Meningitis (bacterial) and meningococcal septicaemia in children & young people: recognition, diagnosis and management

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Stakeholder	Page no.	Line no.	Comments	Developer's response
Alder Hey Children's NHS Foundation Trust	General	General	The draft scope in titled; Meningitis (bacterial) and meningococcal septicaemia in children and young people. However, in the scope the phrase "meningococcal sepsis" is used. As only a third of children with meningococcal disease have "sepsis" (life threatening organ dysfunction) this means the scope will not include the majority of children with meningococcal disease. It would be better to search for evidence about meningococcal disease, to include the whole spectrum of disease in the guideline.	Thank you for your comment. For clarity the scope now refers to meningococcal disease in the title and throughout, rather than septicaemia or sepsis. We will ensure that definitions of key terms are included in the guideline glossary.
British Infection Association	001	007	Most 16,17- and 18-year olds will be managed in adult hospitals/wards whereas under 16s will be in children's hospitals and wards. This seems a strange cut off to have.	Thank you for your comment. We are now extending the population range to include adults. The scope has been amended throughout to reflect this, and the expertise required on the guideline committee has been reconsidered and further recruitment is taking place.
British Infection Association	001	015 - 017	Sepsis can occur following any infection not just meningococcal disease. In particular it can also be caused by all the other bacteria that cause meningitis e.g. pneumococcal etc…	Thank you for your comment. The definition of sepsis has been aligned with the definition in NG51 as follows: "Sepsis is a clinical syndrome caused by the body's immune and coagulation systems being switched on by the presence of an infection (bacteria, viruses or fungi), resulting in organ dysfunction or failure."
British Infection Association	001	019	Not clear why only bacterial disease is being included – why not viral given this will be more commonly seen than bacterial and as a syndrome it is sometimes difficult to differentiate bacterial from viral when a patient presents and so investigations for both should be done. Not least if you can diagnose a viral cause then that helps to exclude a bacterial cause.	Thank you for your comment. The aim of this work is to update the recommendations within CG102, which covers bacterial meningitis only. . All suspected meningitis should be considered to be bacterial until proven otherwise. Focusing on the identification of risk factors, symptoms and signs that are associated with bacterial meningitis should assist with timely investigation and management of suspected cases of bacterial meningitis. Viral meningitis is a large topic in its own right
British Infection Association	001	021	You have included adults here.	Thank you for your comment and for spotting this error. We are now extending the population range to include adults. The scope has been amended throughout to reflect this, and the expertise required on the guideline committee has been reconsidered and further recruitment is taking place.

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British Infection Association	002	016 - 018	Why is this the focus? There are variations in practice throughout the patient journey from triage to follow up.	Thank you for your comment. The text in the scope has been changed to: "…variations in clinical practice including…"
British Infection Association	005	001 - 002	Should be investigating and recognising 'suspected meningitis' not just suspected bacterial meningitis as a patient doesn't present with suspected bacterial meningitis and all suspected meningitis should be considered to be bacterial until proven otherwise.	Thank you for your comment. We agree that all suspected meningitis should be considered to be bacterial until proven otherwise. Focusing on the identification of risk factors, symptoms and signs that are associated with bacterial meningitis should assist with timely investigation and management of suspected cases of bacterial meningitis.
British Infection Association	008	011	What is the accuracy of a positive CSF viral PCR for excluding bacterial meningitis? (important for stopping antibiotics appropriately).	Thank you for your comment. The list of investigations in the scope are provided as examples but is by no means exhaustive. The guideline committee will be able to consider which investigations to include during review protocol development. Note that more detail will be provided in the review protocols.
British Infection Association	008	011	CSF antigen tests should also be evaluated as still used in lots of labs.	Thank you for your comment. The list of investigations in the scope are provided as examples but is by no means exhaustive. The guideline committee will be able to consider whether to include CSF antigen tests during review protocol development.
British Infection Association	008	011	Should also look at what is/are the risk(s) of doing neuro-imaging prior to LP?	Thank you for your comment. This will be discussed in context of question 2.4 "What symptoms or signs (individually or in combination) are risk factors for brain herniation following lumbar puncture in people with suspected bacterial meningitis?" and question 2.5: "What is the effectiveness of neuro-imaging in reducing the occurrence of brain herniation following lumbar puncture?". The positive and negative effects will be discussed by the guideline committee during guideline development.
British Infection Association	009	001 - 004	What is meant by immediate? – at GPs, in ambulance, in ED, before 1 hour after presentation?? Should look at what is the timescale by which antibiotics should be given?	Thank you for your comment. These factors will be considered by the guideline committee during the development of the review protocol for this question.
British Infection Association	009	011 - 021	Should also look at route, duration, dose etc…. (as per rec 3.3).	Thank you for your comment. These factors will be considered by the guideline committee during guideline development. The discussion will be in context of the evidence identified in the evidence review.
British Infection Association	009	016	Should just read Haemophilus influenzae (non-type B much more common than type B now).	Thank you for your comment. This change has been applied in the scope:

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British Infection Association	010	005	What are the risks and complications of meningitis and what is the risk of individual complications? Currently reads as if just going to look at risk of any complication?	Thank you for your comment. In context of the proposed question, the guideline committee will discuss and decide which complications are most relevant and important for the guideline to cover. In the evidence review, selected complications will likely be categorised; e.g. type, and/or timeframe. However, acute complications were not prioritised for inclusion in this guideline as it would be too wide an area and only apply to a subset of the people covered in the scope.
British Infection Association	010	009	Who should have an HIV test?Who should have additional investigations for structural abnormalities?Who should have additional investigations for immunocompromise?	Thank you for your comment. The guideline committee will discuss and decide in context of the identified evidence and in the recommendations.
British Infection Association	General	General	Response to additional question 1: Agree with this change in title.	Thank you for your comment. For clarity the scope now refers to meningococcal disease in the title and throughout, rather than septicaemia or sepsis. We will ensure that definitions of key terms are included in the guideline glossary.
British Infection Association	General	General	Response to additional question 1: I would agree with changing 'meningococcal septicaemia'. Personally, I think it should perhaps change to 'invasive meningococcal disease' rather than meningococcal sepsis.	Thank you for your comment. For clarity the scope now refers to meningococcal disease in the title and throughout, rather than septicaemia or sepsis. We will ensure that definitions of key terms are included in the guideline glossary.
British Infection Association	General	General	Response to additional question 2: Yes, extend the age range. It is much more helpful for users of guidelines to have all the information in one place, rather than looking to NICE document for 17 and half year old, and BIA document for 19 and half year old. It also reduces potentially conflicting / confusing information.	Thank you for your comment. We are now extending the population range to include adults. The scope has been amended throughout to reflect this, and the expertise required on the guideline committee has been reconsidered and further recruitment is taking place.
British Infection Association	General	General	Response to additional question 2: We (the BIA) are in strong support for the inclusion of adolescents and adults in the scope of the new updated NICE guideline on bacterial meningitis and meningococcal sepsis. We are therefore very concerned that adults have now potentially been removed from the scope of the guideline which provides the opportunity to harmonise investigation and management approaches, and improve the outcome for a section of society that increasingly has the larger burden of disease with a worse outcome.	Thank you for your comment. We are now extending the population range to include adults. The scope has been amended throughout to reflect this, and the expertise required on the guideline committee has been reconsidered and further recruitment is taking place.

