

## Meningitis (bacterial) and meningococcal disease: recognition, diagnosis and management

**[A3] Evidence review for symptoms and signs associated with meningococcal disease**

*NICE guideline number tbc*

*Evidence review underpinning recommendations 1.1.1 to 1.1.2, 1.1.5 to 1.1.9, 1.1.13, 1.1.16 to 1.1.17, and 1.2.1 to 1.2.2 in the NICE guideline*

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## Contents

<b>Symptoms and signs associated with meningococcal disease .....</b>	<b>6</b>
Review question .....	6
Introduction .....	6
Summary of the protocol .....	6
Methods and process .....	8
Diagnostic evidence .....	8
Summary of included studies.....	10
Summary of the evidence.....	17
Economic evidence .....	20
Economic model.....	20
The committee’s discussion and interpretation of the evidence .....	20
Recommendations supported by this evidence review .....	24
References – included studies.....	25
<b>Appendices.....</b>	<b>26</b>
<b>Appendix A     Review protocols .....</b>	<b>26</b>
Review protocol for review question: What symptoms and signs, individually or in combination, are associated with meningococcal disease? .....	26
<b>Appendix B     Literature search strategies .....</b>	<b>35</b>
Literature search strategies for review question: What symptoms and signs, individually or in combination, are associated with meningococcal disease? .....	35
<b>Appendix C     Diagnostic evidence study selection.....</b>	<b>42</b>
Study selection for: What symptoms and signs, individually or in combination, are associated with meningococcal disease?.....	42
<b>Appendix D     Evidence tables – Diagnostic evidence.....</b>	<b>43</b>
Evidence tables for review question: What symptoms and signs, individually or in combination, are associated with meningococcal disease? .....	43
<b>Appendix E     Forest plots .....</b>	<b>85</b>
Forest plots for review question: What symptoms and signs, individually or in combination, are associated with meningococcal disease?.....	85
<b>Appendix F GRADE table.....</b>	<b>87</b>
GRADE tables for review question: What symptoms and signs, individually or in combination, are associated with meningococcal disease? .....	87
<b>Appendix F     Economic evidence study selection.....</b>	<b>160</b>
Study selection for: What symptoms and signs, individually or in combination, are associated with meningococcal disease?.....	160
<b>Appendix G     Economic evidence tables .....</b>	<b>161</b>
Economic evidence tables for review question: What symptoms and signs, individually or in combination, are associated with meningococcal disease? .....	161
<b>Appendix H     Economic model .....</b>	<b>162</b>

	Economic model for review question: What symptoms and signs, individually or in combination, are associated with meningococcal disease? .....	162
<b>Appendix I</b>	<b>Excluded studies .....</b>	<b>163</b>
	Excluded studies for review question: What symptoms and signs, individually or in combination, are associated with meningococcal disease? .....	163
<b>Appendix J</b>	<b>Research recommendations – full details .....</b>	<b>166</b>
	Research recommendations for review question: What symptoms and signs, individually or in combination, are associated with meningococcal disease? .....	166

# 1 **Symptoms and signs associated with** 2 **meningococcal disease**

## 3 **Review question**

4 What symptoms and signs, individually or in combination, are associated with meningococcal  
5 disease?

## 6 **Introduction**

7 Meningococcal disease (meningococcal sepsis with or without an associated meningitis) is a  
8 rare but serious infection, which can occur in any age group. Meningococcal disease is a life-  
9 threatening medical emergency, which may progress with devastating speed. Early  
10 recognition of the condition requires a high index of suspicion.

11 The diagnosis of meningococcal disease is frequently hindered by the non-specific nature of  
12 the early symptoms and signs, which may mimic those found in other serious conditions or  
13 milder viral illnesses.

14 The aim of this review is to evaluate the symptoms and signs (and combinations thereof) that  
15 are useful to healthcare professionals in deciding whether meningococcal disease should be  
16 considered in the initial differential diagnosis.

## 17 **Summary of the protocol**

18 See Table 1 for a summary of the Population, Risk markers, Comparison and Outcome  
19 characteristics of this review.

1 **Table 1: Summary of the protocol**

<b>Population</b>	All adults, young people, children and babies (excluding neonates defined as aged 28 days old and younger) with suspected or confirmed meningococcal disease (excluding meningococcal meningitis alone, as this is included in the reviews on bacterial meningitis)
<b>Risk markers</b>	Any signs and symptoms, alone or in combination

<b>Comparison</b>	<p><b>Binary accuracy data</b> N/A</p> <p><b>Association data (if insufficient accuracy data)</b> Absence of sign(s)/symptom(s)</p>
<b>Outcome</b>	<p><b>Critical</b></p> <p><b>Binary accuracy data</b></p> <ul style="list-style-type: none"> <li>• Sensitivity for diagnosis of meningococcal disease*</li> <li>• Specificity for diagnosis of meningococcal disease*</li> </ul> <p><b>Association data (if insufficient accuracy data)</b></p> <ul style="list-style-type: none"> <li>• Risk ratios for diagnosis of meningococcal disease*</li> <li>• Odds ratios for diagnosis of bacterial meningococcal disease*</li> </ul> <p>* Diagnosis of meningococcal disease based on any diagnostic laboratory test for N. meningitidis</p> <p><b>Important</b> None</p>

1 *N/A: Not applicable*

2 For further details see the review protocol in appendix A.

### 3 **Methods and process**

4 This evidence review was developed using the methods and process described in  
5 [Developing NICE guidelines: the manual](#). Methods specific to this review question are  
6 described in the review protocol in appendix A and the methods document (supplementary  
7 document 1).

8 Declarations of interest were recorded according to [NICE's conflicts of interest policy](#).

### 9 **Diagnostic evidence**

#### 10 **Included studies**

11 Seven studies were included for this review, 6 single-gate, cross-sectional, diagnostic test  
12 accuracy (DTA) studies (Baker 1989, Borchsenius 1991, Close 2011, Nielsen 2001,  
13 Waterfield 2021, Wells 2001), and 1 two-gate, cross-sectional, DTA study (Haj-Hassan  
14 2011).

- 1 The included studies are summarised in Table 2.
- 2 Six studies included babies and children, and reported results for babies and children  
3 combined (Baker 1989, Close 2011, Haj-Hassan 2011, Nielsen 2001, Waterfield 2021, Wells  
4 2001), 1 study (in addition to reporting results for babies and children) reported results for an  
5 adults-only (Close 2011), and 1 study had an undefined age range and reported results for  
6 the whole sample (Borchsenius 1991).
- 7 The signs and symptoms of meningococcal disease in babies and children reported by the  
8 studies can be categorised as follows: general signs of illness and duration of illness (Baker  
9 1989, Haj-Hassan 2011, Waterfield 2021, Wells 2001); unusual, abnormal, or pale skin  
10 colour (Haj-Hassan 2011, Waterfield 2021); presence, and type and size, of rash (Close  
11 2011, Haj-Hassan 2011, Nielsen 2001, Waterfield 2021, Wells 2001); distribution and  
12 duration of rash (Baker 1989, Nielsen 2001, Waterfield 2021, Wells 2001); signs or  
13 symptoms of meningism (Baker 1989, Haj-Hassan 2011, Nielsen 2001, Waterfield 2021);  
14 reduced consciousness (Close 2011, Waterfield 2021); signs of shock (Haj-Hassan 2011,  
15 Waterfield 2021, Wells 2001); limb or body pain (Haj-Hassan 2011, Waterfield 2021); cardiac  
16 and respiratory symptoms (Haj-Hassan 2011, Nielsen 2001, Waterfield 2021);  
17 gastrointestinal symptoms and refusal of food and drink (Haj-Hassan 2011, Nielsen 2001,  
18 Waterfield 2021).
- 19 One study (Close 2011) reported presence of haemorrhagic rash and reduced  
20 consciousness as potential signs/symptoms of meningococcal disease in adults.
- 21 One study (Borchsenius 1991) reported the following signs and symptoms of meningococcal  
22 disease in an undefined age range: reduced general condition; cyanosis; petechiae ( $\leq 4$  mm);  
23 ecchymoses ( $>4$  mm); neck stiffness; reduced consciousness; cold extremities; and body  
24 pain.
- 25 One study used blood and/or cerebrospinal (CSF) culture detection for *Neisseria meningitidis*  
26 (Baker 1989) as the reference standard; 1 study used blood and/or CSF culture and/or CSF  
27 leukocyte count (Borchsenius 1991); 1 study used culture (from blood or CSF) and/or  
28 polymerase chain reaction (PCR) for *Neisseria meningitidis* (Waterfield 2021); 1 study used  
29 bacteria, bacterial antigen, bacterial or viral DNA or RNA identified in CSF, bacteria or  
30 viruses obtained from culture of CSF, and/or clinical/laboratory diagnosis of meningitis  
31 accompanied by microbiological evidence of pathogen from another site (for example, blood,  
32 throat swab, skin or faeces) (Close 2011); 1 study used blood and/or CSF and/or skin culture  
33 for *Neisseria meningitidis* and/or gram negative diplococci in CSF and/or positive PCR for  
34 meningococcal DNA from blood or CSF (Wells 2001). Two studies included both confirmed  
35 (blood and/or CSF culture detection for *Neisseria meningitidis*) and probable (clinical  
36 diagnosis without culture confirmation) cases, although the majority (79% and 74%  
37 respectively) were confirmed through microbiological techniques (Haj-Hassan 2011, Nielsen  
38 2001).
- 39 For the 1 two-gate study the comparison group included children presenting in primary care  
40 with minor febrile infection (Haj-Hassan 2011). For 3 (of the 6 single-gate) studies, the  
41 comparison group were those negative for meningococcal disease (Borchsenius 1991,  
42 Waterfield 2021, Wells 2001). For 2 of these studies (Waterfield 2021, Wells 2001) no further  
43 details were provided about those negative for meningococcal disease; in the remaining  
44 study (Borchsenius 1991) the negative for meningococcal disease group included people  
45 with bacterial meningitis or septicaemia with causes other than *Neisseria meningitidis*, other  
46 bacterial infections and viral infections. One study compared those with documented invasive  
47 bacterial disease to those with nonbacteremic disease including those with viral meningitis  
48 (Baker 1989), and 1 study compared those with a confirmed or probable diagnosis of  
49 meningococcal disease with those with no invasive bacterial disease (Nielsen 2001). For 1  
50 study, the comparison group was those with viral meningitis (Close 2011).

- 1 Signs and symptoms were identified or reported by healthcare professionals in 6 studies  
2 (Baker 1989, Borchsenius 1991, Close 2011, Nielsen 2001, Waterfield 2021, Wells 2001),  
3 and by a non-healthcare professional (a parent) in 1 study (Haj-Hassan 2011).  
4 See the literature search strategy in appendix B and study selection flow chart in appendix C.

## 5 Excluded studies

- 6 Studies not included in this review are listed, and reasons for their exclusion are provided in  
7 appendix J.

## 8 Summary of included studies

- 9 Summaries of the studies that were included in this review are presented in Table 2.

10 **Table 2: Summary of included studies**

Study	Population	Index test(s)	Reference standard(s)	Outcomes	Comments
Baker 1989  Single-gate, cross-sectional DTA study  US	N=54  People aged <21 years with fever >38°C and petechial rash  Invasive bacterial disease group (n=15): Median age 41 months (range 6 months to 15 years).  Nonbacteremic disease group (n=39): Median age 45 months (range 3 months to 11 years)	Signs and symptoms taken from medical records: <ul style="list-style-type: none"> <li>• Ill appearance</li> <li>• Signs of meningeal irritation</li> <li>• Petechiae above the nipple line (including the head and upper extremities)</li> <li>• Petechiae on the trunk below the nipple line</li> <li>• Petechiae on the lower extremities</li> </ul>	Meningococcal disease was diagnosed by detection of <i>N. meningitidis</i> on blood or CSF culture.	<ul style="list-style-type: none"> <li>• Sensitivity</li> <li>• Specificity</li> </ul>	40% of MD population is indirect (27% with meningococcal meningitis alone and 13% with meningitis with other causes).  Comparison group includes those with viral meningitis but only 5% of this group.
Borchsenius 1991  Single-gate, cross-sectional DTA study  Norway	N=120  People admitted to hospital with suspected systemic meningococcal disease (those with meningococcal meningitis only (n=56) are included in the review on signs and	Signs and symptoms recorded by healthcare professional on the day of admission to hospital: <ul style="list-style-type: none"> <li>• Petechiae (≤4mm)</li> <li>• Reduced general condition</li> <li>• Ecchymoses</li> </ul>	Method of diagnosing meningococcal disease was reported for the whole MD group only (including those with meningitis alone): Meningococcal disease confirmed with growth of meningococci	<ul style="list-style-type: none"> <li>• Sensitivity</li> <li>• Specificity</li> </ul>	Data was not reported for clinical symptoms that were non-significant (presence of convulsions, back rigidity, headache, nausea, chills, fever, diarrhoea, irritability, systolic blood pressure <100, heart rate ≥120,

Study	Population	Index test(s)	Reference standard(s)	Outcomes	Comments
	<p>symptoms of bacterial meningitis).</p> <p>Meningococcal disease (n=59): Age reported for whole MD group only (including those with meningitis alone): 50% aged &lt; 12 years.</p> <p>No meningococcal disease (n=61): 79% aged &lt; 12 years.</p>	<p>(cutaneous haemorrhages &gt;4 mm</p> <ul style="list-style-type: none"> <li>• Reduced consciousness</li> <li>• Cold extremities</li> <li>• Cyanosis</li> <li>• Neck stiffness</li> <li>• Body pain</li> </ul>	<p>in blood and/or CSF (for 62%), or the diagnosis of meningococcal disease was based on the clinical picture, meningococcal antigen in CSF, or growth of N. meningitidis in pharyngeal swab specimens (for 38%)</p>		<p>rectal temperature ≥40.0)</p>
<p>Close 2011</p> <p>Single-gate, cross-sectional DTA study</p> <p>UK</p>	<p>N=385</p> <p>Confirmed case of bacterial or viral meningitis, or meningococcal septicaemia</p> <p>Babies/children subgroup (aged 19 years or younger) n=230</p> <p>Bacterial meningitis/meningococcal septicaemia (n=191):</p> <p>Age: Mean/median not reported</p> <p>Sex: male: 96 (50%); female: 95 (50%)</p> <p>Viral meningitis (n=39):</p> <p>Age: Mean/median not reported</p> <p>Sex: male: 23</p>	<p>Signs and symptoms, recorded by healthcare professionals on the study data collection forms:</p> <ul style="list-style-type: none"> <li>• Haemorrhagic rash</li> <li>• Level of consciousness (unresponsive)</li> </ul>	<p>Confirmed cases defined as those with any one of the following: bacteria, bacterial antigen, bacterial or viral DNA or RNA identified in cerebrospinal fluid (CSF); bacteria or viruses obtained from culture of CSF; clinical and/or laboratory diagnosis of meningitis accompanied by microbiological evidence of pathogen from another site for example, blood, throat swab, skin or faeces</p>	<ul style="list-style-type: none"> <li>• Sensitivity</li> <li>• Specificity</li> </ul>	<p>Population may be indirect. Unclear how many people have meningitis only (however, only 80% had N. meningitidis as the cause)</p>

Study	Population	Index test(s)	Reference standard(s)	Outcomes	Comments
	<p>(59%); female: 16 (41%)</p> <p>Adult subgroup (aged &gt;19 years) n=155</p> <p>Bacterial meningitis/meningococcal septicaemia (n=102):</p> <p>Age: Mean/median not reported</p> <p>Sex: male: 48 (47%); female: 54 (53%)</p> <p>Viral meningitis (n=53):</p> <p>Age: Mean/median not reported</p> <p>Sex: male: 22 (42%); female: 31 (58%)</p>				
<p>Haj-Hassan 2011</p> <p>Two-gate, cross-sectional DTA study</p> <p>UK</p>	<p>N=752</p> <p>Children aged &lt;16 years with non-fatal MD compared with children with minor febrile infection (presenting in primary care with any acute infection where fever was present [based on parental report])</p> <p>Non-fatal MD (n=345):</p> <p>Age in months: Mean/median not reported; 28% &lt;1 year, 45% 1-4 years, 28% 5-14 years</p> <p>Sex: male 188 (55%); female: 157 (46%)</p>	<p>Signs and symptoms as indicated in parent-reported questionnaire (symptoms in questionnaire based on those included in the meningococcal disease dataset [Thompson 2006] and non-specific symptoms common to childhood illnesses):</p> <ul style="list-style-type: none"> <li>• Irritable or miserable</li> <li>• Pale colour</li> <li>• Rash or new spots on the skin</li> <li>• Cold hands or feet</li> <li>• Neck pain or</li> </ul>	<p>Confirmed and probable cases based on clinical record review (blind to final outcome) by an expert panel of consultants in paediatric emergency medicine, infectious disease, and intensive care. The majority of cases (79%) were confirmed through microbiological techniques</p>	<ul style="list-style-type: none"> <li>• Sensitivity</li> <li>• Specificity</li> </ul>	<p>N=103 fatal MD cases reported in previous dataset (Thompson 2006) but not included in the comparison with minor febrile infection.</p> <p>Data not extracted for fever or high temperature as this was an inclusion criterion.</p>

Study	Population	Index test(s)	Reference standard(s)	Outcomes	Comments
	Minor febrile infection (n=407): Age in months (median; interquartile range (IQR) in parentheses): 42 (22–79); 10% <1 year, 52% 1-4 years, 38% 5-14 years Sex: male: 209 (51%); female: 198 (49%)	<ul style="list-style-type: none"> <li>stiffness</li> <li>• Photophobia</li> <li>• Headache</li> <li>• Nausea or vomiting</li> <li>• Diarrhoea</li> <li>• Tummy pain</li> <li>• Difficult or laboured breathing</li> <li>• Cough</li> <li>• Sore throat</li> <li>• Feeling drowsy or very sleepy</li> <li>• Confusion</li> <li>• Refusing food or feeds</li> <li>• Leg pain</li> <li>• General aching</li> </ul>			
Nielsen 2001  Single-gate, cross-sectional DTA study  Denmark	<p>N=208 analysed</p> <p>Babies and children aged 1 month to 16 years with skin haemorrhages detected at admission/during hospital stay and rectal temperature &gt;38°C within the 24 hours before inclusion.</p> <p>Meningococcal disease (n=39): Confirmed case n=29 (median age 30 months); probable case n=10 (median age 14 months).</p> <p>No invasive bacterial disease</p>	<p>Signs and symptoms, recorded by healthcare professionals on pre-printed study forms and including information from the case history and a standardized physical examination:</p> <ul style="list-style-type: none"> <li>• Case history included coughing prior to inclusion</li> <li>• Case history included vomiting prior to inclusion</li> <li>• Nuchal rigidity</li> <li>• More than 20 skin haemorrhages</li> <li>• Skin haemorrhages with</li> </ul>	<p>Confirmed case defined as clinical diagnosis of meningitis or septicaemia confirmed by culture of <i>Neisseria meningitidis</i> from blood and/or spinal fluid.</p> <p>Probable case defined as clinical diagnosis of meningitis or septicaemia without culture confirmation, but defined by a significant increase in meningococcal antibody titres, or a high antibody titre in a single serum sample drawn during the 2nd or 3rd</p>	<ul style="list-style-type: none"> <li>• Sensitivity</li> <li>• Specificity</li> </ul>	<p>Excluded from analysis: N=6: invasive bacterial infection excluding meningococcal disease; N=50 insufficient information (received antibiotics prior to, or in the absence of, blood culture).</p>

