National Institute for Health and Clinical Excellence

Clinical guideline: Meningitis in children

PRE-PUBLICATION CHECK ERROR TABLE

Organisation	Order number	Section number in FULL guideline	Page number	ERROR REPORT	Response from developers
Royal College of Paediatrics and Child Health	1	Algorithm flow chart	2 (of the Algorithm)	This algorithm does not include duration of treatment for confirmed meningococcal disease, though the duration of treatment is included for other bacteria.	Thank you. This is not a factual accuracy issue as such, but the guideline developers have asked the NICE editor to amend the algorithm so it reflects the recommendations to use ceftriaxone for 7 days for meningococcal disease
Association of Medical Microbiologists/ British Infection Society	1	General		Thank you for allowing us to comment, I am please to see the section on signs, symptoms and initial assessmen has been reworked ,and that there is improved guidance on how to send samples such as those for PCR. I support your recommendation that there should be a seperate review for management encephalitis and viral meningitis. I support the reccomendation for more research on the best treatment of meningitis caused by cephalosporin resistant pneumococci	Thank you
Association of Medical Microbiologists/ British Infection Society	2	General		I have not detected any factual errors.	Thank you
Royal College of	1	General	General	The Royal College of Physicians is grateful for the	Thank you. This is not

Physicians				opportunity to comment. Overall, we found the guidelines extremely comprehensive and useful. We do however, have concerns about two issues: There is no mention of the situation in which the patient has pre-existing intracranial pathology. For example, they may have congenital or post surgical neurological deficit. In these patients we believe it is essential that a CT scan is done before lumbar puncture as it may be difficult to interpret any neurological signs as being old or new (and hence related to the new infection). Nowhere in the document could we find guidance on patients with previous intracranial pathology which has caused either actual, or a predisposition to, abnormal focal neurology. Secondly and similarly, we are concerned about patients who have pre-existing immunosuppressive conditions either primary such as a primary immunodeficiency or secondary such as HIV infection or chemotherapeutic bone marrow suppression. In these patients the signs of raised intracranial pressure may be more subtle and even masked. These patients also we believe should have an obligatory CT head scan before lumbar puncture is performed.	a factual accuracy issue as such. The two issues highlighted by the stakeholder relate to clinical areas that are explicitly excluded from the guideline scope
United Kingdom Clinical Pharmacy Association	1			The UKCPA would like to confirm that it does not have any comments to make on this document.	Thank you
NPSA	1	General		I am happy with the section on page 116 but should remind you that the NPSA "Evidence" is weak as it only gives information on incidents reported.	Thank you. This is not a factual accuracy issue as such, but the guideline developers have revised the GDG interpretation of the evidence in this

					section to note potential limitations of the NRLS database in that it only contains information about reported incidents
RCN	1	General		Nurses working in this area of health have reviewed this document and do not have any further comments to make at this stage. Thank you for the opportunity to participate in the development of this guideline.	Thank you