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British Infection Association	General	General	Response to additional question 2: Meningitis is a rare disease with considerable mortality and morbidity that occurs as frequently, if not more, in adults than in children.	Thank you for your comment. We are now extending the population range to include adults. The scope has been amended throughout to reflect this, and the expertise required on the guideline committee has been reconsidered and further recruitment is taking place.
British Infection Association	General	General	Response to additional question 2: There is evidence that the current management of adult patients with meningitis is sub-optimal (Poster, Federation of Infection Societies Conference, November 2019). This could be improved with NICE guidance.	Thank you for your comment. We are now extending the population range to include adults. The scope has been amended throughout to reflect this, and the expertise required on the guideline committee has been reconsidered and further recruitment is taking place.
British Infection Association	General	General	Response to additional question 2: Patients and groups that represent them frequently report that adult patients are less well served than children in relation to consistency of approach and care of the long-term effects of meningitis.	Thank you for your comment. We are now extending the population range to include adults. The scope has been amended throughout to reflect this, and the expertise required on the guideline committee has been reconsidered and further recruitment is taking place.
British Infection Association	General	General	Response to additional question 2: It is our understanding that after publication of the NICE paediatric guidelines there have been improvements in the care and management of children with meningitis and meningococcal disease.	Thank you for your comment. We are now extending the population range to include adults. The scope has been amended throughout to reflect this, and the expertise required on the guideline committee has been reconsidered and further recruitment is taking place.
British Infection Association	General	General	Response to additional question 2: The current adult guidelines are due for renewal in 2021, in line with when the NICE guidelines will be finalised.	Thank you for your comment. We are now extending the population range to include adults. The scope has been amended throughout to reflect this, and the expertise required on the guideline committee has been reconsidered and further recruitment is taking place.
British Infection Association	General	General	Response to additional question 2: Many aspects of the management of meningitis in older children and adults are the similar and advice comes from the same microbiology departments.	Thank you for your comment. We are now extending the population range to include adults. The scope has been amended throughout to reflect this, and the expertise required on the guideline committee has been reconsidered and further recruitment is taking place.
British Infection Association	General	General	Response to additional question 2: The NICE guideline is aimed at many groups who will be caring for both children and adults with meningitis and meningococcal sepsis and it is helpful to have all the guidance in one place e.g. GPs, ED physicians, microbiologists, paramedics and the ambulance service and patient advocacy groups.	Thank you for your comment. We are now extending the population range to include adults. The scope has been amended throughout to reflect this, and the expertise required on the guideline committee has been reconsidered and further recruitment is taking place.
British Infection Association	General	General	Response to additional question 2: The BIA represents clinicians who work with both adults and children who have meningitis and as such would support all the guidance being in one place.	Thank you for your comment. We are now extending the population range to include adults. The scope has been amended throughout to

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				reflect this, and the expertise required on the guideline committee has been reconsidered and further recruitment is taking place.
British Society of Neuroradiologists	General	General	The key areas in development of the guideline, in which imaging may have a role are: 2 Investigating and diagnosing suspected bacterial meningitis and meningococcal sepsis6 Long-term complications and follow-up for bacterial meningitis and meningococcal sepsis The proposed draft questions of relevance to these areas are: 2 Investigating and diagnosing suspected bacterial meningitis and meningococcal sepsis2.5 What is the effectiveness of neuro-imaging in reducing the occurrence of brain herniation following lumbar puncture? 7 Further investigation 7.1 What additional investigations should be performed in babies, children and young people with recurrent bacterial meningitis? The guidelines should include imaging recommendations where there is concern of acute complication and we should suggest that they include this as an area in which the evidence should be reviewed. If they don't set a draft question, they can't review the evidence or make recommendations in that area. There does seem to be a general lack in the scope of consideration of potential acute complications, not just with regard to imaging but clinical aspects also, and perhaps this is a whole section that they need to include – not just long term complications and follow up of recurrent meningitis.	Thank you for your comment. Complications will be discussed by the guideline committee during review protocol development. However, the assessment of acute neurological complications was not prioritised for inclusion in this guideline as they require more specialist care and apply to only a subset of the population covered in the scope.
British Society of Neuroradiologists	General	General	We recommend MRI if there is any focal neurology or clinical features of complicated meningitis and/or encephalitis. In which case we would add standard MR head with Gd. Also consider MRV if clinical concern of venous thrombosis.	Thank you for your comment. The assessment of acute neurological complications was not prioritised for inclusion in this guideline as they require more specialist care and apply to only a subset of the population covered in the scope. The scope does not attempt to cover management of all scenarios.
Group B Strep Support	003	027	Why just young people? Why not adults too since a large number of these infections will present in adults.	Thank you for your comment. We are now extending the population range to include adults. The scope has been amended throughout to reflect this, and the expertise required on the guideline committee has been reconsidered and further recruitment is taking place.