Study	Population	Index test(s)	Reference standard(s)	Outcomes	Comments
	(n=169): Enterovirus infection n=18 (median age 21 months); adenovirus infection n=11 (median age 22 months); no invasive bacterial disease (either no bacteria in cultures from blood or spinal fluid and no antibiotic treatment prior to culture; or no blood culture, but spontaneous recovery) n=140 (median age 27 months).	<p>maximum diameter &gt;1mm</p> <ul style="list-style-type: none"> <li>• Skin haemorrhages with maximum diameter &gt;2mm</li> <li>• Universal distribution of skin haemorrhages</li> </ul>	week after onset of disease, and/or demonstration of serogroup A or C meningococcal capsular polysaccharide in the acute serum sample by CIEP		
Waterfield 2021  Single-gate, cross-sectional DTA study  UK	<p>N=1329</p> <p>Children (aged under 18 years) presenting to paediatric emergency department with fever (<math>\geq 38^{\circ}\text{C}</math>), new-onset non-blanching rash or features suggestive of meningococcal infection.</p> <p>Meningococcal disease (n=19): Median age 37 months (IQR 9-58)</p> <p>No meningococcal disease (n=1310): Median age 24 months (IQR 12-48)</p>	<p>Signs and symptoms, identified by healthcare professionals and recorded prospectively on an electronic case report form:</p> <ul style="list-style-type: none"> <li>• Duration of illness (&lt;24 hours)</li> <li>• Duration of rash (&lt;4 hours)</li> <li>• Petechiae without purpura</li> <li>• Purpura</li> <li>• SVC distribution of rash</li> <li>• Spreading rash</li> <li>• Unwell appearance (based on an overall assessment)</li> </ul>	Diagnosis based on a positive culture or PCR test for N. meningitidis or other bacterial pathogen from a sterile body site (for example, blood or CSF)	<ul style="list-style-type: none"> <li>• Sensitivity</li> <li>• Specificity</li> </ul>	

Study	Population	Index test(s)	Reference standard(s)	Outcomes	Comments
		<p>of appearance)</p> <ul style="list-style-type: none"> <li>• Signs of shock (defined as clinician-diagnosed shock, a long capillary refill time of 4 seconds or more, or hypotension )</li> <li>• Tachycardia</li> <li>• Tachypnoea</li> <li>• Gastrointestinal symptoms (abdominal pain, abdominal distension, diarrhoea, or nausea or vomiting)</li> <li>• Shivers or chills</li> <li>• Pallor</li> <li>• Unusual skin colour</li> <li>• Cold hands or feet</li> <li>• Respiratory symptoms</li> <li>• Sore throat or coryza</li> <li>• Lethargy</li> <li>• Refusal of food and drink</li> <li>• Limb pain</li> <li>• Signs or symptoms of meningism (a positive Brudzinski's and Kernig's sign, a bulging fontanelle, irritability, photophobia , neck</li> </ul>			

Study	Population	Index test(s)	Reference standard(s)	Outcomes	Comments
		stiffness, and headache) • Reduced consciousness			
Wells 2001  Single-gate, cross-sectional DTA study  UK	N=218  Children aged ≤15 years presenting to an A&E department with a non-blanching rash  Age in months (median): 24; 55% <3 years  Meningococcal disease (n=24): Serogroup of N. meningitidis: B n=12 (50%); C n=11 (46%); unknown n=1 (4%)  Negative for MD (n=194): No further details reported	Signs and symptoms data collected on standard proforma by the paediatric medical team at the time of presentation: • Illness categorisation (defined as toxic, irritable and crying inconsolably, or lethargic) • Purpuric rash (lesions >2 mm in diameter) • Rash distribution beyond the SVC • Fever >38.5°C • Fever >37.5°C • Hypotension (defined as 2 SD or more below the mean for age) • Delayed capillary refill (defined as >2 seconds)	Meningococcal infection defined using a positive blood, CSF, or skin culture for N. meningitidis, Gram negative diplococci in CSF, or PCR for meningococcal DNA from blood or CSF	• Sensitivity • Specificity	Method of diagnosis used in confirmed cases: Positive blood culture alone (n=5; 21%); Positive PCR alone (n=9; 37.5%); Positive PCR and blood culture (n=9; 37.5%); Positive PCR, blood culture, and CSF (n=1; 4%)

1 A&E: accident and emergency; CIEP: counterimmunoelectrophoresis; CSF: cerebrospinal fluid; DTA: diagnostic test accuracy; IQR: interquartile range; MD: meningococcal disease; N. Meningitidis: Neisseria Meningitidis; PCR: positive polymerase chain reaction; SD: standard deviation; SVC: superior vena cava

4 See the full evidence tables in appendix D and the forest plots in appendix E.

## 1 **Summary of the evidence**

2 This section is a narrative summary of the findings of the review, as presented in the GRADE  
3 tables in appendix F. For details of the committee's confidence in the evidence and how this  
4 affected recommendations, see The committee's discussion and interpretation of the  
5 evidence.

6 The evidence was assessed as being high to very low quality. Downgrading of the evidence  
7 was due to risk of bias, imprecision (95% confidence intervals crossing decision making  
8 thresholds), and indirectness. No meta-analyses were conducted for any of the index tests  
9 due to insufficient evidence after stratifying for age, person identifying the sign/symptom  
10 (healthcare professional or non-healthcare professional) and the comparison group. For the  
11 majority of index tests the evidence came from single studies and all index tests were  
12 individual signs and symptoms (no multivariate analysis). See the GRADE tables in appendix  
13 F for the certainty of the evidence for each individual outcome.

14 For interpreting the sensitivity and specificity estimates, the following rules of thumb were  
15 used (as outlined in the review protocol in Appendix A): sensitivity/specificity estimates of at  
16 least 90% were considered as very sensitive/specific; at least 50% as moderately  
17 sensitive/specific; and less than 50% as not sensitive/specific.

18 None of the signs or symptoms examined were both very sensitive and very specific for a  
19 diagnosis of meningococcal disease.

## 20 **Signs and symptoms of meningococcal disease in babies and children**

### 21 ***General signs of illness and duration of illness***

22 There was evidence that the following signs or symptoms were both moderately specific and  
23 moderately sensitive for a diagnosis of meningococcal disease in babies and children:  
24 duration of illness of less than 24 hours; a fever defined as a temperature over 38.5°C or  
25 37.5°C; lethargy; drowsiness.

26 The evidence for illness categorisation or appearance was somewhat mixed, with studies  
27 that included a comparator group of undefined non-meningococcal disease showing  
28 moderate specificity and moderate sensitivity, and a study with a nonbacteremic disease  
29 comparator group (including those with viral meningitis) showing high specificity but non-  
30 significant sensitivity.

31 Shivers or chills, and confusion, were very specific, but not sensitive, for a diagnosis of  
32 meningococcal disease in babies and children.

33 Being considered irritable or miserable was a moderately sensitive symptom of  
34 meningococcal disease, however, was not specific.

### 35 ***Unusual, abnormal, or pale skin colour***

36 There was some evidence that pale skin colour was a moderately to highly specific, but not  
37 sensitive, sign of meningococcal disease in babies and children. Unusual skin colour was  
38 also very specific, but not sensitive.

### 39 ***Presence, and type and size, of rash***

40 There was some evidence that the presence of any rash, and the presence of a  
41 haemorrhagic rash, were both moderately specific and moderately sensitive for a diagnosis  
42 of meningococcal disease in babies and children. There was also some evidence that the  
43 presence of skin haemorrhages with a maximum diameter over 1mm was moderately  
44 specific and very sensitive.

1 The presence of purpura (lesions over 2mm) was a very specific and moderately sensitive  
2 sign of meningococcal disease in babies and children.

3 The presence of petechiae only (without purpura) was neither sensitive nor specific for a  
4 diagnosis of meningococcal disease in babies and children.

#### 5 ***Distribution and duration of rash***

6 There was evidence that the following signs associated with the distribution of the rash were  
7 both moderately specific and moderately sensitive for a diagnosis of meningococcal disease  
8 in babies and children: the presence of a spreading rash; petechiae on the trunk below the  
9 nipple line; petechiae on the lower extremities. Universal distribution of skin haemorrhages  
10 was also a moderately specific, but very sensitive, sign of meningococcal disease.

11 There was some evidence that rash distribution limited to the superior vena cava (SVC) was  
12 moderately specific, but not sensitive, for a diagnosis of meningococcal disease in babies  
13 and children. While, rash distribution beyond the SVC was very sensitive but not specific.

14 The presence of more than 20 skin haemorrhages, the presence of petechiae above the  
15 nipple line (including the head and upper extremities), and the duration from the onset of the  
16 rash of under 4 hours, were all moderately sensitive but not specific signs of a diagnosis of  
17 meningococcal disease in babies and children.

#### 18 ***Signs or symptoms of meningism***

19 There was some evidence that a composite clinical factor of signs or symptoms of  
20 meningism was moderately to highly specific, but not sensitive, for a diagnosis of  
21 meningococcal disease in babies and children.

22 Neck pain or stiffness, and photophobia, were both very specific but not sensitive symptoms  
23 of meningococcal disease in babies and children.

24 Headache was moderately specific, but also not sensitive.

#### 25 ***Reduced consciousness***

26 There was evidence for reduced consciousness as a very specific symptom of  
27 meningococcal disease in babies and children. Reduced consciousness was also moderately  
28 sensitive with a comparator group of undefined non-meningococcal disease, but was not  
29 sensitive with a viral meningitis comparator group.

#### 30 ***Signs of shock***

31 A composite factor of signs of shock (defined as clinician-diagnosed shock, a long capillary  
32 refill time of 4 seconds or more, or hypotension) was very specific and moderately sensitive  
33 for a diagnosis of meningococcal disease in babies and children. Hypotension (defined as 2  
34 standard deviations or more below the mean for age) was also a very specific sign, but was  
35 not sensitive.

36 Delayed capillary refill (defined as over 2 seconds) was both moderately specific and  
37 moderately sensitive for a diagnosis of meningococcal disease in babies and children. Cold  
38 hands or feet was moderately to very specific, but not sensitive.

#### 39 ***Limb or body pain***

40 There was evidence for limb pain as a very specific, but not sensitive, symptom of  
41 meningococcal disease in babies and children. General aching was moderately specific, and  
42 also not sensitive, for a diagnosis of meningococcal disease.

1 **Cardiac and respiratory symptoms**

2 Tachycardia and tachypnoea were both moderately specific and moderately sensitive for a  
3 diagnosis of meningococcal disease in babies and children.

4 There was some evidence that respiratory symptoms, and difficult or laboured breathing,  
5 were moderately specific but not sensitive for a diagnosis of meningococcal disease in  
6 babies and children.

7 The evidence for sore throat and cough were somewhat mixed. Sore throat was moderately  
8 specific but not sensitive, however, a composite factor of sore throat or coryza was neither  
9 sensitive nor specific. There was some evidence for the presence of a cough as moderately  
10 specific but not sensitive in a study with healthcare professional identification of  
11 signs/symptoms. While another study that used non-healthcare (parental) identification of  
12 signs/symptoms showed the presence of a cough as neither sensitive nor specific for a  
13 diagnosis of meningococcal disease.

14 **Gastrointestinal symptoms and food refusal**

15 There was some evidence for nausea or vomiting as moderately specific for a diagnosis of  
16 meningococcal disease in babies and children. This symptom was also shown to be  
17 moderately sensitive with non-healthcare (parental) identification of signs/symptoms, but not  
18 sensitive with healthcare professional identification of signs/symptoms.

19 There was also some evidence for food refusal as a moderately specific symptom of  
20 meningococcal disease, although estimates of sensitivity ranged from moderate to not  
21 sensitive.

22 Gastrointestinal symptoms, diarrhoea, and tummy pain were all moderately specific but not  
23 sensitive for a diagnosis of meningococcal disease in babies and children.

24 **Signs and symptoms of meningococcal disease in adults**

25 There was some evidence for the presence of a haemorrhagic rash and reduced  
26 consciousness, as very specific but not sensitive for a diagnosis of meningococcal disease  
27 (compared to viral meningitis) in adults.

28 **Signs and symptoms of meningococcal disease in an undefined age range**

29 There was some evidence that the following symptoms were moderately specific but not  
30 sensitive for a diagnosis of meningococcal disease in an undefined age range: reduced  
31 general condition; neck stiffness; reduced consciousness; body pain.

32 Cyanosis and cold extremities were both very specific, but not sensitive, signs of  
33 meningococcal disease in an undefined age range.

34 The presence of petechiae (lesions with a maximum diameter up to 4 mm) was both  
35 moderately specific and moderately sensitive for a diagnosis of meningococcal disease in an  
36 undefined age range. Ecchymoses (over 4 mm) were also moderately specific, but were not  
37 sensitive.

38 See appendix F for full GRADE tables.

1 **Economic evidence**

2 **Included studies**

3 A single economic search was undertaken for all topics included in the scope of this  
4 guideline, but no economic studies were identified which were applicable to this review  
5 question.

6 **Economic model**

7 No economic modelling was undertaken for this review because the committee agreed that  
8 other topics were higher priorities for economic evaluation. This was because this review  
9 does not involve a comparison of competing courses of action.

10 **The committee's discussion and interpretation of the evidence**

11 **The outcomes that matter most**

12 The objective of this review was to assess the diagnostic accuracy of signs and symptoms  
13 (index tests) to determine if a person presenting in the community or to hospital has  
14 meningococcal disease. The reference standard was a confirmed diagnosis of  
15 meningococcal disease based on diagnostic laboratory tests for *N. meningitidis*. The  
16 committee considered the impact of true positives (correctly identifying meningococcal  
17 disease and starting the appropriate management), true negatives (being able to provide  
18 reassurance that the person does not have meningococcal disease), false positives  
19 (potentially starting unnecessary treatments) and false negatives (failing to identify people  
20 that require further interventions and intensive management). The committee agreed that  
21 both sensitivity and specificity were important. Sensitivity was important as failing to identify  
22 meningococcal disease could lead to treatment being delayed until the condition worsens  
23 with potentially serious implications (including death). Specificity was important, particularly  
24 when considering signs and symptoms that might lead a clinician to *strongly* suspect  
25 meningococcal disease, as the misdiagnosis of meningococcal disease would result in the  
26 initiation of inappropriate treatment.

27 **The quality of the evidence**

28 The quality of the evidence ranged from high to very low and evidence was typically  
29 downgraded due to risk of bias (for example, due to the index tests being interpreted with  
30 knowledge of the results of the reference standard, and potential for risk of bias and/or  
31 concerns about applicability with regards to patient selection) and imprecision (95%  
32 confidence intervals crossing decision making thresholds).

33 Evidence was found for: general signs of illness and duration of illness; unusual, abnormal,  
34 or pale skin colour; presence of haemorrhagic rash; type and size of rash; distribution and  
35 duration of rash; signs or symptoms of meningism; reduced consciousness; signs of shock;  
36 limb or body pain; cardiac and respiratory symptoms; gastrointestinal symptoms and refusal  
37 of food and drink.

38 No meta-analyses were conducted for any of the index tests due to insufficient evidence after  
39 stratifying for age, person identifying the sign/symptom (healthcare professional or non-  
40 healthcare professional) and the comparison group.

41 **Benefits and harms**

42 The committee noted that all the evidence was based on individual signs and symptoms and  
43 agreed that none of these signs or symptoms alone would be sufficient to make a diagnosis  
44 of meningococcal disease. The committee considered the evidence for sensitivity and

1 specificity of the individual signs and symptoms in this review and drew on their clinical  
2 knowledge and expertise to define combinations of signs and symptoms that might increase  
3 suspicion that a person has meningococcal disease.

4 The committee emphasised that meningococcal disease is a rapidly evolving condition and  
5 can be difficult to distinguish from other infections with similar signs and symptoms, and  
6 included a recommendation that healthcare professionals should be aware of this and not  
7 use individual signs and symptoms to rule meningococcal disease in or out. The committee  
8 also highlighted the importance that healthcare professionals are aware that bacterial  
9 meningitis and meningococcal disease can occur at the same time, particularly in people with  
10 a rash, and included this in the recommendations. Based on their clinical knowledge and  
11 experience, the committee highlighted that meningococcal disease can present with non-  
12 specific symptoms and signs particularly in young babies and older adults, and included this  
13 in the recommendation to raise awareness.

14 The committee considered evidence showing that the presence of a haemorrhagic, non-  
15 blanching rash with lesions larger than 2 mm (purpura) was moderately to highly specific and  
16 moderately sensitive, and the presence of a spreading rash was moderately specific and  
17 moderately sensitive, for a diagnosis of meningococcal disease. There was also evidence  
18 that a number of features of meningitis (including neck pain or stiffness, photophobia, and a  
19 composite clinical factor of signs or symptoms of meningism) were moderately or highly  
20 specific (but not sensitive) for a diagnosis of meningococcal disease, however, most of this  
21 evidence included a non-sepsis and non-meningitis comparison group. The committee  
22 agreed that in order to differentiate meningococcal disease from meningitis, signs or  
23 symptoms of meningism would need to be combined with a non-blanching rash to raise the  
24 index of suspicion for meningococcal disease. Based on their clinical knowledge and  
25 experience, and the evidence for the individual signs and symptoms, the committee agreed  
26 that the presence of purpura, a rapidly progressive and/or spreading non-blanching rash, and  
27 any symptom or sign of bacterial meningitis when combined with a non-blanching rash,  
28 should be considered as red flag symptoms for meningococcal disease.

29 Based on their clinical experience, the committee noted that sometimes rashes can be  
30 difficult to detect and recommended that clinicians look all over the body to check for a rash  
31 (including nappy areas for babies). The committee also noted that healthcare professionals  
32 may need to check the conjunctivae (the membranes lining the inside of the eyelids and  
33 covering the eyeballs) when checking for petechiae. The committee highlighted that rashes  
34 can be harder to detect on brown, black or tanned skin, and included this in the  
35 recommendation to raise awareness of the need to consider this during examination. The  
36 rapidly evolving nature of meningococcal disease also means that a rash can change from  
37 blanching to non-blanching, and based on their clinical knowledge and experience, the  
38 committee recommended that patients, parents and carers were made aware of this and  
39 asked to look out for any changes.

40 The committee highlighted that although non-blanching rashes are classically associated  
41 with meningococcal disease and the association is supported by the evidence in this review,  
42 not everyone with proven meningococcal disease has a rash. Based on their clinical  
43 knowledge and experience, the committee included a recommendation that absence of a  
44 rash should not be used to rule out a diagnosis of meningococcal disease.

