Community-acquired meningitis

Community-acquired meningitis (CAM) is generally more fulminant than meningitis following neurosurgical procedures or trauma. CAM tends to involve certain specific organisms in patients with an intact immune system (viz. in adults: Neisseria meningitidis, Streptococcus pneumoniae, Hamophilus influenza type B…) but can be caused by less virulent organisms in individuals with impaired host defenses.

Waterhouse-Friderichsen syndrome: occurs in 10–20% of children with meningococcal infection (usually disseminated infection in age < 10 yrs), produces large petechial hemorrhages in the skin and mucous membranes, fever, septic shock, adrenal failure (due to hemorrhage into adrenal glands) and DIC. Focal neurologic signs are rare in acute purulent meningitis; however, increased ICP may occur.

Treatment

Community-acquired meningitis: is a medical emergency, and should be treated immediately with corticosteroids, e.g. IV betamethasone 0.12 mg/kg [1] or dexamethasone before or at least with the first dose of antibiotics [2].

External ventricular drain for community-acquired meningitis

External ventricular drain for community-acquired meningitis.

1)
Edberg M, Furebring M, Sjolin J, et al. Neurointensive care of patients with severe community-acquired meningitis. Acta Anaesthesiol Scand. 2011; 55:732–739
2)
Tunkel AR, Hartman BJ, Kaplan SL, et al. Practice guidelines for the management of bacterial meningitis. Clin Infect Dis. 2004; 39:1267–1284