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Bacterial meningitis and meningococcal sepsis are rare

in adults. Any diagnostic delays with subsequent delay to treatment can have disastrous consequences. The decline in bacterial meningitis over the past few decades has not been accompanied by a reduction in case fatality rate which can be as high as 20% for all causes of bacterial meningitis and 30% in pneumococcal meningitis.

S. pneumoniae remains the predominant cause of

community acquired meningitis in adults and *N. meningitidis* serogroup B is responsible for > 80% of meningococcal disease. England and Wales have been experiencing an epidemic of meningococcal disease caused by serogroup W. Most cases occur in adults and there is often an atypical presentation including GI symptoms. The classic triad of neck stiffness, fever and altered consciousness is present in < 50% of cases of bacterial meningitis. These signs may frequently occur in isolation and in more minor, self-limiting illness.

Patients with viral meningitis also present with signs

of meningism (headache, neck stiffness and photophobia) possibly with additional non-specific symptoms such as diarrhoea or sore throat. While they will not have a reduced level of consciousness (which would suggest an alternative diagnosis such as bacterial meningitis or viral encephalitis), it is clear there is an overlap with the symptoms of bacterial meningitis. Mortality is higher in meningococcal sepsis but neurological and other long-term sequelae are more frequent in meningococcal meningitis.

Suspected cases of meningitis or meningococcal sepsis

must be referred for further assessment and consideration of a lumbar puncture. The challenge for GPs is to distinguish the minority of patients who have a life-threatening illness from those who have minor self-limiting infections. Early lumbar puncture is key to establishing a definitive diagnosis, ensuring targeted treatment and minimising risks of overtreatment. Ideally lumbar puncture should be performed before giving antibiotics.

There is currently no evidence to support the use of

antivirals in viral meningitis. Simple supportive measures and reassurance should be the mainstay of treatment. Meningitis is a notifiable disease and all cases must be reported. Secondary care will normally do this. The local health protection team will arrange prophylaxis for contacts. Treatment will differ according to aetiology.

Most patients will fully recover. However, the sequelae

of bacterial meningitis and meningococcal disease can be disabling. Problems are more likely to occur in pneumococcal meningitis than in meningococcal meningitis. Many patients feel well at discharge and do not realise that they may not be able to return to all their normal duties and activities straightaway. Fatigue, headaches, sleep disorders and emotional problems are often reported in the weeks and months after discharge.