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Group B Strep Support	003	027	NICE NNI guideline covers preterm babies up to 28 days corrected age, so perhaps this should be clearer here.	Thank you for your comment. The text in Section 3.1 of the scope has now been changed to read: "… children and babies (29 days old and over, using corrected age for pre-term babies)".
Group B Strep Support	004	012	NICE NNI guideline covers preterm babies up to 28 days corrected age, so perhaps this should be clearer here.	Thank you for your comment. The text in the scope has now been changed to read: ""All babies up to 28 days old (using corrected age for pre-term babies). When updated (publication expected March 2021), the NICE guideline on neonatal infection will include recommendations for this population."
Group B Strep Support	007	013	Would risk-factors be considered too? For example, for LOGBS disease, prematurity would be is a risk factor as would the baby either him/herself having had an invasive GBS infection or his/her co-multiple.	Thank you for your comment. Risk factors will be considered and the draft questions for key issue 1 have been amended in the draft scope as follows: • 1.1: What symptoms and signs, individually or in combination (including clinical scores), and **risk factors**, are associated with an increased risk of bacterial meningitis? • 1.2: What symptoms and signs, individually or in combination (including clinical scores), and **risk factors**, are associated with an increased risk of meningococcal disease? Which risk factors to consider in the evidence review will be discussed during the development of the review protocols.
Group B Strep Support	007	016	Would risk-factors be considered too? For example, for LOGBS disease, prematurity would be is a risk factor as would the baby either him/herself having had an invasive GBS infection or his/her co-multiple.	Thank you for your comment. Risk factors will be considered and the draft questions for key issue 1 have been amended in the draft scope as follows: • 1.1: What symptoms and signs, individually or in combination (including clinical scores), and **risk factors**, are associated with an increased risk of bacterial meningitis? • 1.2: What symptoms and signs, individually or in combination (including clinical scores), and **risk factors**, are associated with an increased risk of meningococcal disease? Which risk factors to consider in the evidence review will be discussed during the development of the review protocols...

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Group B Strep Support	010	010	Plus: when should this be provided and by whom.	Thank you for your comment. The type of information and support that should be provided and by whom will be discussed in context of the identified evidence and explained in the recommendations.
Group B Strep Support	010	013	Plus: when should this be provided and by whom.	Thank you for your comment. The type of information and support that should be provided and by whom will be discussed in context of the identified evidence and explained in the recommendations.
Institute of Infection and Global Health	005	018	We note vaccines and vaccination programmes are not part of the scoping exercise, one question raise was the vaccination post an episode of meningitis.	Thank you for your comment. As you have noted, vaccinations and vaccination programmes are outside the remit of this guideline (including those likely to be administered after an episode of meningitis). Vaccinations and vaccination programmes are the remit of the Joint Committee on Vaccination and Immunisation. This guideline will cross-refer to other guidance on vaccinations and vaccination programmes where necessary.
Institute of Infection and Global Health	008	011	There is no mention of antigen detection in the CSF, has this now been superceded by molecular techniques by most laboratories? But is there a role for antigen detection techniques?	Thank you for your comment.. The list of parameters in the scope are provided as examples but is by no means exhaustive. The guideline committee will be able to consider which investigations to include during review protocol development. Note that more detail will be provided in the review protocols.
Institute of Infection and Global Health	008	028	There is mention of the role of neuroimaging in reducing the occurrence of brain herniation following a lumbar puncture, but is there a role for neuroimaging to predict those who may develop complications from meningitis including developing abscesses or hydrocephalus and thus guidance on the appropriate use of neuroimaging in ongoing management not just initial management.	Thank you for your comment. The management of complications related to meningitis were not prioritised for inclusion in the guideline.
Institute of Infection and Global Health	009	022	There is mention of assessing the non-antibiotic management of bacterial meningitis including effectiveness of intracranial pressure monitoring for example. There does not however appear to be any questions around the clinical assessment and when to call for critical care support at the start of the clinical assessment or ongoing management before mention of these critical care tasks.	Thank you for your comment. Ongoing management will be discussed further by the guideline committee with reference to NICE Clinical Guideline (CG) 50: Acutely ill adults in hospital: recognising and responding to deterioration. In addition, CG50 has been added to the list of "Related NICE Guidance" in the scope.

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Institute of Infection and Global Health	General	General	The draft scope currently excludes adults aged 18 years and over. We feel strongly that all adults should be included in the revised guidelines in light of changing epidemiology of meningitis where strain W of Neisseria meningitidis has increased and caused unusual forms of the illness in young adults and Strep pneumoniae the predominant bacterial cause of meningitis affects mainly adults. Also many of the diagnostic and management aspects will be similar across both adults and children.	Thank you for your comment. We are now extending the population range to include adults. The scope has been amended throughout to reflect this, and the expertise required on the guideline committee has been reconsidered and further recruitment is taking place.
Meningitis Now	001	007	We are concerned that to see that adults are no longer included in this scope but were part of the first version of this scope and discussed in the recent scoping workshop. No explanation has been given around the decision.	Thank you for your comment. We are now extending the population range to include adults. The scope has been amended throughout to reflect this, and the expertise required on the guideline committee has been reconsidered and further recruitment is taking place.
Meningitis Now	001	015	Definition of meningitis incorrect. Meningitis is the inflammation of the membranes that surround the brain and spinal cord. Infection is a cause of meningitis.	Thank you for your comment. The definition in the scope has been edited as follows: "Bacterial meningitis is an inflammation of the membranes that surround the brain and spinal cord, caused by bacterial infection."
Meningitis Now	001	021	There are several references to adults in this scope. If adults are no longer part of this scope, should these references be removed?	Thank you for your comment and for spotting this error. We are now extending the population range to include adults. The scope has been amended throughout to reflect this, and the expertise required on the guideline committee has been reconsidered and further recruitment is taking place.
Meningitis Now	004	004 - 012	Will the groups that are mentioned in points 4 – 12, that are not covered by other guidelines, be covered in the future e.g. viral meningitis?	Thank you for your comment. The groups mentioned in "Groups not covered in this guideline" may be considered for future topics where they are not already covered by other guidelines."
Meningitis Now	004	020	Settings covered, we would like to see NHS 111 specifically mentioned here.	Thank you for your comment. The term "remote contact" was intended to capture NHS 111 and other similar services. However, the text was changed to clarify this as follows: " includes remote contact (e.g. NHS 111) and face-to-face contact)."
Meningitis Now	004 - 005	General	Activities, services or aspects of care: we would like to see something around recovery in this section, especially in relation to information given to young people and parents. Recovery can be difficult, even if there is no evidence of significant complications.	Thank you for your comment. The guideline committee will give consideration to recovery in making its recommendation. This will also take into account the information and support valued by parents or carers of babies, children and young people.

