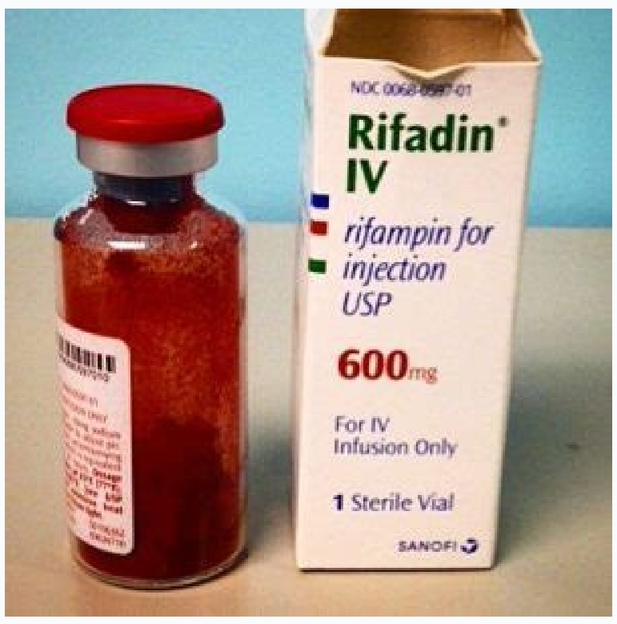
Pediatric meningitis guidelines idsa

Table 2. Empiric Therapy for Childhood CAP

Population	Bacterial Pneumonia[a]	Atypical Pneumonia[a]	Influenza Pneumonia[a]
Outpatient (3 mo-5 y)	Amoxicillin 90 mg/kg/day po in 2-3 divided doses *Alternative:* amoxicillin/clavulanate 90 mg/kg po in 2-3 divided doses	Azithromycin 10 mg/kg po on day 1, followed by 5 mg/kg/day on days 2-5 *Alternatives:* clarithromycin 15 mg/kg/day po in 2 divided doses; erythromycin 40 mg/kg/day po in 4 divided doses	Oseltamivir—*0-8 mo:* 6 mg/kg/day po in 2 divided doses; *9-23 mo:* 7 mg/kg/day po in 2 divided doses; *≥24 mo:* 4 mg/kg/day po in 2 divided doses
Outpatient (5 y-18 y)	Amoxicillin 90 mg/kg/day po in 2-3 divided doses, to max of 4 g/day; in CAP not distinguished between bacterial and atypical: may add macrolide to β-lactam antibiotic for empiric therapy *Alternative:* amoxicillin/clavulanate 90 mg/kg/day po in 2-3 divided doses, to max of 4 g/day; in CAP not distinguished between bacterial and atypical, may add macrolide to β-lactam antibiotic for empiric therapy	Azithromycin 10 mg/kg po on day 1, followed by 5 mg/kg/day on days 2-5, to max of 500 mg on day 1, followed by 250 mg on days 2-5 *Alternatives:* clarithromycin 15 mg/kg/day po in 2 divided doses, to max of 1 g/day; erythromycin 40 mg/kg/day po in 4 divided doses; doxycycline 2-4 mg/kg/day po in 2 divided doses (in children >7 y)	Oseltamivir 4 mg/kg/day po in 2 divided doses; zanamivir 2 inhalations bid (in children ≥7 y) *Alternatives:* peramivir, oseltamivir, zanamivir[b]
Inpatient (3 mo-18 y); fully immunized against *S pneumoniae* and Hib or low *S pneumoniae* resistance (MIC for penicillin ≤2 mcg/mL)	Ampicillin 150-200 mg/kg/day IV in 4 divided doses; penicillin G 200,000-250,000 U/kg/day IV in 4-6 divided doses *Alternatives:* ceftriaxone 100 mg/kg/day IV/IM in 1-2 divided doses; cefotaxime 150 mg/kg/day IV in 3 divided doses; in suspected CA-MRSA, may add vancomycin 40-60 mg/kg/day IV in 3-4 divided doses or clindamycin 30-40 mg/kg/day IV/po in 3 divided doses	Azithromycin 10 mg/kg IV on days 1-2, followed by oral therapy if possible, to max of 500 mg/day; in CAP not distinguished between bacterial and atypical, may add β-lactam to macrolide antibiotic for empiric therapy *Alternatives:* clarithromycin 15 mg/kg/day po in 2 divided doses, to max of 1 g/day; erythromycin lactobionate 20 mg/kg/day IV in 4 divided doses; doxycycline 2-4 mg/kg/day IV/po in 2 divided doses (for children >7 y); levofloxacin 8-10 mg/kg/day IV/po, to max of 750 mg/day (in children who have reached growth maturity or cannot tolerate macrolides)	Oseltamivir—*0-8 mo:* 6 mg/kg/day po in 2 divided doses; *9-23 mo:* 7 mg/kg/day po in 2 divided doses; *≥24 mo:* 4 mg/kg/day po in 2 divided doses Zanamivir—2 inhalations bid (in children ≥7 y) *Alternatives:* peramivir, oseltamivir, zanamivir[b]