45 The committee noted that while people with meningococcal disease may present in the  
46 community or to hospital with 1 or more of the red flag symptoms (presence of purpura, a  
47 rapidly spreading non-blanching rash, and/or any sign or symptom of bacterial meningitis  
48 when combined with a non-blanching rash), some people present with non-specific  
49 symptoms and signs (with none of the red flag symptoms). The committee emphasised that  
50 meningococcal disease can be strongly suspected based on clinical assessment even in  
51 people with none of the red flag symptoms. Based on their clinical knowledge and  
52 experience, the evidence in this review, and other relevant NICE guidance ([Sepsis:](#)

1 [recognition, diagnosis and early management](#) and [Fever in under 5s: assessment and initial](#)  
2 [management](#)) the committee identified a number of non-specific signs and symptoms  
3 associated with serious illness that might also be indicators of meningococcal disease.

4 There was some evidence in this review that pale or unusual skin colour (including cyanosis)  
5 were moderately to highly specific, but not sensitive, signs of meningococcal disease. This is  
6 consistent with evidence reviewed in the NICE Fever in under 5s guideline that identified  
7 pale/mottled/ashen/blue skin, lips or tongue as a high-risk clinical feature of severe illness.  
8 Considering this evidence, together with their clinical experience, the committee agreed to  
9 include this feature in the table of non-specific features that may support the diagnosis of  
10 meningococcal disease, maintaining consistent terminology with the NICE Fever in under 5s  
11 guideline. As with detecting the presence of a rash, the committee noted that skin changes  
12 may be difficult to see in people with darker skin, and included this in the notes section of the  
13 table to increase awareness for the healthcare professional who is undertaking the physical  
14 examination.

15 The committee considered evidence for appearing ill, or being categorised as ill, and overall  
16 studies showed moderate specificity and moderate sensitivity for meningococcal disease.  
17 The committee agreed that appearing ill to a healthcare professional may support the  
18 diagnosis of meningococcal disease but would not distinguish meningococcal disease from  
19 other severe illness and included this clinical feature in the table as a non-specific symptom.

20 There was no specific evidence that quantified the diagnostic accuracy of parental or carer  
21 concern, although some studies included in the evidence review relied on parental report of  
22 signs and symptoms. The committee took into account the lack of any definitive 'index tests'  
23 for meningococcal disease (none of the signs or symptoms examined were both very  
24 sensitive and very specific) and the rapidly evolving nature of the condition and based on  
25 consensus added parent or carer concern to the table of features that may support a  
26 diagnosis of meningococcal disease. This was highlighted as particularly important as  
27 changes to appearance or general signs of illness can be subtle, particularly to people that  
28 are not familiar with the patient's usual state.

29 Another non-specific clinical feature that the committee agreed may support the diagnosis of  
30 meningococcal disease but that was also important to interpret in the context of a person's  
31 normal function was altered mental state. The evidence reviewed showed that reduced  
32 consciousness, confusion, lethargy and drowsiness were at least moderately specific for a  
33 diagnosis of meningococcal disease, although there was more variability in the sensitivity  
34 estimates. There was also some evidence that being considered irritable or miserable was a  
35 moderately sensitive (but not specific) symptom of meningococcal disease. There was some  
36 evidence that objective measures of new or altered mental state, including assessing the  
37 level of consciousness with the Alert, Voice, Pain, Unresponsive (AVPU) scale and/or  
38 Glasgow Coma Scale (GCS), was very specific for a diagnosis of meningococcal disease.  
39 However, in other studies the method of assessing altered mental state was unclear, and the  
40 committee highlighted based on their clinical experience that changes can be subtle.  
41 Drawing on their expertise and the evidence reviewed the committee agreed that altered  
42 behaviour, particularly being unusually aggressive or subdued, can be associated with  
43 meningococcal disease, and highlighted that meningococcal disease can be missed because  
44 delirium may be assumed to be due to cognitive impairment in older adults, whereas altered  
45 behaviour may be attributed to alcohol or substance misuse (rather than meningococcal  
46 disease) in young people and young adults. The committee considered the evidence  
47 reviewed for the NICE Fever in under 5s guideline, and the recommendations that the  
48 guideline makes for the assessment of behaviour such as response to social cues, not  
49 waking easily and type of cry, and based on consensus opinion included no response to  
50 social cues, lethargy, does not wake or if roused does not stay awake, and weak, high-  
51 pitched or continuous cry as clinical features that may support a diagnosis of meningococcal  
52 disease.

- 1 There was some evidence that presence of fever was both moderately specific and  
2 moderately sensitive for a diagnosis of meningococcal disease, when the threshold was  
3 defined as a temperature of over 37.5°C and with a threshold over 38.5°C. The evidence  
4 included was from children aged up to 15 years, however, the age range, mean or median  
5 age of included participants is not reported. Based on their clinical knowledge and  
6 experience, the committee reflected that very high temperature is unusual in young children  
7 and can often be indicative of bacterial infection. The committee considered the evidence  
8 and recommendations in the NICE Fever in under 5s guideline, and agreed to include  
9 consistent thresholds for fever, with a temperature of 39°C or higher potentially supporting a  
10 diagnosis of meningococcal disease in children aged 3 to 6 months, and a temperature of  
11 38°C or higher raising the index of suspicion for children younger than 3 months. Based on  
12 their clinical knowledge, the committee also highlighted that hypothermia can indicate  
13 infection, and included a temperature of less than 36°C as a non-specific feature that may  
14 support the diagnosis of meningococcal disease.
- 15 There was some evidence that tachypnoea (raised respiratory rate) was both moderately  
16 specific and moderately sensitive for a diagnosis of meningococcal disease. There was no  
17 evidence for specific rates for different age bands, but the recommendation highlighted that it  
18 was important to use an age-specific threshold for defining raised respiratory rate. There was  
19 also some evidence that respiratory symptoms, and difficult or laboured breathing, were  
20 moderately specific but not sensitive. The NICE Fever in under 5s guideline included  
21 grunting in their risk stratification and based on their clinical experience and consideration of  
22 the evidence in that guideline, the committee agreed to include grunting as a specific  
23 respiratory symptom that may support the diagnosis of meningococcal disease.
- 24 The committee considered evidence showing that cold hands and/or feet was a moderately  
25 to highly specific, but not sensitive, sign of meningococcal disease. Based on their clinical  
26 knowledge and experience, the committee also noted that cold extremities may be present in  
27 the early stages of the illness and agreed that this clinical feature should be included as a  
28 non-specific sign that might support the diagnosis of meningococcal disease.
- 29 There was some evidence that tachycardia (raised heart rate) was both moderately specific  
30 and moderately sensitive for a diagnosis of meningococcal disease. Based on their clinical  
31 knowledge and experience, the committee were also aware that bradycardia (slow heart  
32 rate) could be an indicator of severe illness. The committee agreed that both high age-  
33 specific heart rate and low heart rate defined as less than 60 beats per minute for babies and  
34 children under 12 years should be included in the table of non-specific signs that may  
35 support a diagnosis of meningococcal disease.
- 36 There was some evidence that hypotension (low blood pressure) was very specific, but not  
37 sensitive, for a diagnosis of meningococcal disease. Based on this evidence, and their  
38 clinical knowledge and experience, the committee agreed that low age-specific blood  
39 pressure should be included in the recommendation, as a clinical feature that may support a  
40 diagnosis of meningococcal disease.
- 41 The committee considered evidence showing that delayed capillary refill time (defined as  
42 over 2 seconds) was both a moderately specific and moderately sensitive sign of  
43 meningococcal disease. There was also evidence showing that a composite factor of signs of  
44 shock (defined as clinician-diagnosed shock, a long capillary refill time of 4 seconds or more,  
45 or hypotension) was very specific and moderately sensitive for a diagnosis of meningococcal  
46 disease. The committee agreed that a capillary refill time of 3 seconds or longer should be  
47 included in the table of non-specific signs that may support a diagnosis of meningococcal  
48 disease.
- 49 The committee highlighted that although prolonged capillary refill time and abnormal  
50 respiratory pattern may be more specific individual signs of dehydration, reduced urine  
51 output is commonly reported as a marker of dehydration. No evidence specific to this review  
52 was identified. However, the committee considered the evidence and recommendations in

1 the NICE Sepsis guideline that included reduced urine output as a high to moderate risk  
2 criterion, and agreed to include this in the table as a clinical feature that may support a  
3 diagnosis of meningococcal disease.

4 There was some evidence for limb pain as a very specific symptom of meningococcal  
5 disease, and some evidence showing general aching to be moderately specific, both  
6 symptoms were not sensitive for a diagnosis of meningococcal disease. The committee  
7 considered the evidence and recommendations in the NICE Sepsis guideline that included  
8 leg pain to indicate high to moderate risk in children with suspected sepsis. The committee  
9 noted that leg pain may be an indicator of reduced perfusion (in addition to prolonged  
10 capillary refill time and cold extremities) and agreed that leg pain should be included as a  
11 potential non-specific symptom of meningococcal disease.

12 There was some evidence for gastrointestinal symptoms, diarrhoea, and tummy pain as  
13 moderately specific but not sensitive for a diagnosis of meningococcal disease, and the  
14 committee agreed to include abdominal pain and diarrhoea in the recommendation.

15 Given the potentially serious implications of a delay to treatment (including death), the  
16 committee agreed based on expert clinical consensus that people with suspected  
17 meningococcal disease should be transferred to hospital as an emergency, and the hospital  
18 should be alerted and informed that an assessment by a senior clinical decision maker will  
19 be required.

20 The committee agreed that it was also important to provide safety netting for people returning  
21 home after clinical assessment for meningococcal disease. Based on their clinical knowledge  
22 and experience and considering the rapidly evolving nature of meningococcal disease, the  
23 committee agreed that a safety netting arrangement should be considered, and people  
24 should be told what to do if they develop new symptoms, if a rash changes from blanching to  
25 non-blanching, or if existing symptoms or signs get worse (namely, return to the GP or ring  
26 NHS 111 or 999). The committee also wanted to raise awareness that although a person  
27 might not have meningococcal disease, they may have another serious condition. The  
28 committee specifically wanted to highlight other forms of sepsis and pneumonia, but also  
29 intracranial bleed or ischaemia that is often overlooked, as potential alternative diagnoses.

### 30 **Cost effectiveness and resource use**

31 This review question did not consider decisions between competing alternatives and  
32 therefore is not directly relevant to the tools of economic evaluation. The recommendations  
33 primarily provide advice to health care professionals on the recognition and diagnosis of  
34 bacterial meningitis rather than specific courses of action. However, the committee  
35 considered that early and correct identification of meningococcal disease was a prerequisite  
36 of cost-effective management. They also reflected that the recommendations largely  
37 reinforce current best practice and knowledge and therefore they did not believe they would  
38 have a significant resource impact.

### 39 **Recommendations supported by this evidence review**

40 This evidence review supports recommendations 1.1.1 to 1.1.2, 1.1.5 to 1.1.9, 1.1.13, 1.1.16  
41 to 1.1.17, and 1.2.1 to 1.2.2. Other evidence supporting these recommendations can be  
42 found in the evidence review on symptoms and signs associated with bacterial meningitis  
43 [A1].

## 1 **References – included studies**

### 2 **Diagnostic**

#### 3 **Baker 1989**

4 Baker, R.C., Seguin, J.H., Leslie, N., Gilchrist, M.J., Myers, M.G., Fever and petechiae in  
5 children, *Pediatrics*, 84, 1051-1055, 1989

#### 6 **Borchsenius 1991**

7 Borchsenius, F., Bruun, J.N., Tonjum, T., Systemic meningococcal disease: the diagnosis on  
8 admission to hospital, *NIPH Annals*, 14, 11-22, 1991

#### 9 **Close 2011**

10 Close, R.M., Ejidokun, O.O., Verlander, N.Q., Fraser, G., Meltzer, M., Rehman, Y., Muir, P.,  
11 Ninis, N., Stuart, J.M., Early diagnosis model for meningitis supports public health decision  
12 making, *Journal of Infection*, 63, 32-38, 2011

#### 13 **Haj-Hassan 2011**

14 Haj-Hassan, T.A., Thompson, M.J., Mayon-White, R.T., Ninis, N., Harnden, A., Smith, L.F.,  
15 Perera, R., Mant, D.C., Which early 'red flag' symptoms identify children with meningococcal  
16 disease in primary care?, *British Journal of General Practice*, 61, e97-e104, 2011

#### 17 **Nielsen 2001**

18 Nielsen, H.E., Andersen, E.A., Andersen, J., Böttiger, B., Christiansen, K.M., Daugbjerg, P.,  
19 Larsen, S.O., Lind, I., Nir, M., Olofsson, K., Diagnostic assessment of haemorrhagic rash and  
20 fever, *Archives of Disease in Childhood*, 85, 160-165, 2001

#### 21 **Waterfield 2021**

22 Waterfield, T., Maney, J.A., Fairley, D., Lyttle, M.D., McKenna, J.P., Roland, D., Corr, M.,  
23 McFetridge, L., Mitchell, H., Woolfall, K., Lynn, F., Validating clinical practice guidelines for  
24 the management of children with non-blanching rashes in the UK (PiC): a prospective,  
25 multicentre cohort study, *Lancet Infectious Diseases*, 21, 569-577, 2021

#### 26 **Wells 2001**

27 Wells, L.C., Smith, J.C., Weston, V.C., Collier, J., Rutter, N., The child with a non-blanching  
28 rash: how likely is meningococcal disease?, *Archives of Disease in Childhood*, 85, 218-222,  
29 2001

### 30 **Economic**

31 No studies were identified which were applicable to this review question.

32

# 1 Appendices

## 2 Appendix A Review protocols

### 3 Review protocol for review question: What symptoms and signs, individually or in combination, are associated with 4 meningococcal disease?

5 **Table 3: Review protocol**

Field	Content
PROSPERO registration number	CRD42021245982
Review title	Symptoms and signs associated with meningococcal disease
Review question	What symptoms and signs, individually or in combination, are associated with meningococcal disease?
Objective	To determine the signs and symptoms (individually or in combination) that are associated with meningococcal disease.
Searches	The following databases will be searched: Embase MEDLINE Cochrane Central Register of Controlled Trials (CENTRAL) Cochrane Database of Systematic Reviews (CDSR) Searches will be restricted by: Date limitations: No date limit English language Human studies The full search strategies for MEDLINE database will be published in the final review. For each search, the principal database search strategy is quality assured by a second information scientist using an adaptation of the PRESS 2015 Guideline Evidence-Based Checklist.
Condition or domain being studied	Meningococcal disease
Population	Inclusion: All adults, young people, children and babies (excluding neonates defined as aged 28 days

Field	Content
	<p>old and younger) with suspected or confirmed meningococcal disease (excluding meningococcal meningitis alone, as this is included in the reviews on bacterial meningitis).</p> <p>Exclusion: People:</p> <ul style="list-style-type: none"> <li>• with known immunodeficiency.</li> <li>• who have brain tumours, pre-existing hydrocephalus, intracranial shunts, previous neurosurgical procedures, or known cranial or spinal anomalies that increase the risk of bacterial meningitis.</li> </ul>
Risk markers	Any signs and symptoms, alone or in combination
Comparator/Reference standard/Confounding factors for prognostic estimates	<p>1. Binary accuracy data: N/A</p> <p>2. Association data (if insufficient accuracy data): Absence of sign(s)/symptom(s)</p>
Types of study to be included	<p>1. Binary accuracy data</p> <ul style="list-style-type: none"> <li>• Systematic reviews of cross-sectional diagnostic accuracy studies.</li> <li>• Individual cross-sectional diagnostic accuracy studies.</li> </ul> <p>Studies with prospective and retrospective data collection will be included. Two-gate studies will only be included if there are insufficient single-gate studies for a given sign, symptom or combination)</p> <p>Conference abstracts will not be considered.</p> <p>2. Association data (if insufficient accuracy data for a given sign, symptom or combination)</p> <ul style="list-style-type: none"> <li>• Systematic reviews</li> <li>• Prospective cohort studies with multivariate analyses</li> <li>• If insufficient prospective cohort studies: retrospective cohort studies with multivariate analyses</li> </ul> <p>Studies with univariate analyses will only be included if there are insufficient studies with multivariate</p>

Field	Content
	<p>analyses for a given sign, symptom or combination.</p> <p>Non-randomised studies will be downgraded for risk of bias if they do not adequately adjust for the following covariates, but will not be excluded for this reason: age (if not possible to stratify)</p> <p>Conference abstracts will not be considered.</p>
Other exclusion criteria	<p>Countries other than OECD high income countries</p> <p>Studies published not in English-language</p>
Context	<p>This guidance will fully update the following: Meningitis (bacterial) and meningococcal septicaemia in under 16s: recognition, diagnosis and management (CG102)</p>
Primary outcomes (critical outcomes)	<p>1. Binary accuracy data</p> <ul style="list-style-type: none"> <li>• Sensitivity for diagnosis of meningococcal disease*</li> <li>• Specificity for diagnosis of meningococcal disease*</li> </ul> <p>2. Association data (if insufficient accuracy data)</p> <ul style="list-style-type: none"> <li>• Risk ratios for diagnosis of meningococcal disease*</li> <li>• Odds ratios for diagnosis of bacterial meningococcal disease*</li> </ul> <p>* Diagnosis of meningococcal disease based on any diagnostic laboratory test for <i>N. meningitidis</i>.</p>
Secondary outcomes (important outcomes)	N/A
Data extraction (selection and coding)	<p>All references identified by the searches and from other sources will be uploaded into STAR and de-duplicated. Titles and abstracts of the retrieved citations will be screened to identify studies that potentially meet the inclusion criteria outlined in the review protocol. 5% of the abstracts will be reviewed by two reviewers, with any disagreements resolved by discussion or, if necessary, a third independent reviewer. Full versions of the selected studies will be obtained for assessment. Studies that fail to meet the inclusion criteria once the full version has been checked will be excluded at this stage. Each study excluded after checking the full version will be listed, along with the reason for its exclusion. A standardised form will be used to extract data from studies. The following data will be extracted: study details (reference, country where study was carried out, type and dates), participant characteristics, inclusion and exclusion criteria, details of the signs and symptoms, setting and follow-</p>