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Meningitis Now	General	General	The term septicaemia is used in the title but in the body of the scope the term sepsis it used. Can the terminology used to be consistent? If there is a reason why these two different terms are being used, can a statement be included to explain this, otherwise we feel this will cause confusion.	Thank you for your comment. For clarity the scope now refers to meningococcal disease in the title and throughout, rather than septicaemia or sepsis. We will ensure that definitions of key terms are included in the guideline glossary.
Meningitis Research Foundation	002	014	It may be confusing that the scope refers to serogroup B and serogroup C meningococcal disease and then to “disease caused by meningitis W strains” since serogroup W meningococcal disease causes both meningitis and meningococcal septicaemia. It would be better to use consistent language.	Thank you for your comment. The text in the scope has been edited to read as follows: "… introduced in response to an increased incidence of disease caused by serogroup W)."
Meningitis Research Foundation	003	010 - 023	Under equality considerations, we agree that people from lower socio-economic and disadvantaged backgrounds should be considered because they are at higher risk of disease. It is also worth considering that people from disadvantaged backgrounds may also not be treated equally in relation to follow up care for sequelae. Meningitis Research Foundation (MRF) conducted a study with the University of Bristol (Clark LJ et al. The health, social and educational needs of children who have survived meningitis and septicaemia: the parents' perspective. BMC Public Health 2013) in which parents highlighted the difficulty they experienced navigating the system, especially for children with complex needs after meningitis as a barrier to satisfactory aftercare, and this is likely to be more of a barrier for socially disadvantaged families.	Thank you for your comment. We have noted this in the equality impact assessment and will ask the guideline committee to consider it in the context of evidence reviews on follow up care and information and support.
Meningitis Research Foundation	003	026 - 028	Including adults in the first version of the current guideline scope that was considered at the NICE scoping workshop on 30 October was an important step forward, and it is unfortunate that this is no longer the case with this more recent version of the draft scope. It was our impression from discussions at the scoping workshop that attendees were in favour of including adults.It is reassuring to see that you are specifically eliciting feedback about this issue in this comments form above. The guideline you refer to was published by the UK Joint Specialist Societies, which includes the British Infection Association and a number of other	Thank you for your comment. We are now extending the population range to include adults. The scope has been amended throughout to reflect this, and the expertise required on the guideline committee has been reconsidered and further recruitment is taking place.

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			societies including MRF. Constituent members are in favour of extending the guideline scope to adults partly because a recent audit of guideline by the National Infections Trainees Collaborative for Audit and Research (NITCAR) found that there was poor adherence to the guideline which could be compromising patient care.Excluding adults means passing up on an opportunity to improve care and welfare for the majority of people in the UK who are affected by bacterial meningitis and meningococcal septicaemia. Although the age-specific incidence of these diseases is higher in children than in adults, every year there are more cases in adults than in children (e.g. 62% of cases of meningococcal disease are in people aged >15 years), and there is evidence that disease outcomes are worse for adults (e.g Invasive meningococcal disease in England: assessing disease burden through linkage of multiple national data sources. Ladhani SN et al. BMC Infectious Diseases 2015; Effect of Pneumococcal Conjugate Vaccines on Pneumococcal Meningitis, England and Wales, July 1, 2000-June 30, 2016. Oligbu G et al. Emerg Infect Dis. 2019). MRF and other UK charities concerned with meningitis and sepsis who work with families in the aftermath of meningitis and meningococcal septicaemia have noticed that since the NICE meningitis/ meningococcal septicaemia guideline for children was published in 2010, follow up assessment and care for children after the illness seemed to improve: the existence of a guideline explaining what children were entitled to made a difference. We now very rarely hear of children being offered no hearing testing or other appointments to assess their recovery. Unfortunately, there has been no such improvement in follow up care for adults who often feel cast adrift after discharge, and there is no standard route for assessment and follow up of their sequelae.	
Meningitis Research Foundation	004	019 - 024	Settings should also include those in which assessment for the follow up of sequelae needs to take place and those in which follow up care will be offered (audiology, neurology, orthopaedics,	Thank you for your comment. All primary, secondary and tertiary healthcare settings will be considered. Community facing services such as community child health will be included where relevant.

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			plastic surgery, community child health, etc) since the scope will cover 'Long-term complications and follow-up for bacterial meningitis and meningococcal sepsis' according to page 5 line 7-8. The transition between acute and follow up care should certainly be explicitly considered.	
Meningitis Research Foundation	005 007 008	002 - 003 019 - 028 001 - 024	We agree that it is important that the guideline considers investigation, diagnosis, and the accuracy of blood and CSF investigations. The guideline should explicitly consider the timing of investigations, as there is currently no widely used rapid test enabling point of care diagnosis of meningitis. Empirical treatment is started on the basis of clinical suspicion and results from culture/PCR of blood and CSF samples are usually not available during the first 24-48 hours. While culture/PCR (in reference laboratories such as the PHE Meningococcal Reference Unit and sometimes in local laboratories) produces crucial information for decisions about whether to stop or change antibiotics, what public health action is needed as well as essential information for evaluation of vaccines, point of care diagnosis is needed to aid immediate clinical management.	Thank you for your comment. The timing of investigations will be considered in review protocol development and will be reviewed with the guideline committee during review protocol development.
Meningitis Research Foundation	005 010	007 - 008 005 - 008	We are very pleased to see that long-term complications and follow up for bacterial meningitis and meningococcal sepsis are included. However the questions asked: what is the risk of long-term complications in meningitis and meningococcal septicaemia, will not by themselves, address how best to identify patients needing follow up care, what care may be needed and in what setting, and how to ensure transition of patients from acute to follow up care. We feel that this is crucial also from an equality standpoint since we find that currently well-educated, articulate families who have the time to seek follow up care for their children/relatives are more likely to get it, and families from disadvantaged backgrounds do not know what care their children/relatives are entitled to or how to advocate for it.The guideline development group should also consider the timing and duration of follow up, in particular for babies. The 2010 NICE	Thank you for your comment. The equality issues you raise regarding access to follow up care have been added to the equality impact assessment. The guideline committee will discuss and decide on which complications are relevant during review protocol development. Where relevant, complications may be categorised e.g. type and/or timeframe. Where evidence allows and where prioritised and agreed by the committee, information regarding follow-up will be incorporated into the recommendations; for example, if the evidence suggests a complication is low risk then people might not be followed-up as often as complications where the risk is identified to be greater..