Inpatient (3 mo-18 y); not fully immunized against *S pneumoniae* and Hib or high *S pneumoniae* resistance (MIC for penicillin ≥4 mcg/mL)	Ceftriaxone 100 mg/kg/day IV/IM in 1-2 divided doses; cefotaxime 150 mg/kg/day IV in 3 divided doses; in suspected CA-MRSA, may add vancomycin 40-60 mg/kg/day IV in 3-4 divided doses or clindamycin IV/po 30-40 mg/kg/day po in 3 divided doses *Alternative:* Levofloxacin 8-10 mg/kg/day IV, to max of 750 mg/day; in suspected CA-MRSA, may add vancomycin 40-60 mg/kg/day IV in 3-4 divided doses or clindamycin 30-40 mg/kg/day IV/po in 3 divided doses	Azithromycin 10 mg/kg IV on days 1-2, followed by oral therapy if possible, to max of 500 mg/day; in CAP not distinguished between bacterial and atypical: may add β-lactam to macrolide antibiotic for empiric therapy *Alternatives:* clarithromycin 15 mg/kg/day po in 2 divided doses, to max of 1 g/day; erythromycin lactobionate 20 mg/kg/day IV in 4 divided doses; deoxycycline 2-4 mg/kg/day IV/po in 2 divided doses (for children >7 y); levofloxacin 8-10 mg/kg/day IV/po to max of 750 mg/day (for children who have reached growth maturity or cannot tolerate macrolides)	Oseltamivir—*0-8 mo:* 6 mg/kg/day po in 2 divided doses; *9-23 mo:* 7 mg/kg/day po in 2 divided doses; *≥24 mo:* 4 mg/kg/day po in 2 divided doses Zanamivir: 2 inhalations twice daily (for children ≥7 y) Alternatives: peramivir, oseltamivir, zanamivir[b]

[a] *Presumed.*
[b] *All above IV preparations are under clinical investigation.*
CA-MRSA: community-associated methicillin-resistant Staphylococcus aureus; *CAP: community-acquired pneumonia; Hib:* Haemophilus influenzae *type b; max: maximum; MIC: minimum inhibitory concentration;* S pneumoniae: Streptococcus pneumoniae.
Source: References 7, 15.



- An increased CSF-opening pressure, high number of polymorphonuclear leukocytes and raised protein concentration, together with decreased CSF-plasma ratio of glucose (<0.3) are characteristic findings supportive of ABM .
- Listerial meningitis may have CSF findings identical to chronic tuberculous or fungal meningitis.
- In patients with ABM, the probability of a negative CSF culture in previously treated patients is increased compared with non-treated patients.
- In ABM, the likelihood of diagnostic yield in CSF microbiology is highest before antibiotic treatment.