Field	Content
	<p>up, relevant outcome data and source of funding. One reviewer will extract relevant data into a standardised form, and this will be quality assessed by a senior reviewer.</p>
<p>Risk of bias (quality) assessment</p>	<p>Quality assessment of individual studies will be performed using the following checklist:</p> <ul style="list-style-type: none"> <li>• ROBIS tool for systematic reviews</li> <li>• QUADAS-2 tool for diagnostic test accuracy studies</li> <li>• Quality in Prognostic Studies (QUIPS) tool for prognostic studies</li> </ul> <p>The quality assessment will be performed by one reviewer and this will be quality assessed by a senior reviewer.</p>
<p>Strategy for data synthesis</p>	<p><b>Binary accuracy data</b></p> <p>Where data is available from two or more studies for the same parameter and is sufficiently consistent, meta-analysis of diagnostic test accuracy will be performed using the metandi and midas applications in STATA/winbugs and Cochrane Review Manager software.</p> <p>Sensitivity and specificity with 95% CIs will be used as outcomes for diagnostic test accuracy. These diagnostic accuracy parameters will be obtained from the studies or calculated by the technical team using data from the studies.</p> <p><b>Association data</b></p> <p>Quantitative findings will be formally summarised in the review. Where multiple studies report on the same factor and the definitions used and approach to analysis in the primary papers is sufficiently consistent, meta-analyses will be conducted using Cochrane Review Manager software. A fixed effect meta-analysis will be conducted and data will be presented as risk ratios if possible or odds ratios when required (for example if only available in this form in included studies). Heterogeneity in the effect estimates of the individual studies will be assessed by visual inspection of the forest plots and consideration of the I<sup>2</sup> statistic. Heterogeneity will be explored as appropriate using sensitivity analyses and pre-specified subgroup analyses. If heterogeneity cannot be explained through subgroup analysis then a random effects model will be used for meta-analysis, or the data will not be pooled if the random effects model does not adequately address heterogeneity.</p> <p>The confidence in the findings across all available evidence will be evaluated for each outcome using an adaptation of the ‘Grading of Recommendations Assessment, Development and Evaluation</p>

Field	Content
	<p>(GRADE) toolbox' developed by the international GRADE working group: <a href="http://www.gradeworkinggroup.org/">http://www.gradeworkinggroup.org/</a></p> <p><b>Minimally important differences:</b> <b>Decision making thresholds (for binary accuracy data)</b></p> <ul style="list-style-type: none"> <li>• Sensitivity: <ul style="list-style-type: none"> <li>○ Very useful test: ≥90%</li> <li>○ Moderately useful test: ≥50%</li> <li>○ Not a useful test &lt;50%</li> </ul> </li> <li>• Specificity: <ul style="list-style-type: none"> <li>○ Very useful test: ≥90%</li> <li>○ Moderately useful test: ≥50%</li> <li>○ Not a useful test &lt;50%</li> </ul> </li> </ul> <p><b>Minimally important differences (for association data)</b></p> <ul style="list-style-type: none"> <li>○ Strong association: &lt;0.5 and &gt;2.00</li> <li>○ Moderate association: &lt;0.80 and &gt;1.25</li> <li>○ Small association: any statistically significant association</li> <li>○ No association: no statistically significant association</li> </ul>
Analysis of sub-groups	<p><b>Evidence will be stratified by:</b> <b>Stratifications:</b></p> <ul style="list-style-type: none"> <li>• Population that do not receive a diagnosis of meningococcal disease: <ul style="list-style-type: none"> <li>○ Non-meningococcal sepsis</li> <li>○ Meningitis</li> <li>○ Absence of sepsis and meningitis</li> </ul> </li> <li>• Person identifying signs/symptoms: <ul style="list-style-type: none"> <li>○ Healthcare professionals</li> <li>○ Non-healthcare professionals</li> </ul> </li> <li>• Age: <ul style="list-style-type: none"> <li>○ Younger Infants: &gt;28 days to ≤3 months of age</li> </ul> </li> </ul>

Field	Content	
	<ul style="list-style-type: none"> <li>○ Older infants: &gt;3 months to &lt;1 year of age</li> <li>○ Children: ≥1 year to &lt;18* years of age</li> <li>○ Adults: ≥18* years of age</li> </ul> <p>*There is variation in clinical practice regarding the treatment of 16 to 18 year olds. Therefore, we will be guided by cut-offs used in the evidence when determining if 16 to 18 year olds should be treated as adults or children.</p> <p>Evidence will be subgrouped by the following only in the event that there is significant heterogeneity in outcomes:</p> <ul style="list-style-type: none"> <li>● Age: <ul style="list-style-type: none"> <li>○ Young and middle aged adults</li> <li>○ Older adults*</li> </ul> </li> <li>● Population that do receive a diagnosis of meningococcal disease: <ul style="list-style-type: none"> <li>○ Non-specific meningococcal disease</li> <li>○ Meningococcal disease excluding meningitis alone</li> </ul> </li> </ul> <p>*There is variation regarding the age at which adults should be considered older adults. Therefore, we will be guided by cut-offs used in the evidence when determining this threshold.</p> <p>Where evidence is stratified or subgrouped the committee will consider on a case by case basis if separate recommendations should be made for distinct groups. Separate recommendations may be made where there is evidence of a differential effect of interventions in distinct groups. If there is a lack of evidence in one group, the committee will consider, based on their experience, whether it is reasonable to extrapolate and assume the interventions will have similar effects in that group compared with others.</p>	
Type and method of review	<input type="checkbox"/>	Intervention
	<input checked="" type="checkbox"/>	Diagnostic
	<input checked="" type="checkbox"/>	Prognostic

Field	Content		
	<input type="checkbox"/>	Qualitative	
	<input type="checkbox"/>	Epidemiologic	
	<input type="checkbox"/>	Service Delivery	
	<input type="checkbox"/>	Other (please specify)	
Language	English		
Country	England		
Anticipated or actual start date	11/03/2021		
Anticipated completion date	07/12/2023		
Stage of review at time of this submission	Review stage	Started	Completed
	Preliminary searches	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
	Piloting of the study selection process	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
	Formal screening of search results against eligibility criteria	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
	Data extraction	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
	Risk of bias (quality) assessment	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
	Data analysis	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Named contact	Named contact: National Guideline Alliance		
	Named contact e-mail: meningitis&meningococcal @nice.org.uk		
	Organisational affiliation of the review: National Institute for Health and Care Excellence (NICE) and National Guideline Alliance		
Review team members	National Guideline Alliance		
Funding sources/sponsor	This systematic review is being completed by the National Guideline Alliance which receives funding from NICE.		

Field	Content
Conflicts of interest	All guideline committee members and anyone who has direct input into NICE guidelines (including the evidence review team and expert witnesses) must declare any potential conflicts of interest in line with NICE's code of practice for declaring and dealing with conflicts of interest. Any relevant interests, or changes to interests, will also be declared publicly at the start of each guideline committee meeting. Before each meeting, any potential conflicts of interest will be considered by the guideline committee Chair and a senior member of the development team. Any decisions to exclude a person from all or part of a meeting will be documented. Any changes to a member's declaration of interests will be recorded in the minutes of the meeting. Declarations of interests will be published with the final guideline.
Collaborators	Development of this systematic review will be overseen by an advisory committee who will use the review to inform the development of evidence-based recommendations in line with section 3 of <a href="#">Developing NICE guidelines: the manual</a> . Members of the guideline committee are available on the NICE website: <a href="https://www.nice.org.uk/guidance/indevelopment/gid-ng10149">https://www.nice.org.uk/guidance/indevelopment/gid-ng10149</a> .
Other registration details	None
Reference/URL for published protocol	<a href="#">CRD42021245982</a>
Dissemination plans	NICE may use a range of different methods to raise awareness of the guideline. These include standard approaches such as: <ul style="list-style-type: none"> <li>• notifying registered stakeholders of publication</li> <li>• publicising the guideline through NICE's newsletter and alerts</li> <li>• issuing a press release or briefing as appropriate, posting news articles on the NICE website, using social media channels, and publicising the guideline within NICE</li> </ul>
Keywords	Prognostic, diagnostic, meningococcal disease, signs and symptoms, risk factors, systematic review
Details of existing review of same topic by same authors	None
Current review status	<input type="checkbox"/> Ongoing <input type="checkbox"/> Completed but not published <input type="checkbox"/> Completed and published <input type="checkbox"/> Completed, published and being updated <input type="checkbox"/> Discontinued

Field	Content
Additional information	None
Details of final publication	<a href="http://www.nice.org.uk">www.nice.org.uk</a>

- 1 *CDSR: Cochrane Database of Systematic Reviews; CENTRAL: Cochrane Central Register of Controlled Trials; GRADE: Grading of Recommendations Assessment,*  
2 *Development and Evaluation; MID: minimally important difference; NICE: National Institute for Health and Care Excellence; OECD: Organisation for Economic Co-operation*  
3 *and Development; PRESS: Peer Review of Electronic Search Strategies; QUADAS: quality assessment of diagnostic accuracy studies; QUIPS: Quality in Prognostic Studies;*  
4 *ROBIS: Risk of Bias in Systematic Reviews; SD: standard deviation*  
5

# 1 Appendix B Literature search strategies

## 2 Literature search strategies for review question: What symptoms and signs, 3 individually or in combination, are associated with meningococcal disease? 4

### 5 Clinical Search 6

7 This was a combined search to cover both this review and the reviews on risk factors  
8 associated with meningococcal disease and signs, symptoms and risk factors associated  
9 with bacterial meningitis.  
10

### 11 Database(s): Medline & Embase (Multifile) – OVID interface

12 **Embase Classic+Embase** 1947 to 2022 November 07, **Ovid MEDLINE(R) ALL** 1946 to  
13 November 07, 2022

14 Date of last search: 08 November 2022

15 *Multifile database codes: emczd = Embase Classic+Embase; medall = Ovid MEDLINE(R) ALL*

#	Searches
1	Meningitis/ or Meningitis, Bacterial/ or Meningitis, Escherichia Coli/ or Meningitis, Haemophilus/ or Meningitis, Listeria/ or Meningitis, Meningococcal/ or Meningitis, Pneumococcal/ or Meningoencephalitis/
2	1 use medall
3	meningitis/ or bacterial meningitis/ or haemophilus meningitis/ or hemophilus influenzae meningitis/ or listeria meningitis/ or meningococcal meningitis/ or pneumococcal meningitis/ or meningoencephalitis/
4	3 use emczd
5	((bacter* or infect*) adj3 (meningit* or meninges* or leptomeninges* or subarachnoid space?)).ti,ab.
6	(meningit* adj3 (e coli or escherichia coli or h?emophilus or hib or h?emophilus influenz* or h influenz* or listeria* or meningococc* or pneumococc* or gram-negativ* bacill* or gram negativ* bacill* or streptococc* or group B streptococc* or GBS or streptococcus pneumon* or s pneumon* or septic* or sepsis* or bacter?emi?)).ti,ab.
7	((e coli or escherichia coli or h?emophilus or hib or h?emophilus influenz* or h influenz* or listeria* or meningococc* or pneumococc* or gram-negativ* bacill* or gram negativ* bacill* or streptococc* or group B streptococc* or GBS or streptococcus pneumon* or s pneumon*) adj3 (septic* or sepsis* or bacter?emi?)).ti,ab.
8	(meningit* or mening?encephalitis* or mening* encephalitis*).ti,ab.
9	Meningococcal Infections/ or exp Neisseria meningitidis/
10	9 use medall
11	Meningococcosis/ or Meningococcemia/ or Neisseria Meningitidis/
12	11 use emczd
13	(meningococc* adj3 (sepsis* or septic* or toxic* or endotoxic* or disease? or infection?)).ti,ab.
14	(meningococcus* or meningococci* or meningococc?emi?).ti,ab.
15	(Neisseria* mening* or n mening*).ti,ab.
16	or/2,4-8,10,12-15
17	"Signs and Symptoms"/ or Fever/ or Vomiting/ or Nausea/ or Diarrhea/ or Chills/ or Shivering/ or Sleepiness/ or Headache/ or Photophobia/ or Intracranial Pressure/ or exp Consciousness Disorders/ or *Coma/ or Seizures/ or Seizures, Febrile/ or Irritable Mood/ or Crying/ or Decerebrate State/ or Lethargy/ or Fatigue/ or Confusion/ or Malnutrition/ or exp Purpura/ or Muscle Hypotonia/ or exp Tachycardia/
18	17 use medall
19	*physical disease by body function/ or *fever/ or *vomiting/ or *nausea/ or *diarrhea/ or *chill/ or *shivering/ or *somnolence/ or *headache/ or *photophobia/ or *intracranial pressure/ or exp *consciousness disorder/ or *coma/ or *seizure/ or *febrile convulsion/ or *irritability/ or *crying/ or *decerebration/ or *lethargy/ or *fatigue/ or *confusion/ or *malnutrition/ or exp *purpura/ or *muscle hypotonia/ or exp *tachycardia/
20	19 use emczd
21	((head or cranial or intracranial) adj3 pain*).ti,ab.
22	((stiff* or rigid*) adj3 (neck* or nuchal or cervical or spine or spinal)).ti,ab.
23	(light adj3 (intoleran* or sensitiv*)).ti,ab.
24	((tense or bulge or bulging or full*) adj3 fontanelle?).ti,ab.
25	((raise? or rise or high or elevat*) adj3 intracranial pressure?).ti,ab.
26	((level? or decreas*) adj3 consciousness).ti,ab.
27	(irritab* or petulan* or bad mood or moody).ti,ab.
28	((symphyseal or cheek) adj3 sign?).ti,ab.
29	(abnormal adj3 postur*).ti,ab.
30	(muscle? adj3 (atonic or flaccid*)).ti,ab.
31	((decreas* or alter* or chang*) adj3 (conscious* or mental state?)).ti,ab.
32	((hemorrhagic or haemorrhagic) adj3 rash).ti,ab.
33	(capillar* adj2 refill*).ti,ab.
34	((cold or clammy or temperature) adj3 (hand? or feet or extremities)).ti,ab.
35	((limb? or extremities or arms or legs) adj3 pain*).ti,ab.
36	((mottled or mottling) adj3 (skin or epidermal)).ti,ab.
37	((elevated or rapid* or fast*) adj3 (heart?beat or heart rate)).ti,ab.
38	(sign? or symptom* or complain*).ti,ab.

#	Searches
39	(clinical adj3 (manifestation* or feature* or finding* or aspect*)).ti,ab.
40	(present* adj3 (feature* or finding* or factor*)).ti,ab. or presentation*.ti.
41	(physical* adj3 (manifest* or characteristic* or featur* or finding*)).ti,ab.
42	or/18,20-41
43	exp "SENSITIVITY AND SPECIFICITY"/ or Likelihood Functions/ or Diagnostic Test Routine/ or Differential Diagnosis/
44	43 use medall
45	"sensitivity and specificity"/ or statistical model/ or differential diagnosis/ or *diagnostic accuracy/ or diagnostic test accuracy study/
46	45 use emczd
47	Prognosis/
48	(sensitivity or specificity).ti,ab.
49	((pre test or pretest or post test or posttest) adj probability).ti,ab.
50	((predict* adj3 (value* or factor*)) or (PPV or NPV)).ti,ab.
51	likelihood ratio*.ti,ab.
52	(ROC curve* or AUC).ti,ab.
53	diagnos*.ti.
54	((diagnos* adj2 (performance* or accurac* or utilit* or value* or efficien* or effectiveness)) or (accurat* adj5 diagnos*)).ti,ab.
55	gold standard.ab.
56	di.fs.
57	or/44,46-56
58	Obstetric Labor, Premature/ or Premature Birth/ or Infant, Premature/ or Fetal Membranes, Premature Rupture/ or Ear, Inner/ or exp Smoking/ or Tobacco Smoke Pollution/ or Cochlear Implants/ or Spleen/ or Splenectomy/ or *Socioeconomic Factors/ or Environment/ or Crowding/ or exp Otitis Media/ or exp Sinusitis/ or exp Pneumonia/ or Mastoiditis/ or Cochlear Implantation/ or Streptococcal Infections/
59	58 use medall
60	*premature labor/ or *prematurity/ or *premature fetus membrane rupture/ or *inner ear/ or exp *smoking/ or *passive smoking/ or *cochlea prosthesis/ or *spleen/ or *splenectomy/ or *socioeconomics/ or *environment/ or "crowding (area)"/ or exp *otitis media/ or exp *sinusitis/ or exp *pneumonia/ or *mastoiditis/ or *cochlear implantation/ or *streptococcus infection/
61	60 use emczd
62	((preterm* or pre-term* or premature*) adj10 (birth* or born* or deliver* or labour* or labor* or infant* or newborn* or new-born* or neonate* or neo-nate* or baby or babies or child or children)).ti,ab.
63	((premature* or prolong*) adj2 rupture*).ti,ab.
64	(inner adj ear).ti,ab.
65	smok*.ti,ab.
66	(cochlea* adj2 implant*).ti,ab.
67	((spleen* or splen*) adj3 (impair* or dysfunc* or absen* or non-function* or nonfunction*)).ti,ab.
68	splenectom*.ti,ab.
69	asplenia.ti,ab.
70	((crowd* or over-crowd* or overcrowd*) adj3 (environment* or place* or premise* or house* or household* or venue* or condition* or living or setting* or transport* or sleep* or room*)).ti,ab.
71	((partial or incomplet*) adj2 immuni*).ti,ab.
72	((vaccin* or immuni*) adj coverage*).ti,ab.
73	(contiguous* adj (spread or foci)).ti,ab.
74	(contiguous adj3 infection*).ti,ab.
75	(otitis media* or sinusitis* or pneumonia* or mastoiditis*).ti,ab.
76	(streptococc* adj (infect* or diseas*)).ti,ab.
77	or/59,61-76
78	Risk/ or Risk Factors/
79	78 use medall
80	*risk/ or *risk factor/
81	80 use emczd
82	risk?.ti.
83	risk factor?.ab.
84	or/79,81-83
85	16 and 77 and 84
86	16 and 42 and 57
87	16 and 42 and 84
88	**Signs and Symptoms"/ use medall
89	*physical disease by body function/ use emczd
90	(signs adj2 symptom*).ti,ab.
91	or/88-90
92	16 and 91
93	85 or 86 or 87 or 92
94	limit 93 to English language [General Exclusions filter applied]

1

2 Database(s): Cochrane Library – Wiley interface

1 **Cochrane Database of Systematic Reviews**, Issue 11 of 12, November 2022, **Cochrane**  
2 **Central Register of Controlled Trials**, Issue 11 of 12, November 2022  
3 Date of last search: 08 November 2022