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			guideline (CG102) recommends hearing testing as soon as the patient is well enough but within 4 weeks and a follow up appointment within 6 weeks of discharge. However, children <1 year of age are insufficiently advanced developmentally for cognitive, psychological or some physical impairments due to meningitis or meningococcal septicaemia to be evident 6 weeks from discharge.Patients without long-term sequelae may also experience temporary developmental setbacks (in children), fatigue and socio-psychological symptoms which may resolve but are distressing to patients and their families. A study designed to measure quality of life of children with meningococcal disease when the illness was at its worst, and in the months immediately afterwards found that “The magnitude of QoL loss is staggering, with the reported health state being at, or close to, the worst possible outcome imaginable” Kennedy ITR et al. Short-term changes in the health state of children with group B meningococcal disease: A prospective, national cohort study. PLoS One 2017. Information for patients and their families about what to expect and how to manage in the weeks and months after discharge would be helpful.	
Meningitis Research Foundation	005 007	010 012 - 018	We agree that it is important that the guideline considers recognition of suspected bacterial meningitis and meningococcal septicaemia, and part of this requires finding out which symptoms and signs are associated with these diseases. For meningococcal disease, atypical gastro-intestinal symptoms have become more common since the expansion of a new, virulent strain of serogroup W [e.g. Campbell H et al. Presentation with gastrointestinal symptoms and high case fatality associated with group W meningococcal disease (MenW) in teenagers, England, July 2015 to January 2016. Euro Surveill. 2016.]However, only listing the symptoms and signs will not be sufficient. It would be more helpful to parents and to front-line health professionals to identify symptoms and signs according to a traffic light (red, amber, green) system. It is also important that the evidence is	Thank you for your comment. Depending on the available evidence, a "traffic light system" may be considered by the guideline committee during guideline development. In addition, Key area 1 has been amended to clarify that safety netting will be covered, as follows: "Recognising suspected bacterial meningitis and meningococcal disease, including safety netting."

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			searched in such a way as to enable clear recommendations to be made about safety-netting. A recent MRF funded study found that 30% of young infants with bacterial meningitis had inappropriate pre-hospital management which led to delays in seeking help despite the presence of clinical features of serious illness (Okike, I O, et al. Assessment of healthcare delivery in the early management of bacterial meningitis in UK young infants: an observational study. BMJ open 2017). Last year MRF surveyed parents of children who had meningitis/meningococcal septicaemia to find out about the experiences of those sent home after a first visit to a health professional and found that 103 of 134 parents who responded had been falsely reassured.	
Meningitis Research Foundation	008	025 - 029	We agree that it is important to consider which symptoms or signs (individually or in combination) are risk factors for brain herniation following lumbar puncture (LP), and the effectiveness of neuro-imaging in reducing the occurrence of brain herniation in order to make evidence-based recommendations on contraindications to LP. However it is important to consider also how timely LP can be promoted as currently, inappropriate delays in lumbar puncture (due to unnecessary CT scans or doctors' reluctance to undertake an unfamiliar and potentially risky procedure e.g. Defres S et al. Performing lumbar punctures for suspected CNS infections: experience and practice of trainee doctors. British Journal of Hospital Medicine 2015) also delay or hinder diagnosis and this could be compromising patient care, as highlighted in a recent audit of the Joint Specialist Societies adult meningitis guideline. In two recent national or multicentre studies MRF has funded (separate studies in children and adults) 30-50% of cases had no aetiology confirmed. This may not only hinder effective treatment if a patient does not respond well to empirical antibiotics, but patients lacking a confirmed diagnosis of bacterial meningitis may find it more difficult to get assessment and follow up care for impairments after their illness.	Thank you for your comment. Thank you for your comment. The guideline committee will consider these aspects during review protocol development. Note that more detail will be provided in the review protocols.

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Meningitis Research Foundation	009	022 - 029	We agree that it is important to consider the non-antibiotic management of bacterial meningitis, and that it is valuable to search for evidence on the questions listed here, but since there may be additional methods for managing raised intra-cranial pressure (RICP) in meningitis the guideline should also look for evidence on the more general question of how RICP should best be managed.	Thank you for your comment. The question "What is the effectiveness of intracranial pressure monitoring in bacterial meningitis?" has been retained and will include review of RICP management, but the question related to specialist neurosurgical management has been removed as this was deemed too specialised and was not prioritised for inclusion in the guideline. We will have neurological and intensive care expert representation on the committee management.
Meningitis Research Foundation	010	003 - 004	The current NICE guideline on bacterial meningitis and meningococcal septicaemia recommends fluid resuscitation for meningococcal septicaemia with shock using saline solutions or Human Albumin Solution. However, there is now some evidence that these fluids may be harmful (Levin M et al. Effects of saline or albumin fluid bolus in resuscitation: evidence from re-analysis of the FEAST trial. Lancet Respir Med. 2019) and we understand that hospitals are increasingly using buffered solutions such as plasmalyte. A recent Cochrane review of fluids in critically ill children and adults found no difference, but points to studies currently underway that may provide further evidence. The upcoming NICE guideline should consider this.	Thank you for your comment and for providing this information for consideration in guideline development in respect of question 5. "What is the effectiveness of fluid management in meningococcal sepsis?"
Meningitis Research Foundation	010	009 - 011	The 2010 NICE guideline (CG102) recommends testing for complement deficiency in children with recurrent meningococcal disease, and after a single episode of meningococcal disease if the child has a history of serious infections, a family history of meningococcal disease, or if the single episode is due to an unusual strain of low virulence (although serogroup W was unusual and of low virulence in 2010 and no longer is). The current scope for the new guideline focuses on additional investigations after recurrent bacterial meningitis. This should include meningococcal septicaemia. We agree that recurrent bacterial meningitis (not just meningococcal) should be within the scope. This seems to be an area in which there is variability in practice: some children's hospitals offer immunological investigation after any recurrent bacterial meningitis and some do not, and this can be confusing for families.	Thank you for your comment. The investigation of patients with recurrent bacterial infections was considered a complex area and the guideline committee will consider this during the guideline development. Recommendations will be made in context of the available evidence.