CONTRAINDICATIONS FOR LUMBAR PUNCTURE IN SUSPECTED ACUTE BACTERIAL MENINGITIS

ABSOLUTE (lumbar puncture is not to be recommended)	RELATIVE (appropriate therapeutic measures and/or investigations are indicated before lumbar puncture)
• Signs of raised intracranial pressure (papilloedema, decrebrate posturing) • Local skin infection in needle track • Evidence of obstructive hydrocephalus, cerebral oedema or herniation in imaging.	• Sepsis or hypotension (systolic blood pressure <100 mmHg, diastolic blood pressure <60 mmHg): patients should be stabilized first • Coagulation disorder (DIC, platelet count <50 000/mm^3, therapeutic use of warfarin): appropriate correction first • Presence of focal neurological deficit, especially when posterior fossa lesion is suspected[a]

Idsa guidelines for bacterial meningitis. Pediatric idsa guidelines. Meningitis idsa guidelines.

Epidemiological data refers to the US, unless otherwise specified. Patient population Pathogen By age < 1 month [1] 1 month–2 years [2] 2–50 years [2][8] > 50 years [2][9] By underlying condition Immunocompromise [10] Basilar skull fracture [9] Penetrating trauma [9] Health care-associated [11] Bacterial Viral: Risk is higher in individuals with cell-mediated immune deficiencies (e.g., in HIV infection). [16] HerpesvirusesCMV, EBV, VZV, and HSV6 HIV Adenovirus JC virus Fungal: Risk is higher in individuals with cell-mediated immune deficiencies (e.g., HIV infection). [17] Protozoal: Toxoplasma gondii (rare) Bacterial meningitis: usually 3–7 days In neonates, meningitis often manifests with nonspecific symptoms and without the classic triad of meningitis. Children and adults (meningismus) The classical features of acute bacterial meningitis are fever, neck stiffness, and headache. However, this triad of symptoms only manifests in approx. 50% of cases. Physical examination [20][31] Features suggestive of meningoencephalitis [34][35] In addition to the features of meningitis, meningoencephalitis is characterized by signs of inflammation of the brain parenchyma (encephalitis). Focal neurological signsparesisextrapyramidal symptomsaphasia Seizures Factors to consider: Epidemiological factors (e.g., local flora, resistance patterns) Bioavailability: Antimicrobial agents should cross the blood-brain barrier and higher doses may be needed. Ampicillin is added if patients are at risk of Listeria spp. infection newbornsimmunocompromisedcephalosporins Ceftriaxone is contraindicated in patients aged < 1 month because of a higher risk of biliary sludging and kernicterus. Cefotaxime or ceftazidime can be used instead. [46] Empiric therapy for viral meningitis [19][48] Most cases of viral meningitis (e.g., caused by enteroviruses) can be treated supportively.encephalitisHSV encephalitis Corticosteroids [39][49] Tunkel AR, Hartman BJ, Kaplan SL, et al. Practice Guidelines for the Management of Bacterial Meningitis. Clinical Infectious Diseases. 2004; 39 (9): p.1267-1284. doi: 10.1086/425368 . | Open in Read by QxMD Mount HR, Boyle SD. Aseptic and Bacterial Meningitis: Evaluation, Treatment, and Prevention.. Am Fam Physician. 2017; 96 (5): p.314-322. Bamberger. Diagnosis, Initial Management, and Prevention of Meningitis. American Family Physician. 2010 . Ku LC, Boggess KA, Cohen-Wolkowiez M. Bacterial Meningitis in Infants. Clin Perinatol. 2015; 42 (1): p.29-45. doi: 10.1016/j.clp.2014.10.004 . | Open in Read by QxMD Stoll BJ, Hansen NI, Sanchez PJ, et al. Early Onset Neonatal Sepsis: The Burden of Group B Streptococcal and E. coli Disease Continues. 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Movement Disorders From the Use of Metoclopramide and Other Antiemetics in the Treatment of Migraine. Headache: The Journal of Head and Face Pain. 2015; 56 (1): p.153-161. doi: 10.1111/head.12712 . | Open in Read by QxMD Sheldon L Kaplan. Bacterial meningitis in children older than one month: Clinical features and diagnosis. In: Post TW, ed. UpToDate. Waltham, MA: UpToDate. updated: August 15, 2018. Accessed: February 28, 2020.You have 3 free member-only articles left this month. Sign up and get unlimited access. Evidence-based content, created and peer-reviewed by physicians. Read the disclaimer