#	Searches
#1	MeSH descriptor: [Meningitis] this term only
#2	MeSH descriptor: [Meningitis, Bacterial] this term only
#3	MeSH descriptor: [Meningitis, Escherichia coli] this term only
#4	MeSH descriptor: [Meningitis, Haemophilus] this term only
#5	MeSH descriptor: [Meningitis, Listeria] this term only
#6	MeSH descriptor: [Meningitis, Meningococcal] this term only
#7	MeSH descriptor: [Meningitis, Pneumococcal] this term only
#8	MeSH descriptor: [Meningoencephalitis] this term only
#9	MeSH descriptor: [Neisseria meningitidis] explode all trees
#10	((bacter* or infect*) near/3 (mening* or leptomening* or subarachnoid space*)):ti,ab,kw
#11	((("e coli" or "escherichia coli" or haemophilus or hemophilus or hib or (h next influenz*) or listeria* or pneumococc* or (gram next negativ* next bacill*) or streptococc* or GBS or (s next pneumon*)) near/3 (septic* or sepsis* or bacteraemi* or bacteremi* or infect*)):ti,ab,kw
#12	(meningit* or mening?encephalitis* or (mening* next encephalitis*)):ti,ab,kw
#13	((neisseria* next mening*) or (n next mening*)):ti,ab,kw
#14	MeSH descriptor: [Meningococcal Infections] this term only
#15	meningococc*:ti,ab,kw
#16	{or #1-#15}
#17	MeSH descriptor: [Signs and Symptoms] this term only
#18	MeSH descriptor: [Fever] this term only
#19	MeSH descriptor: [Vomiting] this term only
#20	MeSH descriptor: [Nausea] this term only
#21	MeSH descriptor: [Diarrhea] this term only
#22	MeSH descriptor: [Chills] this term only
#23	MeSH descriptor: [Shivering] this term only
#24	MeSH descriptor: [Sleepiness] this term only
#25	MeSH descriptor: [Headache] this term only
#26	MeSH descriptor: [Photophobia] this term only
#27	MeSH descriptor: [Intracranial Pressure] this term only
#28	MeSH descriptor: [Consciousness Disorders] explode all trees
#29	MeSH descriptor: [Coma] this term only
#30	MeSH descriptor: [Seizures] this term only
#31	MeSH descriptor: [Seizures, Febrile] this term only
#32	MeSH descriptor: [Irritable Mood] this term only
#33	MeSH descriptor: [Crying] this term only
#34	MeSH descriptor: [Decerebrate State] this term only
#35	MeSH descriptor: [Lethargy] this term only
#36	MeSH descriptor: [Fatigue] this term only
#37	MeSH descriptor: [Confusion] this term only
#38	MeSH descriptor: [Malnutrition] this term only
#39	MeSH descriptor: [Purpura] explode all trees
#40	MeSH descriptor: [Muscle Hypotonia] this term only
#41	MeSH descriptor: [Tachycardia] explode all trees
#42	((head or cranial or intracranial) near/3 pain*):ti,ab,kw
#43	((stiff* or rigid*) near/3 (neck* or nuchal or cervical or spine or spinal)):ti,ab,kw
#44	(light near/3 (intoleran* or sensitiv*)):ti,ab,kw
#45	((tense or bulge or bulging or full*) near/3 fontanelle*):ti,ab,kw
#46	((raise* or rise or high or elevat*) near/3 intracranial pressure*):ti,ab,kw
#47	((level* or decreas*) near/3 consciousness):ti,ab,kw
#48	(irritab* or petulan* or "bad mood" or moody):ti,ab,kw
#49	((symphyseal or cheek) near/3 sign*):ti,ab,kw
#50	(abnormal near/3 postur*):ti,ab,kw
#51	(muscle* near/3 (atonic or flaccid*)):ti,ab,kw
#52	((decreas* or alter* or chang*) near/3 (conscious* or "mental state" or "mental states")):ti,ab,kw
#53	((hemorrhagic or haemorrhagic) near/3 rash):ti,ab,kw
#54	(capillar* near/2 refill*):ti,ab,kw
#55	((cold or clammy or temperature) near/3 (hand* or feet or extremities)):ti,ab,kw
#56	((limb* or extremities or arms or legs) near/3 pain*):ti,ab,kw
#57	((mottled or mottling) near/3 (skin or epidermal)):ti,ab,kw
#58	((elevated or rapid* or fast*) near/3 (heartbeat or "heart beat" or "heart rate")):ti,ab,kw
#59	(sign? or symptom* or complain*):ti,ab,kw
#60	(clinical near/3 (manifest* or featur* or finding* or aspect*)):ti,ab,kw
#61	(present* near/3 (feature* or finding* or factor*)):ti,ab,kw or presentation*:ti
#62	(physical* near/3 (manifest* or characteristic* or featur* or finding*)):ti,ab,kw
#63	{or #17-#62}
#64	MeSH descriptor: [Sensitivity and Specificity] explode all trees
#65	MeSH descriptor: [Likelihood Functions] this term only

#	Searches
#66	MeSH descriptor: [Diagnostic Tests, Routine] this term only
#67	MeSH descriptor: [Diagnosis, Differential] this term only
#68	MeSH descriptor: [Prognosis] this term only
#69	((sensitivity or specificity)):ti,ab,kw
#70	((("pre test" or pretest or "post test" or posttest) next probability)):ti,ab,kw
#71	((predict* near/3 (value* or factor*)) or (PPV or NPV)):ti,ab,kw
#72	("likelihood ratio"):ti,ab,kw
#73	((("ROC curve*" or AUC)):ti,ab,kw
#74	diagnos*:ti
#75	((diagnos* near/2 (performance* or accurac* or utilit* or value* or efficien* or effectiveness)) or (accurat* near/5 diagnos*)):ti,ab,kw
#76	"gold standard":ab
#77	MeSH descriptor: [] explode all trees and with qualifier(s): [diagnosis - DI]
#78	{or #64-#77}
#79	MeSH descriptor: [Obstetric Labor, Premature] this term only
#80	MeSH descriptor: [Premature Birth] this term only
#81	MeSH descriptor: [Infant, Premature] this term only
#82	MeSH descriptor: [Fetal Membranes, Premature Rupture] this term only
#83	MeSH descriptor: [Ear, Inner] this term only
#84	MeSH descriptor: [Smoking] explode all trees
#85	MeSH descriptor: [Tobacco Smoke Pollution] this term only
#86	MeSH descriptor: [Cochlear Implants] this term only
#87	MeSH descriptor: [Spleen] this term only
#88	MeSH descriptor: [Splenectomy] this term only
#89	MeSH descriptor: [Socioeconomic Factors] this term only
#90	MeSH descriptor: [Environment] this term only
#91	MeSH descriptor: [Crowding] this term only
#92	MeSH descriptor: [Otitis Media] this term only
#93	MeSH descriptor: [Sinusitis] this term only
#94	MeSH descriptor: [Pneumonia] explode all trees
#95	MeSH descriptor: [Mastoiditis] this term only
#96	MeSH descriptor: [Cochlear Implantation] this term only
#97	MeSH descriptor: [Cochlear Implantation] this term only
#98	((preterm* or "pre term*" or prematur*) near/10 (birth* or born* or deliver* or labour* or labor* or infant* or newborn* or "new born*" or neonate* or "neo nate*" or baby or babies or child or children)):ti,ab,kw
#99	((preterm* or prolong* near/2 rupture*)):ti,ab,kw
#100	((inner next ear)):ti,ab,kw
#101	smok*:ti,ab,kw
#102	((cochlea* near/2 implant*)):ti,ab,kw
#103	((spleen* or splen*) near/3 (impair* or dysfunc* or absen* or "non function*" or nonfunction*)):ti,ab,kw
#104	(splenectom*):ti,ab,kw
#105	(asplenia):ti,ab,kw
#106	((crowd* or "over crowd*" or overcrowd*) near/3 (environment* or place* or premise* or house* or household* or venue* or condition* or living or setting* or transport* or sleep* or room*)):ti,ab,kw
#107	((partial or incomplet*) near/2 immuni*)):ti,ab,kw
#108	((vaccin* or immuni*) next coverage*)):ti,ab,kw
#109	((contiguous* next (spread or foci)):ti,ab,kw
#110	((contiguous near/3 infection*)):ti,ab,kw
#111	((otitis media*" or sinusitis* or pneumonia* or mastoiditis*)):ti,ab,kw
#112	((streptococc* next (infect* or diseas*)):ti,ab,kw
#113	{or #79-#112}
#114	MeSH descriptor: [Risk] this term only
#115	MeSH descriptor: [Risk Factors] this term only
#116	risk*:ti
#117	"risk factor":ab
#118	{or #114-#117}
#119	#16 and #63
#120	#16 and #113
#121	MeSH descriptor: [Signs and Symptoms] this term only
#122	((signs near/2 symptom*)):ti,ab,kw
#123	#121 or #122
#124	#16 and #123
#125	#119 or #120 or #124
#126	"conference":pt or (clinicaltrials or trialsearch):so
#127	#125 not #126

1

## 2 Economic Search

3 One global search was conducted for economic evidence across the guideline.

1  
2 **Database(s): NHS Economic Evaluation Database (NHS EED), HTA Database – CRD**  
3 **interface**  
4 Date of last search: 11 March 2021

#	Searches
1	MeSH DESCRIPTOR meningitis IN NHSEED,HTA
2	MeSH DESCRIPTOR Meningitis, Bacterial IN NHSEED,HTA
3	MeSH DESCRIPTOR Meningitis, Escherichia coli IN NHSEED,HTA
4	MeSH DESCRIPTOR Meningitis, Haemophilus EXPLODE ALL TREES IN NHSEED,HTA
5	MeSH DESCRIPTOR Meningitis, Listeria IN NHSEED,HTA
6	MeSH DESCRIPTOR Meningitis, Meningococcal IN NHSEED,HTA
7	MeSH DESCRIPTOR Meningitis, Pneumococcal IN NHSEED,HTA
8	MeSH DESCRIPTOR Meningoencephalitis IN NHSEED,HTA
9	((bacter* or infect*) NEAR3 (meningit* or meninges* or leptomeninges* or subarachnoid space*)) IN NHSEED, HTA
10	((meningit* NEAR3 (e coli or escherichia coli or h?emophilus or hib or h?emophilus influenz* or h influenz* or listeria* or meningococc* or pneumococc* or gram-negativ* bacill* or gram negativ* bacill* or streptococc* or group B streptococc* or GBS or streptococcus pneumon* or s pneumon* or septic* or sepsis* or bacter?emi?)) IN NHSEED, HTA
11	((e coli or escherichia coli or h?emophilus or hib or h?emophilus influenz* or h influenz* or listeria* or meningococc* or pneumococc* or gram-negativ* bacill* or gram negativ* bacill* or streptococc* or group B streptococc* or GBS or streptococcus pneumon* or s pneumon*) NEAR3 (septic* or sepsis* or bacter?emi?)) IN NHSEED, HTA
12	((meningencephalitis* or meningoencephalitis* or meningit*) IN NHSEED, HTA
13	MeSH DESCRIPTOR Meningococcal Infections IN NHSEED,HTA
14	MeSH DESCRIPTOR Neisseria meningitidis EXPLODE ALL TREES IN NHSEED,HTA
15	((meningococc* NEAR3 (sepsis* or septic* or toxic* or endotoxic* or disease* or infection*)) IN NHSEED, HTA
16	((meningococcus* or meningococci* or meningococcaemia* or meningococcemia*) IN NHSEED, HTA
17	((Neisseria* NEXT mening*) IN NHSEED, HTA
18	#1 OR #2 OR #3 OR #4 OR #5 OR #6 OR #7 OR #8 OR #9 OR #10 OR #11 OR #12 OR #13 OR #14 OR #15 OR #16 OR #17

5  
6 **Database(s): Medline & Embase (Multifile) – OVID interface**  
7 **Embase Classic+Embase 1947 to 2022 November 09, Ovid MEDLINE(R) and Epub**  
8 **Ahead of Print, In-Process & Other Non-Indexed Citations and Daily 1946 to November**  
9 **09, 2022**  
10 Date of last search: 10 November 2022  
11 *Multifile database codes: emczd = Embase Classic+Embase; ppez= MEDLINE(R) and Epub Ahead of*  
12 *Print, In-Process & Other Non-Indexed Citations and Daily*

#	Searches
1	Meningitis/ or Meningitis, Bacterial/ or Meningitis, Escherichia Coli/ or Meningitis, Haemophilus/ or Meningitis, Listeria/ or Meningitis, Meningococcal/ or Meningitis, Pneumococcal/ or Meningoencephalitis/
2	1 use ppez
3	meningitis/ or bacterial meningitis/ or haemophilus meningitis/ or listeria meningitis/ or pneumococcal meningitis/ or meningoencephalitis/
4	3 use emczd
5	((bacter* or infect*) adj3 (meningit* or meninges* or leptomeninges* or subarachnoid space?)).ti,ab.
6	(meningit* adj3 (e coli or escherichia coli or h?emophilus or hib or h?emophilus influenz* or h influenz* or listeria* or meningococc* or pneumococc* or gram-negativ* bacill* or gram negativ* bacill* or streptococc* or group B streptococc* or GBS or streptococcus pneumon* or s pneumon* or septic* or sepsis* or bacter?emi?)).ti,ab.
7	((e coli or escherichia coli or h?emophilus or hib or h?emophilus influenz* or h influenz* or listeria* or meningococc* or pneumococc* or gram-negativ* bacill* or gram negativ* bacill* or streptococc* or group B streptococc* or GBS or streptococcus pneumon* or s pneumon*) adj3 (septic* or sepsis* or bacter?emi?)).ti,ab.
8	(mening?encephalitis* or meningit*).ti,ab.
9	or/2,4-8
10	Meningococcal Infections/ or exp Neisseria meningitidis/
11	10 use ppez
12	Meningococcosis/ or Meningococcemia/ or Neisseria Meningitidis/
13	12 use emczd
14	(meningococc* adj3 (sepsis* or septic* or toxic* or endotoxic* or disease? or infection?)).ti,ab.
15	(meningococcus* or meningococci* or meningococc?emi?).ti,ab.
16	(Neisseria* mening* or n mening*).ti,ab.
17	or/11,13-16
18	Economics/ use ppez
19	Value of life/ use ppez
20	exp "Costs and Cost Analysis"/ use ppez
21	exp Economics, Hospital/ use ppez
22	exp Economics, Medical/ use ppez
23	Economics, Nursing/ use ppez
24	Economics, Pharmaceutical/ use ppez

#	Searches
25	exp "Fees and Charges"/ use ppez
26	exp Budgets/ use ppez
27	health economics/ use emczd
28	exp economic evaluation/ use emczd
29	exp health care cost/ use emczd
30	exp fee/ use emczd
31	budget/ use emczd
32	funding/ use emczd
33	budget*.ti,ab.
34	cost*.ti.
35	(economic* or pharmaco?economic*).ti.
36	(price* or pricing*).ti,ab.
37	(cost* adj2 (effective* or utilit* or benefit* or minimi* or unit* or estimat* or variable*)).ab.
38	(financ* or fee or fees).ti,ab.
39	(value adj2 (money or monetary)).ti,ab.
40	or/18-39
41	Quality-Adjusted Life Years/ use ppez
42	Sickness Impact Profile/
43	quality adjusted life year/ use emczd
44	"quality of life index"/ use emczd
45	(quality adjusted or quality adjusted life year*).tw.
46	(qaly* or qal or qald* or qale* or qtime* or qwb* or daly).tw.
47	(illness state* or health state*).tw.
48	(hui or hui2 or hui3).tw.
49	(multiattribute* or multi attribute*).tw.
50	(utilit* adj3 (score*1 or valu* or health* or cost* or measur* or disease* or mean or gain or gains or index*)).tw.
51	utilities.tw.
52	(eq-5d* or eq5d* or eq-5* or eq5* or euroqual* or euro qual* or euroqual 5d* or euro qual 5d* or euro qol* or euroqol* or euro qol* or euroquol* or euro quol5d* or euroquol5d* or eur qol* or eurqol* or eur qol5d* or eurqol5d* or eur?qul* or eur?qul5d* or euro* quality of life or european qol).tw.
53	(euro* adj3 (5 d* or 5d* or 5 dimension* or 5dimension* or 5domain* or 5domain*)).tw.
54	(sf36 or sf 36 or sf thirty six or sf thirtysix).tw.
55	(time trade off*1 or time tradeoff*1 or tto or timetradeoff*1).tw.
56	Quality of Life/ and ((quality of life or qol) adj (score*1 or measure*1)).tw.
57	Quality of Life/ and ec.fs.
58	Quality of Life/ and (health adj3 status).tw.
59	(quality of life or qol).tw. and Cost-Benefit Analysis/ use ppez
60	(quality of life or qol).tw. and cost benefit analysis/ use emczd
61	((qol or hrqol or quality of life).tw. or *quality of life/) and ((qol or hrqol* or quality of life) adj2 (increas* or decreas* or improv* or declin* or reduc* or high* or low* or effect or effects or worse or score or scores or change*1 or impact*1 or impacted or deteriorat*)).ab.
62	Cost-Benefit Analysis/ use ppez and cost-effectiveness ratio*.tw. and (cost-effectiveness ratio* and (perspective* or life expectanc*)).tw.
63	cost benefit analysis/ use emczd and cost-effectiveness ratio*.tw. and (cost-effectiveness ratio* and (perspective* or life expectanc*)).tw.
64	*quality of life/ and (quality of life or qol).ti.
65	quality of life/ and ((quality of life or qol) adj3 (improv* or chang*)).tw.
66	quality of life/ and health-related quality of life.tw.
67	Models, Economic/ use ppez
68	economic model/ use emczd
69	care-related quality of life.tw,kw.
70	((capability\$ or capability-based\$) adj (measure\$ or index or instrument\$)).tw,kw.
71	social care outcome\$.tw,kw.
72	(social care and (utility or utilities)).tw,kw.
73	or/41-72
74	(9 or 17) and 40
75	(9 or 17) and 73
76	letter/
77	editorial/
78	news/
79	exp historical article/
80	Anecdotes as Topic/
81	comment/
82	case report/
83	(letter or comment*).ti.
84	76 or 77 or 78 or 79 or 80 or 81 or 82 or 83
85	randomized controlled trial/ or random*.ti,ab.
86	84 not 85
87	animals/ not humans/
88	exp Animals, Laboratory/
89	exp Animal Experimentation/

#	Searches
90	exp Models, Animal/
91	exp Rodentia/
92	(rat or rats or mouse or mice).ti.
93	86 or 87 or 88 or 89 or 90 or 91 or 92
94	letter.pt. or letter/
95	note.pt.
96	editorial.pt.
97	case report/ or case study/
98	(letter or comment*).ti.
99	94 or 95 or 96 or 97 or 98
100	randomized controlled trial/ or random*.ti,ab.
101	99 not 100
102	animal/ not human/
103	nonhuman/
104	exp Animal Experiment/
105	exp Experimental Animal/
106	animal model/
107	exp Rodent/
108	(rat or rats or mouse or mice).ti.
109	101 or 102 or 103 or 104 or 105 or 106 or 107 or 108
110	93 use ppez
111	109 use emczd
112	110 or 111
113	74 not 112
114	limit 113 to English language
115	75 not 112
116	limit 115 to English language
117	114 or 116