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Meningitis Research Foundation	010	012 - 018	Information and support needs exist during the acute illness, during and after recovery and may differ at these different times. Patients and their families also need clear safety netting information if they are not considered to have meningitis/septicaemia/severe illness by a health professional (see point 8), especially when the parent/patient believes that they do.	Thank you for your comment. The questions have been revised to focus on what information and support is valued by different stakeholders when concerns arise regarding the possibility of bacterial meningitis or meningococcal disease (question 8.1), and in cases of confirmed diagnosis (question 8.2).
Meningitis Research Foundation	General	General	We feel that the title should retain meningococcal septicaemia as there is evidence that the public understand this term better. However, as the term sepsis is increasingly used in the public press and is quite often used to refer to cases of meningococcal disease, a definition of terms and their overlap and how they will be used in the guideline would be helpful.	Thank you for your comment. For clarity the scope now refers to meningococcal disease in the title and throughout, rather than septicaemia or sepsis. We will ensure that definitions of key terms are included in the guideline glossary.
Meningitis Research Foundation	General	General	The draft scope is titled; Meningitis (bacterial) and meningococcal septicaemia in children and young people. However, throughout the scope the phrase “meningococcal sepsis” is used. As not all children with meningococcal disease have “sepsis” (life threatening organ dysfunction) this means the scope will not include everyone with meningococcal disease. It would be better to use the term meningococcal septicaemia and to search for evidence about meningococcal disease, to include the whole spectrum of disease in the guideline.	Thank you for your comment. For clarity the scope now refers to meningococcal disease in the title and throughout, rather than septicaemia or sepsis. We will ensure that definitions of key terms are included in the guideline glossary.
Meningitis Research Foundation	General	General	The scope should include bacterial meningitis and meningococcal septicaemia in all ages as explained in point 5, and this will in many cases mean that recommendations will need to be made separately for children and adults.	Thank you for your comment. We are now extending the population range to include adults. The scope has been amended throughout to reflect this and the expertise required on the guideline committee has been reconsidered and further recruitment is taking place. The presentation of recommendations in the guideline will be given careful consideration, to enable recommendations specifically for treatment of children and young people to be clearly distinguished from those of adults.
NHS Digital	003	017	As a Clinical Advisor at NHS Digital producing clinical content for the public it is important that we are as inclusive as possible when giving signs and symptoms information. This is particularly important with regards to how a rash may present on non-white	Thank you for your comment and the offer of contacts from NHS Digital on the issues you raise. We have already highlighted this issue within the equality impact assessment and will make sure the guideline

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			skin. Something we get quite a lot of feedback about and need to be clearer about for our users. We are currently ourselves looking into how to improve our content in this respect.Nam Nguyen The Clinical Lead for NHS.UK NHS Digital e-mailed you recently:"We are current discussing improving the BAME representation of other rashes with the British Association of Dermatologists and Primary Care Dermatology Society, and was wondering if we could be of assistance to introduce you to our current contacts there?"Please contact Nam or me if you require any assistance with this.	committee are aware of the work you are doing in the context of considering recommendations.
NHS Digital	010	013	I think it's important to retain and develop our information for Parents and carers. Recent research into the Nhs.uk website Sepsis content has told us that users/parents/carers want information about the symptoms, diagnosis and treatment of Sepsis. They want to understand more about the how to recognise the symptoms.	Thank you for your comment. The guideline committee will consider this in the context of the review protocols and evidence reviews about information and support.
Public Health England	001	015	Meningococcal septicaemia is specified in the title, but this is not defined in section 1. Both meningitis and septicaemia can trigger sepsis. Meningococcal septicaemia would be the preferred term.	Thank you for your comment. For clarity the scope now refers to meningococcal disease in the title and throughout, rather than septicaemia or sepsis. We will ensure that definitions of key terms are included in the guideline glossary.
Public Health England	005	001	'Recognising suspected bacterial meningitis and meningococcal sepsis' could this be revised to:• Recognising suspected bacterial meningitis and meningococcal septicaemia including atypical presentations	Thank you for your comment. The evidence reviews will consider which signs and symptoms are associated with an increased risk of bacterial meningitis and/or meningococcal disease. This will include both typical and atypical presentation. We don't think this needs to be specified in the key area but it will be clear in the protocols for those questions.
Public Health England	005	018	Under areas that will not be covered, referring to vaccination, it may be helpful to link to the Green Book page on the gov.uk website Immunisation against infectious disease. It may also be helpful to set out that this doesn't cover public health management of cases and their contacts which is covered by PHE Guidance for IMD.	Thank you for your comment which is noted and will be considered nearer the publication of the guideline

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Public Health England	007	019	The PHE guidance sets out the need for throat swabs in the investigation of IMD (nasopharyngeal (throat) swab for meningococcal culture (all suspected cases); a positive meningococcal swab should not be used to diagnose meningococcal disease (e.g. pneumonia). However, in PCR-confirmed cases, a positive nasopharyngeal swab culture provides important information about the infecting strain and should, therefore, be submitted to the National Reference Laboratory for additional characterisation). NICE guidance current lack of consistency with PHE guidance has created some issues and it would be helpful to include this in the scope under "2 Investigating and diagnosing suspected bacterial meningitis and meningococcal sepsis". There are detailed descriptions of the list of available tests for meningococcal disease including specimen types available from the Meningococcal Reference Unit: https://www.gov.uk/government/publications/meningococcal-reference-unit-mru-user-manual	Thank you for the comment and for providing the link to the detailed descriptions of the list of available tests for meningococcal disease. Note that more detail will be provided in the review protocols.
Public Health England	010	010	PHE guidance on public health management of invasive meningococcal disease covers the follow up of cases of recurrent IMD – perhaps this should be referenced here - 7.1 What additional investigations should be performed in babies, children and young people with recurrent bacterial meningitis?	Thank you for your comment and for the suggestion. Although there will be overlap the PHE guidance relates specifically relates to meningococcal disease rather than to bacterial meningitis. The proposed question will be discussed further by the guideline committee to decide whether the PHE guidance can be used to infer what is required for bacterial meningitis or whether the question should be retained for full review.
Public Health England	010	016	Medium to Long-term support should be highlighted under 8.2 What support is valued by patients, and by the parents or carers of babies, children and young people with suspected or confirmed bacterial meningitis or meningococcal sepsis?	Thank you for your comment. The guideline committee will consider this in the context of the review protocols and evidence reviews about information and support.
Public Health England	General	General	Our view is that the title should retain meningococcal septicaemia. Both meningitis and septicaemia can trigger sepsis. Also that meningococcal septicaemia would be the preferred term throughout.	Thank you for your comment. For clarity the scope now refers to meningococcal disease in the title and throughout, rather than septicaemia or sepsis. We will ensure that definitions of key terms are included in the guideline glossary.

