American Public Health Association, 2008:415-421.

Centers for Disease Control and Prevention. Exposure to patients with meningococcal disease on aircrafts – United States, 1999-2001. MMWR 2001;50(23):485-9.

Centers for Disease Control and Prevention. Meningococcal disease. In: Atkinson W, Wolfe S, Hamborsky J, McIntyre L, eds. *Epidemiology and Prevention of Vaccine-Preventable Diseases*. 11th ed. Washington, DC: Public Health Foundation, 2009:177-187.

Centers for Disease Control and Prevention. Prevention and control of meningococcal disease: Recommendations of the Advisory Committee on Immunization Practices (ACIP). *MMWR* 2005;54(no. RR-7).

Centers for Disease Control and Prevention. Prevention and control of meningococcal disease: Recommendations of the Advisory Committee on Immunization Practices (ACIP). *MMWR* 2000;49(no. RR-7).

National Foundation for Infectious Diseases. The changing epidemiology of meningococcal disease among U.S. children, adolescents and young adults. November, 2004:1-15.