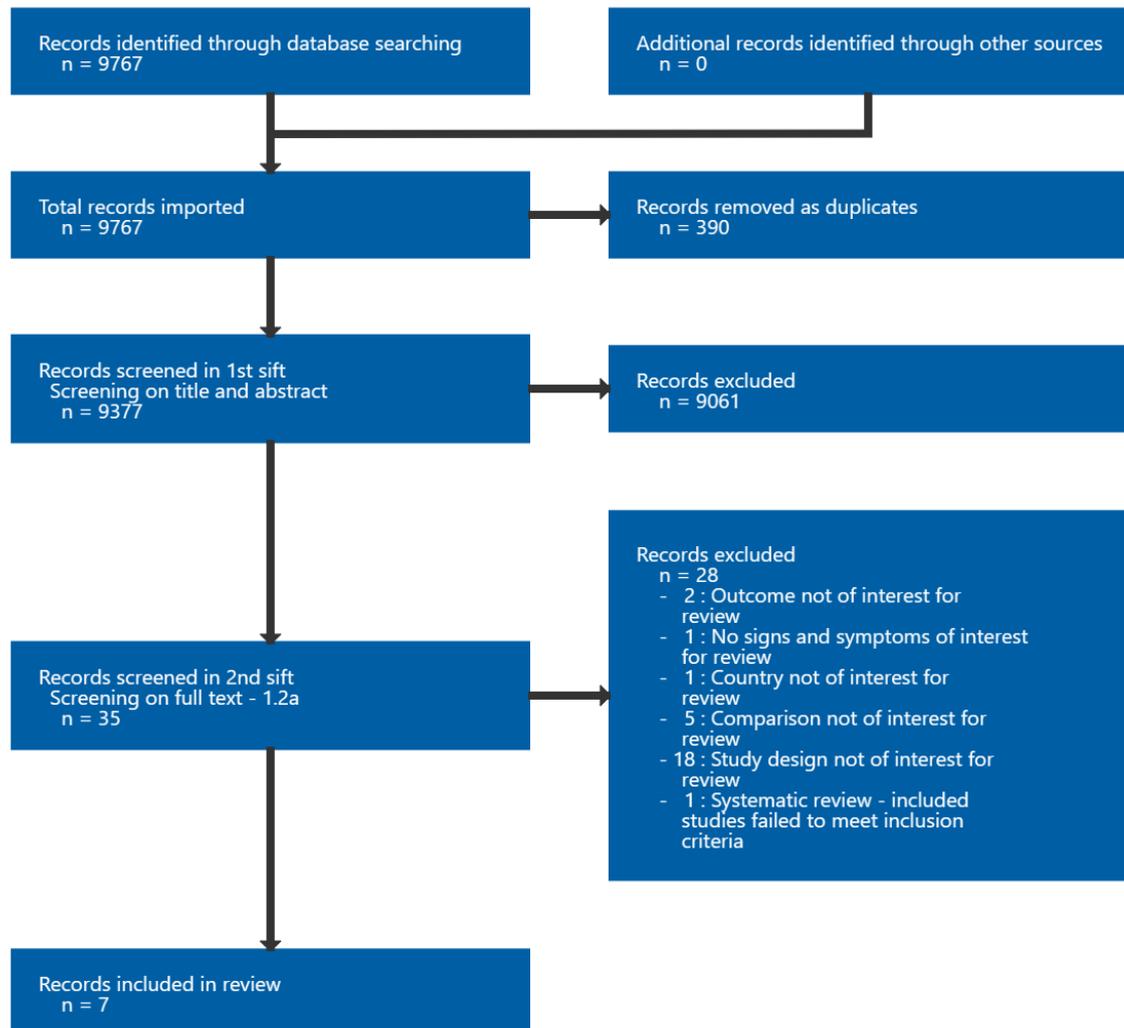
1  
2

# 1 Appendix C Diagnostic evidence study selection

## 2 Study selection for: What symptoms and signs, individually or in combination, 3 are associated with meningococcal disease?

4 Figure 1: Study selection flow chart

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7

## 1 Appendix D Evidence tables – Diagnostic evidence

### 2 Evidence tables for review question: What symptoms and signs, individually or in combination, are associated with 3 meningococcal disease?

#### 4 Table 4: Evidence tables

##### 5 6 Baker, 1989

**Bibliographic Reference** Baker, R.C; Seguin, J.H; Leslie, N; Gilchrist, M.J; Myers, M.G.; Fever and petechiae in children; Pediatrics; 1989; vol. 84 (no. 6); 1051-1055

##### 7 Study details

<b>Country/ies where study was carried out</b>	US
<b>Study type</b>	Single-gate, cross-sectional DTA study
<b>Study dates</b>	November 1982 to October 1983
<b>Inclusion criteria</b>	People aged <21 years with fever >38°C and petechial rash
<b>Exclusion criteria</b>	Children with purpura fulminans; known bleeding diatheses; neonates
<b>Patient characteristics</b>	N=54: n=15 (8%) with documented invasive bacterial disease; n=39 (21%) nonbacteremic disease.  Invasive bacterial disease group (n=15):  Age in months (median; range in parentheses): 41 (6-180)  n=4 (27%) meningococcal meningitis and bacteraemia; n=4 (27%) meningococcal meningitis without bacteraemia; and n=7 (47%) bacteraemia without meningitis (5 with <i>N. meningitidis</i> , 1 with <i>H. influenzae</i> type b, and 1 with <i>S. pneumoniae</i> )

	<p>Nonbacteremic disease group (n=39):</p> <p>Age in months (median; range in parentheses): 45 (3-132)</p> <p>n=34 (87%) pharyngitis/upper respiratory tract infection; n=3 (8%) urinary tract infection/acute gastroenteritis; n=2 (5%) viral meningitis</p>
<b>Index test(s)</b>	<p>Signs and symptoms taken from medical records:</p> <p>(a) Ill appearance</p> <p>(b) Signs of meningeal irritation</p> <p>(c) Petechiae above the nipple line (including the head and upper extremities)</p> <p>(d) Petechiae on the trunk below the nipple line</p> <p>(e) Petechiae on the lower extremities</p>
<b>Reference standard(s)</b>	Meningococcal disease was diagnosed by detection of <i>N. meningitidis</i> on blood or CSF culture.
<b>Duration of follow-up</b>	Not reported
<b>Sources of funding</b>	Not reported
<b>Other information</b>	40% of MD population is indirect (27% with meningococcal meningitis alone and 13% with meningitis with other causes). Comparison group includes those with viral meningitis but only 5% of this group.

1 Abbreviations: CSF: cerebrospinal fluid; DTA: diagnostic test accuracy; *H. influenzae* type B: *Haemophilus influenzae* type b (Hib); *N. Meningitidis*: *Neisseria Meningitidis*; *S.*  
2 *pneumoniae*: *Streptococcus pneumoniae*

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#### 4 Outcomes

#### 5 Signs/symptoms of invasive bacterial disease

<b>Outcome</b>	<b>N = 54</b>
<b>Ill appearance</b>	TP 7; FP 4; FN 8; TN 35
Custom value	
<b>Signs of meningeal irritation</b>	TP 5; FP 1; FN 10; TN 38
Custom value	
<b>Petechiae above the nipple line (including the head and upper extremities)</b>	TP 12; FP 35; FN 3; TN 4
Custom value	
<b>Petechiae on the trunk below the nipple line</b>	TP 11; FP 16; FN 4; TN 23
Custom value	
<b>Petechiae on the lower extremities</b>	TP 12; FP 11; FN 3; TN 28
Custom value	

1 **Critical appraisal - QUADAS-2**

2

Section	Question	Answer
Patient selection: risk of bias	Was a consecutive or random sample of patients enrolled?	Yes
Patient selection: risk of bias	Was a case-control design avoided?	Yes
Patient selection: risk of bias	Did the study avoid inappropriate exclusions?	No <i>(Only those with identified infective organisms were included in the analysis (excludes 85 patients where no organism was isolated))</i>

Section	Question	Answer
Patient selection: risk of bias	Could the selection of patients have introduced bias?	Unclear <i>(Consecutive sample enrolled but only those with identified infective organisms included in the analysis (excludes 85 patients where no organism was isolated))</i>
Patient selection: applicability	Are there concerns that included patients do not match the review question?	High <i>(40% of MD population is indirect (27% with meningococcal meningitis alone and 13% with meningitis with other causes))</i>
Index tests: risk of bias	Were the index test results interpreted without knowledge of the results of the reference standard?	Unclear <i>(No information about whether index tests were interpreted without knowledge of the reference standard)</i>
Index tests: risk of bias	If a threshold was used, was it pre-specified?	No <i>(Index tests were not systematically quantified, and some were subjective (for example, ill appearance))</i>
Index tests: risk of bias	Could the conduct or interpretation of the index test have introduced bias?	High <i>(No information about whether index tests were interpreted without knowledge of the reference standard, index tests were not systematically quantified, and some were subjective)</i>
Index tests: applicability	Are there concerns that the index test, its conduct, or interpretation differ from the review question?	Low
Reference standard: risk of bias	Is the reference standard likely to correctly classify the target condition?	Yes
Reference standard: risk of bias	Were the reference standard results interpreted without knowledge of the results of the index test?	Unclear <i>(No information about whether reference standards were interpreted without knowledge of the index tests)</i>

Section	Question	Answer
Reference standard: risk of bias	Could the reference standard, its conduct, or its interpretation have introduced bias?	Low <i>(No information about whether reference standards were interpreted without knowledge of the index tests; however, tests are objective so unlikely that knowledge of results would introduce bias)</i>
Reference standard: applicability	Is there concern that the target condition as defined by the reference standard does not match the review question?	Low
Flow and timing: risk of bias	Was there an appropriate interval between index test(s) and reference standard?	Unclear <i>(Interval between index test and reference standard is not clear)</i>
Flow and timing: risk of bias	Did all patients receive a reference standard?	Yes
Flow and timing: risk of bias	Did patients receive the same reference standard?	Yes
Flow and timing: risk of bias	Were all patients included in the analysis?	Yes
Flow and timing: risk of bias	Could the patient flow have introduced bias?	Unclear <i>(Unclear interval between index test and reference standard)</i>

1 **Borchsenius, 1991**

**Bibliographic Reference** Borchsenius, F; Bruun, J. N; Tonjum, T.; Systemic meningococcal disease: the diagnosis on admission to hospital; NIPH annals; 1991; vol. 14 (no. 1); Nov-22

2 **Study details**

<b>Country/ies where study was carried out</b>	Norway
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<b>Study type</b>	Single-gate, cross-sectional DTA study (a very small number of patients [5% of full sample that included those with meningitis only] included retrospectively)
<b>Study dates</b>	December 1981 to April 1982
<b>Inclusion criteria</b>	People admitted to hospital with suspected systemic meningococcal disease (those with meningococcal meningitis only (n=56) are included in the review on signs and symptoms of bacterial meningitis)
<b>Exclusion criteria</b>	Not reported
<b>Patient characteristics</b>	<p>N=120</p> <p>Meningococcal disease (n=59):</p> <p>Age: Reported for whole MD group only; Mean/median not reported; 50% aged &lt; 12 years</p> <p>Septicaemia (arterial hypotension or cutaneous haemorrhages; n=21, 36%); meningitis and septicaemia (both meningitis and septicaemia; n=17, 29%); other (other systemic meningococcal infections; n=21, 36%).</p> <p>No meningococcal disease (n=61):</p> <p>Age: Mean/median not reported; 79% aged &lt; 12 years.</p> <p>Bacterial meningitis or septicaemia, excluding those due to <i>N. meningitidis</i> (n=16, 26%); bacterial infection (with known bacterial aetiology; n=9, 15% [pneumonia, n=4; urinary tract infection, n=1; toxic shock syndrome, n=1; systemic bacterial infections, n=3]; viral infections (positive viral isolation or serious meningitis; n=14, 23%); other diseases (n=22, 36%; includes n=15 with upper respiratory tract infections of unknown aetiology). n=2 who were difficult to categorize included in the control group as meningitis of unknown microbiological aetiology).</p>
<b>Index test(s)</b>	<p>Signs and symptoms recorded by healthcare professional on the day of admission to hospital:</p> <p>(a) Petechiae (<math>\leq 4</math>mm)</p>

	(b) Reduced general condition
	(c) Ecchymoses (cutaneous haemorrhages >4 mm)
	(d) Reduced consciousness
	(e) Cold extremities
	(f) Cyanosis
	(g) Neck stiffness
	(h) Body pain
<b>Reference standard(s)</b>	Method of diagnosing meningococcal disease was reported for the whole MD group only (including those with meningitis alone): Meningococcal disease confirmed with growth of meningococci in blood and/or CSF (for 62%), or the diagnosis of meningococcal disease was based on the clinical picture, meningococcal antigen in CSF, or growth of <i>N. meningitidis</i> in pharyngeal swab specimens (for 38%).
<b>Duration of follow-up</b>	Not reported
<b>Sources of funding</b>	Not reported
<b>Other information</b>	Data was not reported for clinical symptoms that were non-significant (presence of convulsions, back rigidity, headache, nausea, chills, fever, diarrhoea, irritability, systolic blood pressure <100, heart rate ≥120, rectal temperature ≥40.0)

1 Abbreviations: CSF: cerebrospinal fluid; DTA: diagnostic test accuracy; MD: meningococcal disease; *N. Meningitidis*: *Neisseria Meningitidis*

## 2 Outcomes

### 3 Signs and symptoms of meningococcal disease

<b>Outcome</b>	<b>N = 120</b>
<b>Petechiae (&lt;=4mm)</b>	TP 48; FP 11; FN 11; TN 50
Custom value	

<b>Outcome</b>	<b>N = 120</b>
<b>Reduced general condition</b>	TP 28; FP 10; FN 31; TN 51
Custom value	
<b>Ecchymoses (cutaneous haemorrhages &gt;4 mm)</b>	TP 27; FP 9; FN 32; TN 52
Custom value	
<b>Reduced consciousness</b>	TP 25; FP 11; FN 34; TN 50
Custom value	
<b>Cold extremities</b>	TP 20; FP 4; FN 39; TN 57
Custom value	
<b>Cyanosis</b>	TP 9; FP 0; FN 50; TN 61
Custom value	
<b>Neck stiffness</b>	TP 20; FP 26; FN 39; TN 35
Custom value	
<b>Body pain</b>	TP 17; FP 8; FN 42; TN 53
Custom value	

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2 **Critical appraisal - QUADAS-2**

3

Section	Question	Answer
Patient	Was a consecutive or random	Yes

Section	Question	Answer
selection: risk of bias	sample of patients enrolled?	
Patient selection: risk of bias	Was a case-control design avoided?	Yes
Patient selection: risk of bias	Did the study avoid inappropriate exclusions?	Unclear <i>(Exclusion criteria not reported)</i>
Patient selection: risk of bias	Could the selection of patients have introduced bias?	Unclear <i>(Generally a consecutive sample enrolled (5% included retrospectively), but exclusion criteria not reported. Inclusion criteria limited to patients hospitalized with suspected systemic meningococcal disease, but no further details reported.)</i>
Patient selection: applicability	Are there concerns that included patients do not match the review question?	Low
Index tests: risk of bias	Were the index test results interpreted without knowledge of the results of the reference standard?	Unclear <i>(No information about whether index tests were interpreted without knowledge of the reference standard)</i>
Index tests: risk of bias	If a threshold was used, was it pre-specified?	No <i>(No detail on how clinical features measured, and many of these factors are subjective, for instance, reduced general condition, and reduced consciousness. Data not reported for non-significant signs and symptoms)</i>
Index tests: risk of bias	Could the conduct or interpretation of the index test have introduced bias?	High <i>(No information about whether index tests were interpreted without knowledge of the reference standard, and no detail on how clinical features measured and many of these factors are subjective (for example, reduced general condition and reduced consciousness). Data not reported for non-significant signs and symptoms)</i>

Section	Question	Answer
Index tests: applicability	Are there concerns that the index test, its conduct, or interpretation differ from the review question?	Low
Reference standard: risk of bias	Is the reference standard likely to correctly classify the target condition?	Unclear <i>(The study includes patients without bacteriological proof (N=44, 38% of the full sample that includes those with meningitis only), and in the full sample there is a statistically significant difference between these patients and those with growth of N. meningitidis from CSF or blood in terms of neck stiffness (69% of culture proven cases had neck stiffness relative to 48% in culture negative cases))</i>
Reference standard: risk of bias	Were the reference standard results interpreted without knowledge of the results of the index test?	Unclear <i>(No information about whether reference standards were interpreted without knowledge of the index tests)</i>
Reference standard: risk of bias	Could the reference standard, its conduct, or its interpretation have introduced bias?	High <i>(Study includes patients without bacteriological proof (N=44, 38% of the full sample that includes those with meningitis only), and in the full sample there is a statistically significant difference between these patients and those with growth of N. meningitidis from CSF or blood in terms of neck stiffness (69% of culture proven cases had neck stiffness relative to 48% in culture negative cases))</i>
Reference standard: applicability	Is there concern that the target condition as defined by the reference standard does not match the review question?	Low
Flow and timing: risk of bias	Was there an appropriate interval between index test(s) and reference standard?	Unclear <i>(Interval between index test and reference standard is not clear)</i>
Flow and timing: risk of bias	Did all patients receive a reference	Yes

Section	Question	Answer
	standard?	
Flow and timing: risk of bias	Did patients receive the same reference standard?	Yes
Flow and timing: risk of bias	Were all patients included in the analysis?	Yes
Flow and timing: risk of bias	Could the patient flow have introduced bias?	Unclear ( <i>Unclear interval between index test and reference standard</i> )

1

2 **Close, 2011**

**Bibliographic Reference** Close, R.M; Ejidokun, O.O; Verlander, N.Q; Fraser, G; Meltzer, M; Rehman, Y; Muir, P; Ninis, N; Stuart, J.M.; Early diagnosis model for meningitis supports public health decision making; Journal of Infection; 2011; vol. 63 (no. 1); 32-38

3 **Study details**

<b>Country/ies where study was carried out</b>	UK
<b>Study type</b>	Single-gate, cross-sectional DTA study
<b>Study dates</b>	July 2008 to June 2009
<b>Inclusion criteria</b>	Confirmed case of bacterial or viral meningitis, or meningococcal septicaemia.  Suspected cases (those with a clinical diagnosis of bacterial or viral meningitis, or meningococcal septicaemia) were recruited, but only confirmed cases were included in the analysis.
<b>Exclusion criteria</b>	Neonates (aged <1 month).
<b>Patient</b>	N=719 suspected cases, of which 293 (41%) confirmed as bacterial meningitis or meningococcal septicaemia, and 92 (13%)

<b>characteristics</b>	<p>as viral meningitis.</p> <p>N=385 confirmed cases (those included in analysis).</p> <p>Babies/children subgroup (aged 19 years or younger) n=230</p> <p>Bacterial meningitis/meningococcal septicaemia (n=191):</p> <p>Age: Mean/median not reported</p> <p>Sex: male: 96 (50%); female: 95 (50%)</p> <p>Viral meningitis (n=39):</p> <p>Age: Mean/median not reported</p> <p>Sex: male: 23 (59%); female: 16 (41%)</p> <p>Adult subgroup (aged &gt;19 years) n=155</p> <p>Bacterial meningitis/meningococcal septicaemia (n=102):</p> <p>Age: Mean/median not reported</p> <p>Sex: male: 48 (47%); female: 54 (53%)</p> <p>Viral meningitis (n=53):</p>
------------------------	---