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Royal College of Anaesthetists – Faculty of Intensive Care Medication	General	General	The scoping document is fine, it aligns well with the previous CG102, but clearly is brief in its structure.	Thank you for your comment and for taking the time to comment on the scope.
Royal College of General Practitioners	004	026	Can the committee consider adding clarity on safety netting advice to give to parents and carers when assessing unwell children at risk of meningitis but who do not meet the criteria for diagnosis due to the indolent way meningitis can present in the early phase of the illness.	Thank you for your comment. Key Area 1 has been amended to clarify that safety netting will be covered, as follows: "Recognising suspected bacterial meningitis and meningococcal disease, including safety netting."
Royal College of Nursing	General	General	The Royal College of Nursing (RCN) welcomes proposals to develop this guideline.	Thank you for your comment
Royal College of Nursing	General	General	The RCN is supportive of this approach.	Thank you for your comment
Royal College of Paediatrics and Child Health	005	001	Recognition of children who are at greater risk of meningitis includes certain children who are known to have a unilateral hearing loss associated with an inner ear malformation.Ref: Life threatening unilateral hearing impairments. Review of the literature on the association between inner ear malformations and meningitis.E Muzzi, S.Battelino, M Gregori, A Pellegrin, E.Orzan. International Journal of Pediatric Otolaryngology59 (2015) 1969 – 1974.	Thank you for the comment and for providing the link. The guideline committee will be considering these aspects during review protocol development. Note that more detail will be provided in the review protocols.
Royal College of Paediatrics and Child Health	005	004	Research suggests that there was a reduction in the incidence of hearing loss with meningitis when adjunctive dexamethasone was used.Ref: Meta-analysis of adjunctive dexamethasone to improve clinical outcome of bacterial meningitis in children. Wang, Ying; Liu, Xinjie; Wang, Yuzhen; Liu, Qi; Kong, Cuicui; Xu, Guixia. Child's nervous system: ChNS: official journal of the International Society for Pediatric Neurosurgery; Feb 2018; vol. 34 (no. 2); p. 217-223.	Thank you for your comment. and for providing this information..
Royal College of Paediatrics and Child Health	005	007	Sensorineural hearing loss is a well-known complication of bacterial meningitis. This may develop at any level and configuration and may also be progressive. Meningitis may also	Thank you for your comment. The guideline committee will discuss and decide on which complications are relevant during review protocol

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			result in ossification of the cochlear therefore surgically implanting a cochlear implant electrode may prove difficult. Early referral to the cochlear implant unit is therefore of great importance. Audiological assessment is recommended within 4 weeks of developing meningitis at all ages. Neonates suspected of having meningitis are excluded from the newborn hearing screen but are immediately referred for a full audiological assessment.Ref: 1. Systematic Review: Incidence and Course of Hearing Loss Caused by Bacterial Meningitis: In Search of an Optimal Timed Audiological Follow-up. Rodenburg-Vlot M.B.; Ruytjens L.; Oostenbrink R.; Goedegebure A.; van der Schroeff M.P. Otology & neurotology: official publication of the American Otological Society, American Neurotology Society [and] European Academy of Otology and Neurotology; Jan 2016; vol. 37 (no. 1); p. 1-8. 2. Repeated Audiometry After Bacterial Meningitis: Consequences for Future Management. Rodenburg-Vlot M.B.A.; Ruytjens L.; Oostenbrink R.; van der Schroeff M.P. Otology & neurotology: official publication of the American Otological Society, American Neurotology Society [and] European Academy of Otology and Neurotology; Jun 2018; vol. 39 (no. 5).3. https://www.gov.uk/government/publications/surveillance-and-audiological-referral-guidelines/guidelines-for-surveillance-and-audiological-referral-for-infants-and-children-following-newborn-hearing-screen#appendix-b-guidelines-for-audiological-follow-up-of-babies-diagnosed-with-bacterial-meningitis-andor-meningococcal-septicaemia-june-2012	development. Where relevant, complications may be categorised e.g. type and/or timeframe.
Royal College of Paediatrics and Child Health	General	General	The reviewer was happy with the draft scope.	Thank you for your comment.
Royal College of Paediatrics and Child Health	General	General	The reviewer noted that Guidance for children (up to the age of 18 years) and adults should be separate. This is because there are sometimes substantial differences in presentation signs and symptoms and management of the same condition is dependent on age. Having separate documents makes it much easier to read	Thank you for your comment. We are now extending the population to include adults. The scope has been amended throughout to reflect this. However we want to assure you that we will consider very carefully how the recommendations are presented in the guideline to enable

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			and understand the guidance without having to decipher information on which the clinician is more interested in.	recommendations specifically for treatment of children and young people to be clearly distinguished from those of adults.
Royal College of Paediatrics and Child Health	General	General	There is no mention of anyone with expertise in hearing impairment in childhood after meningitis. This could be a paediatrician, a cochlear implant surgeon or an audiovestibular physician.	Thank you for your comment. We are currently recruiting guideline committee members with a broad range of expertise and specialist interests, including paediatric development. When the guideline committee is appointed and the scope of the review questions agreed we will make sure to consider any additional expertise still needed on the committee.
Royal College of Physicians	General	General	The RCP would like to endorse the responses submitted by the Society for Acute Medicine.	Thank you for your comment.
Scottish Antimicrobial Prescribing Group	General	General	It would be helpful if the title aligned with that for the Quality Standard on Meningitis (bacterial) and meningococcal septicaemia in children and young people.	Thank you for your comment. For clarity the scope now refers to meningococcal disease in the title and throughout, rather than septicaemia or sepsis. We will ensure that definitions of key terms are included in the guideline glossary. The quality standard may be updated also once the guideline has been updated.
Scottish Antimicrobial Prescribing Group	General	General	It seems reasonable to extend to include those aged up to 18 years. This aligns with the BNF for children, which provides medicines advice for adolescents aged 12 to 18 years.	Thank you for your comment. We are now extending the population range to include adults. The scope has been amended throughout to reflect this.
Scottish Antimicrobial Prescribing Group	General	General	The BIA guidance provides evidence-based advice for adult patients and assuming that they plan to keep it updated there would be no need for inclusion of this population in the NICE guideline.	Thank you for your comment. We are now extending the population range to include adults. The BIA supports the development of a NICE guideline that covers adults. The scope has been amended throughout to reflect this, and the expertise required on the guideline committee has been reconsidered and further recruitment is taking place.
Scottish Antimicrobial Prescribing Group	General	General	The scope of the proposed guideline seems reasonable.	Thank you for your comment.
Society for Acute Medicine	General	General	The paragraphs below relate to the question of whether adult should be included in these guidelines. Based on the current plan to expand the remit to include patients aged 16-18, the answer is that they already are. Patients in this age group will be managed on adult acute admission units. If it is thought appropriate to	Thank you for your comment. We are now extending the population range to include adults. The scope has been amended throughout to reflect this, and the expertise required on the guideline committee has been reconsidered and further recruitment is taking place.

