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CORRIGENDUM



Corrigendum to “The UK joint specialist societies guideline on the diagnosis and management of acute meningitis and meningococcal sepsis in immunocompetent Adults” [J Infect 72 (2016) 405–438][☆]

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The authors regret the following footnote should have been included with Table 6:

In cases where Chloramphenicol is used (known anaphylaxis to penicillins or cephalosporins) the dose may be reduced to 12.5 mg/kg 6 hourly if the patient is recovering, to reduce the risk of a dose-related anaemia.

Table 6 is reproduced again here with the addition of the footnote.

The authors would like to apologise for any inconvenience caused.

Table 6 Definitive antibiotic treatment.

Aetiology	Antibiotic (s)	Dose	Alternative antibiotic choices	Dose	Duration ^b
<i>Neisseria meningitidis</i>	Cefotaxime	2 g 6 hourly/2 g	Chloramphenicol (if anaphylaxis) OR Benzylpenicillin	25 mg/kg	5 days
	OR Ceftriaxone	12 hourly		6 hourly	
<i>Streptococcus pneumoniae</i> (sensitivities unknown or penicillin resistant, cephalosporin sensitive)	Cefotaxime ^a	2 g 6 hourly	Chloramphenicol	25 mg/kg	10 days (if stable) Up to 14 days if taking longer to respond
	OR Ceftriaxone ^a	2 g 12 hourly		6 hourly	
<i>Streptococcus pneumoniae</i> (penicillin sensitive, MIC ≤ 0.06)	Benzylpenicillin	2.4 g 4 hourly	Chloramphenicol	25 mg/kg	10 days (if stable) Up to 14 days if taking longer to respond
	OR Cefotaxime	2 g 6 hourly/2 g		6 hourly	
	OR Ceftriaxone ^c	12 hourly			
<i>Streptococcus pneumoniae</i> (penicillin and cephalosporin non-susceptible, penicillin MIC > 0.06 or cefotaxime/ceftriaxone MIC > 0.5)	Cefotaxime	2 g 6 hourly	Chloramphenicol ^e	25 mg/kg	14 days
	OR Ceftriaxone	2 g 12 hourly		6 hourly	
	AND Vancomycin ^d	15–20 mg/kg			
	OR Rifampicin	12 hourly (adjusting according to serum trough levels)			
		600 mg bd			
<i>Listeria monocytogenes</i>	Amoxicillin	2 g 4 hourly	Co-trimoxazole	10–20 mg/kg (of the trimethoprim component) in 4 divided doses	21 days
<i>Haemophilus influenzae</i>	Cefotaxime	2 g 6 hourly	Moxifloxacin	400 mg od	10 days
	OR Ceftriaxone	2 g 12 hourly			

^a Add in IV Vancomycin 15–20 mg/kg bd or Rifampicin 600 mg bd if penicillin resistance is suspected e.g. patient has recently arrived from a country where penicillin resistant pneumococci is prevalent (if unsure, check with local infectious diseases/microbiology expertise).

^b Treatment durations may need to be extended if patient is not responding.

^c If low risk of *Clostridium difficile* infection and/or requiring outpatient therapy.

^d Serum vancomycin trough concentrations of 15–20 µg/ml should be aimed for.

^e In cases where Chloramphenicol is used (known anaphylaxis to penicillins or cephalosporins) the dose may be reduced to 12.5 mg/kg 6 hourly if the patient is recovering, to reduce the risk of a dose-related anaemia.