	<p>Age: Mean/median not reported</p> <p>Sex: male: 22 (42%); female: 31 (58%)</p> <p>For whole sample (babies/children and adult subgroups combined): <i>N. meningitidis</i> n=234 (80%), <i>S. pneumoniae</i> n=49 (17%), <i>H. influenzae</i> n=3 (1%), other bacterial n=7 (2%)</p> <p>Of the 234 cases of meningococcal infection, 67 were reported as meningococcal septicaemia without meningitis. Proportion of those with meningitis only not reported.</p> <p>Viral meningitis (babies/children and adult subgroups combined): Enterovirus N=70 (76%), Herpes simplex virus N=7 (8%), Varicella zoster virus N=5 (5%), other viral N=10 (11%)</p>
<b>Index test(s)</b>	<p>Signs and symptoms, recorded by healthcare professionals on the study data collection forms:</p> <p>(a) Haemorrhagic rash</p> <p>(b) Level of consciousness (unresponsive)</p>
<b>Reference standard(s)</b>	<p>Confirmed cases defined as those with any one of the following: bacteria, bacterial antigen, bacterial or viral DNA or RNA identified in CSF; bacteria or viruses obtained from culture of CSF; clinical and/or laboratory diagnosis of meningitis accompanied by microbiological evidence of pathogen from another site, for example blood, throat swab, skin or faeces.</p>
<b>Duration of follow-up</b>	Not reported
<b>Sources of funding</b>	Not industry funded
<b>Other information</b>	Population may be indirect. Unclear how many people have meningitis only (however, only 80% had <i>N. meningitidis</i> as the cause)

Abbreviations: CSF: cerebrospinal fluid; DNA: deoxyribonucleic acid; DTA: diagnostic test accuracy; *H. influenzae*: *Haemophilus influenzae*; *N. Meningitidis*: *Neisseria Meningitidis*; RNA: ribonucleic acid; *S. pneumoniae*: *Streptococcus pneumoniae*

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1 **Outcomes**

2 **Signs and symptoms of meningococcal disease**

<b>Outcome</b>	<b>N = 385</b>
<b>Babies/children</b> Data available for 75% of subgroup  Custom value	TP 107; FP 7; FN 48; TN 10
<b>Adults</b> Data available for 63% of subgroup  Custom value	TP 22; FP 0; FN 50; TN 26
<b>Babies/children</b> Data available for 65% of subgroup  Custom value	TP 14; FP 0; FN 116; TN 19
<b>Adults</b> Data available for 61% of subgroup  Custom value	TP 9; FP 0; FN 60; TN 26

3

4 **Critical appraisal - QUADAS-2**

5

<b>Section</b>	<b>Question</b>	<b>Answer</b>
Patient selection: risk of bias	Was a consecutive or random sample of patients enrolled?	Yes
Patient	Was a case-control design avoided?	Yes

Section	Question	Answer
selection: risk of bias		
Patient selection: risk of bias	Did the study avoid inappropriate exclusions?	No <i>(Included only laboratory confirmed cases, and this may have biased results through the exclusion of bacterial meningitis cases where no organism could be identified (possibly because of antibiotics given prior to arrival at the hospital). Comparison limited to viral meningitis)</i>
Patient selection: risk of bias	Could the selection of patients have introduced bias?	Unclear <i>(Consecutive sample enrolled, but included only laboratory confirmed cases, which may have biased results through the exclusion of bacterial meningitis cases where no organism could be identified (possibly because of antibiotics given prior to arrival at the hospital))</i>
Patient selection: applicability	Are there concerns that included patients do not match the review question?	Unclear <i>(Population may be indirect. Unclear how many people have meningitis only (however, only 80% had N. meningitidis as the cause))</i>
Index tests: risk of bias	Were the index test results interpreted without knowledge of the results of the reference standard?	Unclear <i>(No information about whether index tests were interpreted without knowledge of the reference standard)</i>
Index tests: risk of bias	If a threshold was used, was it pre-specified?	Yes
Index tests: risk of bias	Could the conduct or interpretation of the index test have introduced bias?	Low <i>(No information about whether index tests were interpreted without knowledge of the reference standards; however, tests are objective (and standardized) so unlikely that knowledge of results would introduce bias)</i>
Index tests: applicability	Are there concerns that the index test, its conduct, or interpretation differ from the review question?	Low

Section	Question	Answer
Reference standard: risk of bias	Is the reference standard likely to correctly classify the target condition?	Yes
Reference standard: risk of bias	Were the reference standard results interpreted without knowledge of the results of the index test?	Unclear <i>(No information about whether reference standards were interpreted without knowledge of the index tests)</i>
Reference standard: risk of bias	Could the reference standard, its conduct, or its interpretation have introduced bias?	Low <i>(No information about whether reference standards were interpreted without knowledge of the index tests; however, tests are objective so unlikely that knowledge of results would introduce bias)</i>
Reference standard: applicability	Is there concern that the target condition as defined by the reference standard does not match the review question?	Low
Flow and timing: risk of bias	Was there an appropriate interval between index test(s) and reference standard?	Unclear <i>(Interval between index test and reference standard is not clear)</i>
Flow and timing: risk of bias	Did all patients receive a reference standard?	Yes
Flow and timing: risk of bias	Did patients receive the same reference standard?	Yes
Flow and timing: risk of bias	Were all patients included in the analysis?	No <i>(Data is missing (for between 25% and 39% across variables and subgroups) and no attempts to collect information for those who dropped out is described. Reasons for loss to follow-up are not described. Patients with missing data are not adequately described)</i>

Section	Question	Answer
Flow and timing: risk of bias	Could the patient flow have introduced bias?	High <i>(Interval between index tests and reference standard is unclear. All patients not included in the analysis, data is missing (for between 25% and 39% across variables and subgroups) and no attempts to collect information for those who dropped out is described. Reasons for loss to follow-up are not described. Patients with missing data are not adequately described)</i>

1 **Haj-Hassan, 2011**

**Bibliographic Reference** Haj-Hassan, T.A; Thompson, M.J; Mayon-White, R.T; Ninis, N; Harnden, A; Smith, L.F.P; Perera, R; Mant, D.C.; Which early 'red flag' symptoms identify children with meningococcal disease in primary care?; British Journal of General Practice; 2011; vol. 61 (no. 584); e97-e104

2 **Study details**

<b>Country/ies where study was carried out</b>	UK
<b>Study type</b>	Two-gate, cross-sectional DTA study  Frequency of presenting symptoms in children attending primary care with acute febrile infections compared with previously reported frequencies in children with meningococcal disease (Thompson 2006)
<b>Study dates</b>	Non-fatal MD: December 1997 to February 1999.  Minor febrile infection: June 2007 to July 2009 (children recruited at a similar seasonal rate to that found in the meningococcal disease study (Thompson 2006) in 20 sampling periods of 1-week's duration).
<b>Inclusion criteria</b>	Non-fatal MD: Children aged 0 to 16 years; non-fatal cases matched with children who had died from meningococcal disease (fatal cases reported in Thompson 2006 but not included in current study).  Minor febrile infection: Children between 1 month and 16 years of age presenting in primary care with acute illness; accompanied by an adult caregiver who was able to provide informed consent; attending an acute appointment made within the previous 72 hours; minor febrile infection (defined as any acute infection in which the parent indicated on the symptoms

	questionnaire that fever was present in current illness).
<b>Exclusion criteria</b>	<p>Non-fatal MD: Diagnoses did not meet criteria for inclusion; parental consent not given.</p> <p>Minor febrile infection: Final diagnosis not consistent with an acute infection (for example, minor trauma, atopic eczema, asthma, allergic rhinitis, infantile colic); insufficient information to determine a diagnosis; serious illness (defined as those referred acutely to hospital [emergency department or admission] within the subsequent 2 weeks); children in 15-16 year age group excluded from analysis as only N=12 recruited.</p>
<b>Patient characteristics</b>	<p>N=752</p> <p>Non-fatal MD (n=345):</p> <p>Age in months: Mean/median not reported; 28% &lt;1 year, 45% 1-4 years, 28% 5-14 years</p> <p>Sex: male 188 (55%); female: 157 (46%)</p> <p>n=103 fatal MD cases reported in previous dataset (Thompson 2006) but not included in the comparison with minor febrile infection.</p> <p>Further MD details not available for non-fatal MD alone. Data for combined fatal and non-fatal cases (n=448): 66% septicaemia; 22% meningitis; 12% both. For n=307 in whom meningococcal serogrouping data available (fatal and non-fatal cases combined): 50% serogroup B; 47% serogroup C; 3% W135 and Y serogroups collectively.</p> <p>Minor febrile infection (n=407):</p> <p>Age in months (median; interquartile range (IQR) in parentheses): 42 (22–79); 10% &lt;1 year, 52% 1-4 years, 38% 5-14 years</p> <p>Sex: male: 209 (51%); female: 198 (49%)</p> <p>Duration of illness in days, reported by parents (median; IQR in parentheses): 4 (2-6)</p>

	Diagnoses included: upper respiratory tract infections (33%); acute otitis media (15%); tonsillitis or pharyngitis (14%); non-specific viral illness (14%); LRTI or pneumonia (9%).
<b>Index test(s)</b>	<p>Signs and symptoms as indicated in parent-reported questionnaire (symptoms in questionnaire based on those included in the meningococcal disease dataset [Thompson 2006] and non-specific symptoms common to childhood illnesses).</p> <p>Classic meningeal features:</p> <ul style="list-style-type: none"> <li>(a) Photophobia</li> <li>(b) Neck pain or stiffness</li> <li>(c) Headache</li> </ul> <p>Suggested red flags:</p> <ul style="list-style-type: none"> <li>(a) Leg pain</li> <li>(b) Cold hands and feet</li> <li>(c) Pale colour</li> </ul> <p>Other features:</p> <ul style="list-style-type: none"> <li>(a) Confusion</li> <li>(b) Drowsy or very sleepy</li> <li>(c) Rash or new spots on skin (defined as any type of rash. MD dataset included all rash types mentioned by the parent and/or GP; minor febrile infection dataset based on parental reports only)</li> </ul>

	<p>(d) Nausea or vomiting</p> <p>(e) Irritable or miserable</p> <p>(f) General aching</p> <p>(g) Refusing food or feeds</p> <p>(h) Difficult/laboured breathing</p> <p>(i) Diarrhoea</p> <p>(j) Sore throat</p> <p>(k) Tummy pain</p> <p>(l) Cough</p>
<b>Reference standard(s)</b>	Clinical record review (blind to final outcome) by an expert panel of consultants in paediatric emergency medicine, infectious disease, and intensive care, although the majority of cases (79%) were confirmed through microbiological techniques. A case was categorised as meningitis if the child had neck stiffness, photophobia, or other CNS signs, and as septicaemia if the child had cardiovascular shock or multiorgan failure but no signs of meningitis. Some children had features of both meningitis and septicaemia.
<b>Duration of follow-up</b>	Not reported (MD study parents interviewed a median of 4 months after hospital admission; minor febrile infection data collected at point of care)
<b>Sources of funding</b>	Not industry funded
<b>Other information</b>	<p>N=103 fatal MD cases reported in previous dataset (Thompson 2006) but not included in the comparison with minor febrile infection.</p> <p>Thompson 2006:</p> <p>Thompson, M.J., Ninis, N., Perera, R., Mayon-White, R., Phillips, C., Bailey, L., Harnden, A., Mant, D., Levin, M., Clinical</p>

recognition of meningococcal disease in children and adolescents, The Lancet, 367, 397-403, 2006

Data not extracted for fever or high temperature as this was an inclusion criterion

1 Abbreviations: CNS: central nervous system; DTA: diagnostic test accuracy; MD: meningococcal disease

## 2 Outcomes

### 3 Signs and symptoms for meningococcal disease

Outcome	N = 752
<b>Photophobia</b>	TP 73; FP 16; FN 272; TN 391
Custom value	
<b>Neck pain or stiffness</b>	TP 86; FP 23; FN 259; TN 384
Custom value	
<b>Headache</b>	TP 79; FP 130; FN 171; TN 236
Analysed in children >1 year (as considered age-specific by authors of the meningococcal paper)	
Custom value	
<b>Leg pain</b>	TP 94; FP 21; FN 156; TN 345
Analysed in children >1 year (as considered age-specific by authors of the meningococcal paper)	
Custom value	
<b>Cold hands and feet</b>	TP 139; FP 74; FN 206; TN 333
Custom value	
<b>Pale colour</b>	TP 65; FP 169; FN 280; TN 238
Custom value	
<b>Confusion</b>	TP 101; FP 7; FN 149; TN 359

<b>Outcome</b>	<b>N = 752</b>
Analysed in children >1 year (as considered age-specific by authors of the meningococcal paper)	
Custom value	
<b>Drowsy or very sleepy</b>	TP 275; FP 142; FN 70; TN 265
Custom value	
<b>Rash or new spots on skin</b>	TP 267; FP 57; FN 78; TN 350
Custom value	
<b>Nausea or vomiting</b>	TP 250; FP 147; FN 95; TN 260
Custom value	
<b>Irritable or miserable</b>	TP 236; FP 213; FN 109; TN 194
Custom value	
<b>General aching</b>	TP 129; FP 94; FN 216; TN 313
Custom value	
<b>Refusing food or feeds</b>	TP 200; FP 181; FN 145; TN 226
Custom value	
<b>Difficult/laboured breathing</b>	TP 42; FP 54; FN 303; TN 353
Custom value	
<b>Diarrhoea</b>	TP 35; FP 80; FN 310; TN 327
Custom value	

<b>Outcome</b>	<b>N = 752</b>
<b>Sore throat</b>	TP 50; FP 198; FN 295; TN 209
Custom value	
<b>Tummy pain</b> Analysed in children >1 year (as considered age-specific by authors of the meningococcal paper)	TP 12; FP 95; FN 238; TN 271
Custom value	
<b>Cough</b>	TP 6; FP 268; FN 339; TN 139
Custom value	

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### Critical appraisal - QUADAS-2

Section	Question	Answer
Patient selection: risk of bias	Was a consecutive or random sample of patients enrolled?	No <i>(Two-gate study design)</i>
Patient selection: risk of bias	Was a case-control design avoided?	No <i>(Children with confirmed MD compared with those presenting in primary care with minor febrile infection)</i>
Patient selection: risk of bias	Did the study avoid inappropriate exclusions?	No <i>(Those with serious illness excluded from the comparison group)</i>
Patient selection: risk of bias	Could the selection of patients have introduced bias?	High <i>(Two-gate study design comparing children with confirmed MD with those presenting in primary care with minor febrile infection, and those with serious illness excluded from the comparison group)</i>

Section	Question	Answer
Patient selection: applicability	Are there concerns that included patients do not match the review question?	Unclear <i>(Only those with non-fatal MD included in analysis, and proportions of people with meningitis, septicaemia, or both, only reported for combined fatal and non-fatal cases (22% meningitis only in combined dataset))</i>
Index tests: risk of bias	Were the index test results interpreted without knowledge of the results of the reference standard?	Unclear <i>(No information about whether index tests were interpreted without knowledge of the reference standard)</i>
Index tests: risk of bias	If a threshold was used, was it pre-specified?	No <i>(Limited detail on how the index tests were measured and defined and many are subjective)</i>
Index tests: risk of bias	Could the conduct or interpretation of the index test have introduced bias?	High <i>(No information about whether index tests were interpreted without knowledge of the reference standard, and index tests subjective and poorly defined)</i>
Index tests: applicability	Are there concerns that the index test, its conduct, or interpretation differ from the review question?	Low
Reference standard: risk of bias	Is the reference standard likely to correctly classify the target condition?	Unclear <i>(Clinical record review (blind to final outcome) by an expert panel of consultants in paediatric emergency medicine, infectious disease, and intensive care, although the majority of cases (79%) were confirmed through microbiological techniques)</i>
Reference standard: risk of bias	Were the reference standard results interpreted without knowledge of the results of the index test?	Unclear <i>(No information about whether reference standards were interpreted without knowledge of the index tests)</i>
Reference standard: risk of bias	Could the reference standard, its conduct, or its interpretation have introduced bias?	Unclear <i>(Clinical record review (blind to final outcome) by an expert panel of consultants in paediatric emergency medicine, infectious disease, and intensive care, although the majority of cases (79%) were confirmed through microbiological techniques)</i>

Section	Question	Answer
Reference standard: applicability	Is there concern that the target condition as defined by the reference standard does not match the review question?	Low
Flow and timing: risk of bias	Was there an appropriate interval between index test(s) and reference standard?	No <i>(There was not an appropriate interval between index test(s) and reference standard. For the MD group, parents were interviewed a median of 4 months after hospital admission about signs and symptoms)</i>
Flow and timing: risk of bias	Did all patients receive a reference standard?	Yes
Flow and timing: risk of bias	Did patients receive the same reference standard?	Yes <i>(Some patients (21%) did not have diagnosis confirmed through microbiological techniques, but the results of the index test did not influence the decision on whether to perform the reference standard or which reference standard to use)</i>
Flow and timing: risk of bias	Were all patients included in the analysis?	No <i>(For some index tests, only children aged &gt;1 year were included)</i>
Flow and timing: risk of bias	Could the patient flow have introduced bias?	High <i>(There was not an appropriate interval between index test(s) and reference standard. For the MD group, parents were interviewed a median of 4 months after hospital admission about signs and symptoms)</i>

1 **Nielsen, 2001**

**Bibliographic Reference**

Nielsen, H.E; Andersen, E.A; Andersen, J; Bottiger, B; Christiansen, K.M; Daugbjerg, P; Larsen, S.O; Lind, I; Nir, M; Olofsson, K.; Diagnostic assessment of haemorrhagic rash and fever; Archives of Disease in Childhood; 2001; vol. 85 (no. 2); 160-165

2 **Study details**

**Country/ies where study was carried out**

Denmark

<b>Study type</b>	Single-gate, cross-sectional DTA study
<b>Study dates</b>	September 1993 to June 1996
<b>Inclusion criteria</b>	Babies and children aged 1 month to 16 years with skin haemorrhages detected at admission/during hospital stay and rectal temperature >38°C within the 24 hours before inclusion
<b>Exclusion criteria</b>	If a child was admitted twice during the study period and fulfilled the inclusion criteria on both occasions, only the first admission was included in the study.
<b>Patient characteristics</b>	<p>N=264 included in the study and N=208 analysed (excluded from analysis were those with: invasive bacterial infection excluding meningococcal disease, n=6; insufficient information [either antibiotic treatment prior to blood culture, or no blood culture but treated with antibiotics], n=50).</p> <p>Meningococcal disease (n=39): Confirmed case n=29 (median age 30 months); probable case n=10 (median age 14 months). N=9 serogroup C cases.</p> <p>No invasive bacterial disease (n=169): Enterovirus infection n=18 (median age 21 months); adenovirus infection n=11 (median age 22 months); no invasive bacterial disease (either no bacteria in cultures from blood or spinal fluid and no antibiotic treatment prior to culture; or no blood culture, but spontaneous recovery) n=140 (median age 27 months).</p>
<b>Index test(s)</b>	<p>Signs and symptoms, recorded by healthcare professionals on preprinted study forms and including information from the case history and a standardized physical examination:</p> <ul style="list-style-type: none"> <li>(a) Case history included coughing prior to inclusion</li> <li>(b) Case history included vomiting prior to inclusion</li> <li>(c) Nuchal rigidity</li> <li>(d) More than 20 skin haemorrhages</li> <li>(e) Skin haemorrhages with maximum diameter &gt;1mm</li> <li>(f) Skin haemorrhages with maximum diameter &gt;2mm</li> </ul>

	(g) Universal distribution of skin haemorrhages
<b>Reference standard(s)</b>	Confirmed case defined as clinical diagnosis of meningitis or septicaemia confirmed by culture of <i>Neisseria meningitidis</i> from blood and/or spinal fluid.  Probable case defined as clinical diagnosis of meningitis or septicaemia without culture confirmation, but defined by a significant increase in meningococcal antibody titres, or a high antibody titre in a single serum sample drawn during the 2nd or 3rd week after onset of disease, and/or demonstration of serogroup A or C meningococcal capsular polysaccharide in the acute serum sample by counterimmunoelectrophoresis.
<b>Duration of follow-up</b>	Not reported
<b>Sources of funding</b>	Not industry funded
<b>Other information</b>	Paper reports many outcomes as medians rather than dichotomised. Factors reported as percentages rather than numbers (converted to numbers based on assumption that data available for whole sample).