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			include these patients there does not appear to be any clinical rationale to exclude adults of an older age. It is also of concern to the Society for Acute Medicine that the proposed guideline group is made up entirely of people from the paediatric services despite including patients who will be treated by the adult services. To highlight this concern, the proposed approach is inconsistent with the age cut off used by NICE in the recent guideline Emergency and acute medical care in over 16s: service delivery and organisation (NG94). This previous guideline clearly acknowledges that patients aged 16-18 are cared for within the adult services. A rationale for the inconsistency demonstrated with the proposal for meningitis guidelines needs to be provided by NICE. Ultimately, without the inclusion of adult care providers on the committee the Society for Acute Medicine cannot support this scoping document in its current form.The more fundamental question is why adult patient aged over 18 are being excluded. It is the view of the Society for Acute Medicine that it is wrong to exclude them. In the stakeholder scoping meeting on 30th October 2019, there was no obvious indication that there was concern about adult patients being included. Indeed, the initial scoping document sent out ahead of that meeting did include all adults and pointed out that approximately half of meningitis cases occur in adults. Excluding adult patients could surely only be justified if the plan is for an independent set of guidelines to be developed or that NICE will endorse the UK joint specialist societies guidelines developed by McGill et al in 2016, which is suggested above. Including all adults was originally planned and was not opposed in the scoping meeting, some adult patients are still being included in the current planned guideline scope, and half of meningitis cases occur in adults. In terms of the evidence review process, including all adult patients may not add significantly to the workload burden because including patients aged 16-18 in paediatric guidelines as currently planned will	

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			necessitate a review of all available evidence of adult patients anyway.	
Society for Acute Medicine	General	General	“Meningococcal sepsis” should be replaced by “invasive meningococcal disease”.	Thank you for your comment. For clarity the scope now refers to meningococcal disease in the title and throughout, rather than septicaemia or sepsis. We will ensure that definitions of key terms are included in the guideline glossary.
St. Mary’s Hospital	009	022	I feel this section is incomplete. As far as I am aware there is no indication for ICP monitoring in meningitis, unless neurosurgical complications occur. Do you have a neurosurgeon on the GDG?You ask about osmotic agents, but will this include hypertonic saline as well as mannitol and what about glycerol?	Thank you for your comment. This detail will be discussed with the guideline committee as part of the development of review protocols. We are not currently recruiting for a neurosurgeon on the guideline committee. However, when the committee is appointed and agree the scope of the questions they will also consider any additional expertise required in specialist areas, including the potential need for a neurosurgeon.
St. Mary’s Hospital	Comment form questions	N/A	Q. As part of the update of this guideline NICE is considering changing the title to “Meningitis (bacterial) and meningococcal sepsis: recognition, diagnosis and management”. We would like your views on this. A. It is fine to change the title of the guideline	Thank you for your comment. For clarity the scope now refers to meningococcal disease in the title and throughout, rather than septicaemia or sepsis. We will ensure that definitions of key terms are included in the guideline glossary.
St. Mary’s Hospital	Comment form questions	N/A	Q. We are extending the age range of this guideline to include all people up to 18 years old. We would like your views on whether the age range should be extended further to cover the adult population, bearing in mind that the British Infection Association published a guideline on meningitis and meningococcal sepsis in immunocompetent adults in 2016. A. This guideline should include adults. The published guidelines have not gone through a NICE process and it would be a worthwhile opportunity to change this	Thank you for your comment. We are now extending the population range to include adults. The scope has been amended throughout to reflect this, and the expertise required on the guideline committee has been reconsidered and further recruitment is taking place.
UK Clinical Pharmacy Association	General	General	There seems to be one omission from the scope regarding lumbar punctures. The scope discusses the value of results obtained from LPs, risks and risk avoidance, and fluid drainage, etc. However, it does not seem to be explicitly looking at the timing of this LP. There is some anecdotal and audit evidence to show that we’re not doing LPs at the front door, and locally we’ve found a number of reasons for this. Personally, I feel the NICE	Thank you for your comment. The guideline committee will be considering these aspects during review protocol development. Note that more detail will be provided in the review protocols.

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			guideline needs to stress that LPs are vital, need to be done as early as possible, especially within ED (it is in the RCEM curriculum). Given that meningitis can be fatal, we should be mirroring the sentiments of the sepsis campaign, which includes blood cultures before antimicrobials. The NICE guideline for meningitis in children doesn't make this recommendation strongly enough in my opinion.	
University College London – Hospital for Tropical Diseases	003	027	The draft scope includes young people, children and babies (aged 28 days and over) with suspected 27 or confirmed bacterial meningitis or meningococcal sepsis.It should include ADULTS for the following reasons:Meningitis is affects adults as frequently as, if not more than, children.Diagnosis and management of bacterial meningitis is broadly similar and is not fundamentally different enough to warrant exclusion from this guideline. The target audience for the NICE guideline includes GPs, ED physicians, microbiologists, paramedics and the ambulance services all of whom will manage both adult and paediatric cases of meningitis.Current management of adult patients with meningitis could be improved (Poster, Federation of Infection Societies Conference, November 2019). This could be strengthened by inclusion in NICE guidance.The current Joint Societies adult guidelines are due for renewal in 2021, in line with when the NICE guidelines will be finalised	Thank you for your comment. We are now extending the population range to include adults. The scope has been amended throughout to reflect this, and the expertise required on the guideline committee has been reconsidered and further recruitment is taking place.