Aug 31, 2021 · Current guidelines should be consulted for additional information. Usual Pediatric Dose for Meningitis. IDSA Recommendations: Infants and children: 10 to 20 mg/kg/day (trimethoprim component) IV in divided doses every 6 to 12 hours; Duration of therapy: Aerobic gram-negative bacilli: 21 days; L monocytogenes: At least 21 days; Comments: May 06, 2022 · Meningitis is a serious infection of the meninges in the brain or spinal cord that is most commonly viral or bacterial in origin, although fungal, parasitic, and noninfectious causes are also possible. Enteroviruses and herpes simplex virus are the leading causes of viral meningitis, while Neisseria meningitidis and Streptococcus pneumoniae are the pathogens ... Mar 18, 2022 · IDSA guidelines: Some experts prefer this drug (instead of fluconazole) for coccidioidal meningitis, but this requires closer monitoring to assure adequate absorption. ... Usual Pediatric Dose for Cryptococcal Meningitis - Immunosuppressed Host. US CDC, NIH, HIVMA/IDSA, PIDS, and AAP Recommendations for HIV-Exposed and HIV-Infected Children: ... This report updates and combines earlier versions of guidelines for the prevention and treatment of opportunistic infections (OIs) in HIV-infected adults (i.e., persons aged >18 years) and adolescents (i.e., persons aged 13--17 years), last published in 2002 and 2004, respectively. It ... Oct 01, 2007 · The IDSA updates its guidelines when new data or publications might change a prior recommendation or when the panel feels clarification or additional guidance is warranted. ... Meningitis is common in progressive disseminated ... and David S. McKinsey (ID Associates of Kansas City, Kansas City, MO). Pediatric infectious diseases: Martin B ... Oct 01, 2007 · The IDSA updates its guidelines when new data or publications might change a prior recommendation or when the panel feels clarification or additional guidance is warranted. ... Meningitis is common in progressive disseminated ... and David S. McKinsey (ID Associates of Kansas City, Kansas City, MO). Pediatric infectious diseases: Martin B ... Nov 30, 2020 · This evidence-based clinical practice guideline for the prevention, diagnosis, and treatment of Lyme disease was developed by a multidisciplinary panel representing the Infectious Diseases Society of America (IDSA), the American Academy of Neurology (AAN), and the American College of Rheumatology (ACR). The scope of this guideline includes prevention of ... 50 mg/kg/dose IV or IM every 24 hours is recommended by the American Academy of Pediatrics (AAP).[63245] The FDA-approved labeling recommends 50 to 75 mg/kg/day IV or IM divided every 12 hours for serious infections in pediatric patients.[29920] Start within 1 hour for septic shock or within 3 hours for sepsis-associated organ dysfunction without shock. May 06, 2022 · Meningitis is a serious infection of the meninges in the brain or spinal cord that is most commonly viral or bacterial in origin, although fungal, parasitic, and noninfectious causes are also possible. Enteroviruses and herpes simplex virus are the leading causes of viral meningitis, while Neisseria meningitidis and Streptococcus pneumoniae are the pathogens ... 50 mg/kg/dose IV or IM every 24 hours is recommended by the American Academy of Pediatrics (AAP).[63245] The FDA-approved labeling recommends 50 to 75 mg/kg/day IV or IM divided every 12 hours for serious infections in pediatric patients.[29920] Start within 1 hour for septic shock or within 3 hours for sepsis-associated organ dysfunction without shock. This report updates and combines earlier versions of guidelines for the prevention and treatment of opportunistic infections (OIs) in HIV-infected adults (i.e., persons aged >18 years) and adolescents (i.e., persons aged 13--17 years), last published in 2002 and 2004, respectively. It ...

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