1 *Abbreviations: DTA: diagnostic test accuracy*

## 2 Outcomes

### 3 Signs and symptoms of meningococcal disease

<b>Outcome</b>	<b>N = 208</b>
<b>Case history included coughing prior to inclusion</b>	TP 6; FP 63; FN 33; TN 106
Custom value	
<b>Case history included vomiting prior to inclusion</b>	TP 17; FP 68; FN 22; TN 101
Custom value	
<b>Nuchal rigidity</b>	TP 16; FP 5; FN 23; TN 164
Custom value	
<b>More than 20 skin haemorrhages</b>	TP 29; FP 86; FN 10; TN 83

<b>Outcome</b>	<b>N = 208</b>
Custom value	
<b>Skin haemorrhages with maximum diameter &gt;1mm</b>	TP 37; FP 37; FN 2; TN 132
Custom value	
<b>Skin haemorrhages with maximum diameter &gt;2mm</b>	TP 29; FP 14; FN 10; TN 155
Custom value	
<b>Universal distribution of skin haemorrhages</b>	TP 36; FP 68; FN 3; TN 101
Custom value	

1 **Critical appraisal - QUADAS-2**

2

Section	Question	Answer
Patient selection: risk of bias	Was a consecutive or random sample of patients enrolled?	Yes
Patient selection: risk of bias	Was a case-control design avoided?	Yes
Patient selection: risk of bias	Did the study avoid inappropriate exclusions?	Yes <i>(There was only one exclusion criterion: if a child was admitted twice during the study period and fulfilled the inclusion criteria on both occasions, only the first admission was included in the study)</i>
Patient selection: risk of bias	Could the selection of patients have introduced bias?	Low <i>(Consecutive sample enrolled and the study avoided inappropriate exclusions)</i>
Patient selection: applicability	Are there concerns that included patients do not match the review question?	Low

Section	Question	Answer
Index tests: risk of bias	Were the index test results interpreted without knowledge of the results of the reference standard?	Unclear <i>(No information about whether index tests were interpreted without knowledge of the reference standard)</i>
Index tests: risk of bias	If a threshold was used, was it pre-specified?	Unclear <i>(Not all prognostic factors clearly described, although all with extractable data are objective. Non-standard thresholds used for size of skin haemorrhages.)</i>
Index tests: risk of bias	Could the conduct or interpretation of the index test have introduced bias?	Unclear <i>(No information about whether index tests were interpreted without knowledge of the reference standard; not all prognostic factors clearly described, although all with extractable data are objective. Non-standard thresholds used for size of skin haemorrhages.)</i>
Index tests: applicability	Are there concerns that the index test, its conduct, or interpretation differ from the review question?	Low
Reference standard: risk of bias	Is the reference standard likely to correctly classify the target condition?	Yes
Reference standard: risk of bias	Were the reference standard results interpreted without knowledge of the results of the index test?	Unclear <i>(No information about whether reference standards were interpreted without knowledge of the index tests)</i>
Reference standard: risk of bias	Could the reference standard, its conduct, or its interpretation have introduced bias?	Low <i>(No information about whether reference standards were interpreted without knowledge of the index tests; however, tests are objective so unlikely that knowledge of results would introduce bias)</i>
Reference standard: applicability	Is there concern that the target condition as defined by the reference standard does not match the review question?	Low

Section	Question	Answer
Flow and timing: risk of bias	Was there an appropriate interval between index test(s) and reference standard?	Yes <i>(Index tests and reference standard conducted at the same time)</i>
Flow and timing: risk of bias	Did all patients receive a reference standard?	Yes
Flow and timing: risk of bias	Did patients receive the same reference standard?	Yes
Flow and timing: risk of bias	Were all patients included in the analysis?	Yes
Flow and timing: risk of bias	Could the patient flow have introduced bias?	Low <i>(Index tests and reference standard conducted at the same time, and all patients included in the analysis)</i>

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## 2 Waterfield, 2021

**Bibliographic Reference** Waterfield, T; Maney, J. A; Fairley, D; Lyttle, M. D; McKenna, J. P; Roland, D; Corr, M; McFetridge, L; Mitchell, H; Woolfall, K; Lynn, F; Patenall, B; Shields, M. D; Paediatric Emergency Research in the, U. K; Ireland, Group; Validating clinical practice guidelines for the management of children with non-blanching rashes in the UK (PiC): a prospective, multicentre cohort study; The Lancet Infectious Diseases; 2021; vol. 21 (no. 4); 569-577

## 3 Study details

<b>Country/ies where study was carried out</b>	UK
<b>Study type</b>	Single-gate, cross-sectional DTA study
<b>Study dates</b>	November 2017 to June 2019

<b>Inclusion criteria</b>	Children (aged under 18 years) presenting to paediatric emergency department with fever ( $\geq 38^{\circ}\text{C}$ ), new-onset non-blanching rash or features suggestive of meningococcal infection
<b>Exclusion criteria</b>	Pre-existing haematological condition (haematological malignancy, idiopathic thrombocytopenic purpura, or coagulopathy); existing diagnosis of Henoch-Schönlein purpura
<b>Patient characteristics</b>	<p>N=1329</p> <p>Meningococcal disease (n=19):</p> <p>Age in months (median; interquartile range (IQR) in parentheses): 37 (9-58)</p> <p>Sex: male: 16 (84%); female: 3 (16%)</p> <p>Serogroup of <i>N. meningitidis</i>: B n=17 (89%); C n=1 (5%); W n=1 (5%)</p> <p>No meningococcal disease (n=1310):</p> <p>Age in months (median; interquartile range (IQR) in parentheses): 24 (12-48)</p> <p>Sex: male: 765 (58%); female: 545 (42%)</p> <p>No further details provided for those negative for meningococcal disease</p>
<b>Index test(s)</b>	<p>Signs and symptoms, identified by healthcare professionals and recorded prospectively on an electronic case report form:</p> <p>(a) Duration of illness (&lt;24 hours)</p> <p>(b) Duration of rash (&lt;4 hours)</p> <p>(c) Petechiae only (without purpura)</p>

- (d) Purpura
- (e) Superior vena cava distribution of rash
- (f) Spreading rash
- (g) Unwell appearance (based on an overall assessment of appearance)
- (h) Signs of shock (defined as clinician-diagnosed shock, a long capillary refill time of 4 seconds or more, or hypotension)
- (i) Tachycardia
- (j) Tachypnoea
- (k) Gastrointestinal symptoms (abdominal pain, abdominal distension, diarrhoea, or nausea or vomiting)
- (l) Shivers or chills
- (m) Pallor
- (n) Unusual skin colour
- (o) Cold hands or feet
- (p) Respiratory symptoms
- (q) Sore throat or coryza
- (r) Lethargy
- (s) Refusal of food and drink

	(t) Limb pain
	(u) Signs or symptoms of meningism (a positive Brudzinski's and Kernig's sign, a bulging fontanelle, irritability, photophobia, neck stiffness, and headache)
	(v) Reduced consciousness
<b>Reference standard(s)</b>	Diagnosis based on a positive culture or PCR test for <i>N. meningitidis</i> or other bacterial pathogen from a sterile body site (for example, blood or CSF)
<b>Duration of follow-up</b>	Not reported
<b>Sources of funding</b>	Not industry funded

1 *Abbreviations: CSF: cerebrospinal fluid; DTA: diagnostic test accuracy; N. Meningitidis: Neisseria Meningitidis; PCR: positive polymerase chain reaction*

## 2 Outcomes

### 3 Signs and symptoms of meningococcal disease

Outcome	N = 1329
<b>Duration of illness (&lt;24 hours)</b> Data available for 99% of sample  Custom value	TP 10; FP 430; FN 9; TN 873
<b>Duration of rash (&lt;4 hours)</b> Data available for 93% of sample  Custom value	TP 12; FP 753; FN 7; TN 461
<b>Petechiae only (without purpura)</b>  Custom value	TP 6; FP 1245; FN 13; TN 65
<b>Purpura</b>	TP 13; FP 65; FN 6; TN 1245

<b>Outcome</b>	<b>N = 1329</b>
Custom value	
<b>Superior vena cava distribution of rash</b>	TP 6; FP 482; FN 13; TN 828
Custom value	
<b>Spreading rash</b>	TP 12; FP 308; FN 7; TN 1002
Custom value	
<b>Unwell appearance</b>	TP 16; FP 362; FN 3; TN 948
Custom value	
<b>Signs of shock</b>	TP 13; FP 67; FN 6; TN 1243
Custom value	
<b>Tachycardia</b>	TP 15; FP 592; FN 4; TN 718
Custom value	
<b>Tachypnoea</b> Data available for 99% of sample	TP 12; FP 431; FN 7; TN 863
Custom value	
<b>Gastrointestinal symptoms</b>	TP 8; FP 557; FN 11; TN 753
Custom value	
<b>Shivers or chills</b>	TP 6; FP 106; FN 13; TN 1204
Custom value	
<b>Pallor</b>	TP 8; FP 95; FN 11; TN 1215

<b>Outcome</b>	<b>N = 1329</b>
Custom value	
<b>Unusual skin colour</b>	TP 9; FP 108; FN 10; TN 1202
Custom value	
<b>Cold hands or feet</b>	TP 9; FP 129; FN 10; TN 1181
Custom value	
<b>Respiratory symptoms</b>	TP 8; FP 400; FN 11; TN 910
Custom value	
<b>Sore throat or coryza</b>	TP 5; FP 673; FN 14; TN 637
Custom value	
<b>Lethargy</b>	TP 13; FP 307; FN 6; TN 1003
Custom value	
<b>Refusal of food and drink</b>	TP 8; FP 403; FN 11; TN 907
Custom value	
<b>Limb pain</b>	TP 6; FP 66; FN 13; TN 1244
Custom value	
<b>Signs or symptoms of meningism</b>	TP 7; FP 273; FN 12; TN 1037
Custom value	
<b>Reduced consciousness</b>	TP 10; FP 13; FN 9; TN 1297
Custom value	

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## Critical appraisal - QUADAS-2

Section	Question	Answer
Patient selection: risk of bias	Was a consecutive or random sample of patients enrolled?	Yes
Patient selection: risk of bias	Was a case-control design avoided?	Yes
Patient selection: risk of bias	Did the study avoid inappropriate exclusions?	Unclear <i>(Children with clear alternative diagnoses were excluded)</i>
Patient selection: risk of bias	Could the selection of patients have introduced bias?	Unclear <i>(Consecutive sample enrolled, but excluded children with clear alternative diagnoses)</i>
Patient selection: applicability	Are there concerns that included patients do not match the review question?	Low
Index tests: risk of bias	Were the index test results interpreted without knowledge of the results of the reference standard?	Unclear <i>(No information about whether index tests were interpreted without knowledge of the reference standard)</i>
Index tests: risk of bias	If a threshold was used, was it pre-specified?	No <i>(Limited detail on how the index tests were measured and defined and many are subjective)</i>
Index tests: risk of bias	Could the conduct or interpretation of the index test have introduced bias?	High <i>(No information about whether index tests were interpreted without knowledge of the reference standard, and index tests subjective and poorly defined)</i>
Index tests: applicability	Are there concerns that the index test, its	Low

Section	Question	Answer
	conduct, or interpretation differ from the review question?	
Reference standard: risk of bias	Is the reference standard likely to correctly classify the target condition?	Yes
Reference standard: risk of bias	Were the reference standard results interpreted without knowledge of the results of the index test?	Unclear <i>(No information about whether reference standards were interpreted without knowledge of the index tests)</i>
Reference standard: risk of bias	Could the reference standard, its conduct, or its interpretation have introduced bias?	Low <i>(No information about whether reference standards were interpreted without knowledge of the index tests; however, tests are objective so unlikely that knowledge of results would introduce bias)</i>
Reference standard: applicability	Is there concern that the target condition as defined by the reference standard does not match the review question?	Low
Flow and timing: risk of bias	Was there an appropriate interval between index test(s) and reference standard?	Unclear <i>(Interval between index test and reference standard is not clear)</i>
Flow and timing: risk of bias	Did all patients receive a reference standard?	Yes
Flow and timing: risk of bias	Did patients receive the same reference standard?	Yes
Flow and timing: risk of bias	Were all patients included in the analysis?	No <i>(Some missing data but limited attrition (1-7%))</i>
Flow and timing: risk of bias	Could the patient flow have introduced bias?	Unclear <i>(Unclear interval between index test and reference standard, and some missing data but limited attrition (1-7%))</i>

1

2 **Wells, 2001**

**Bibliographic Reference**

Wells, L.C; Smith, J.C; Weston, V.C; Collier, J; Rutter, N.; The child with a non-blanching rash: how likely is meningococcal disease?; Archives of Disease in Childhood; 2001; vol. 85 (no. 3); 218-222

3 **Study details**

<b>Country/ies where study was carried out</b>	UK
<b>Study type</b>	Single-gate, cross-sectional DTA study
<b>Study dates</b>	1 November 1998 to 31 October 1999
<b>Inclusion criteria</b>	Babies and children aged up to 15 years; presenting to an accident and emergency department with a non-blanching rash.
<b>Exclusion criteria</b>	Not explicitly reported, but excluded those with a clear alternative diagnosis (11 with Henoch–Schonlein purpura, 1 with idiopathic thrombocytopenic purpura, 1 with haemolytic uraemic syndrome, 1 with acute leukaemia, and 1 with a previously recognised clotting disorder)
<b>Patient characteristics</b>	<p>N=218</p> <p>Age in months (median): 24; 55% &lt;3 years</p> <p>Meningococcal disease (n=24)</p> <p>Serogroup of N. meningitidis: B n=12 (50%); C n=11 (46%); unknown n=1 (4%).</p> <p>No further details provided for those negative for meningococcal disease</p>
<b>Index test(s)</b>	<p>Signs and symptoms data collected on standard proforma by the paediatric medical team at the time of presentation.</p> <p>Clinical features:</p> <p>(a) Illness categorisation (defined as toxic, irritable and crying inconsolably, or lethargic)</p>

	(b) Purpura (lesions >2 mm in diameter)
	(c) Rash beyond superior vena cava (SVC)
	(d) Fever >38.5°C
	(e) Fever >37.5°C
	(f) Hypotension (defined as 2 SD or more below the mean for age)
	(g) Capillary refill >2 seconds
<b>Reference standard(s)</b>	Meningococcal infection defined using a positive blood, CSF, or skin culture for <i>N. meningitidis</i> , Gram negative diplococci in CSF, or PCR for meningococcal DNA from blood or CSF.  Method of diagnosis used in confirmed cases: Positive blood culture alone (n=5; 21%); Positive PCR alone (n=9; 37.5%); Positive PCR and blood culture (n=9; 37.5%); Positive PCR, blood culture, and CSF (n=1; 4%).
<b>Duration of follow-up</b>	Not reported
<b>Sources of funding</b>	Not reported

1 Abbreviations: CSF: cerebrospinal fluid; DNA: deoxyribonucleic acid; DTA: diagnostic test accuracy; *N. Meningitidis*: *Neisseria Meningitidis*; PCR: positive polymerase chain  
2 reaction; SD: standard deviation  
3

#### 4 Outcomes

#### 5 Signs and symptoms for meningococcal disease

<b>Outcome</b>	<b>N = 218</b>
<b>Illness categorisation</b>	TP 19; FP 36; FN 5; TN 158
Custom value	
<b>Purpura</b>	TP 20; FP 23; FN 4; TN 171

<b>Outcome</b>	<b>N = 218</b>
Lesions >2 mm in diameter	
Custom value	
<b>Rash beyond superior vena cava (SVC)</b>	TP 24; FP 120; FN 0; TN 74
Custom value	
<b>Fever &gt;38.5°C</b>	TP 14; FP 37; FN 10; TN 157
Custom value	
<b>Fever &gt;37.5°C</b>	TP 19; FP 88; FN 5; TN 106
Custom value	
<b>hypotension</b>	TP 5; FP 2; FN 13; TN 66
Custom value	
<b>Capillary refill &gt;2 seconds</b>	TP 20; FP 28; FN 4; TN 165
Custom value	

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2 **Critical appraisal - QUADAS-2**

3

<b>Section</b>	<b>Question</b>	<b>Answer</b>
Patient selection: risk of bias	Was a consecutive or random sample of patients enrolled?	Yes

Section	Question	Answer
Patient selection: risk of bias	Was a case-control design avoided?	Yes
Patient selection: risk of bias	Did the study avoid inappropriate exclusions?	Unclear <i>(Children with clear alternative diagnoses were excluded)</i>
Patient selection: risk of bias	Could the selection of patients have introduced bias?	Unclear <i>(Consecutive sample enrolled but excluded children with clear alternative diagnoses)</i>
Patient selection: applicability	Are there concerns that included patients do not match the review question?	Low
Index tests: risk of bias	Were the index test results interpreted without knowledge of the results of the reference standard?	Unclear <i>(No information about whether index tests were interpreted without knowledge of the reference standard)</i>
Index tests: risk of bias	If a threshold was used, was it pre-specified?	Unclear <i>(Most index tests were systematically quantified and thresholds defined, although thresholds for the categorisation of 'ill' are unclear)</i>
Index tests: risk of bias	Could the conduct or interpretation of the index test have introduced bias?	Unclear <i>(No information about whether index tests were interpreted without knowledge of the reference standards. Most index tests were systematically quantified and thresholds defined, although thresholds for the categorisation of 'ill' are unclear)</i>
Index tests: applicability	Are there concerns that the index test, its conduct, or interpretation differ from the review question?	Low
Reference standard: risk of bias	Is the reference standard likely to correctly classify the target condition?	Yes

Section	Question	Answer
Reference standard: risk of bias	Were the reference standard results interpreted without knowledge of the results of the index test?	Unclear <i>(No information about whether reference standards were interpreted without knowledge of the index tests)</i>
Reference standard: risk of bias	Could the reference standard, its conduct, or its interpretation have introduced bias?	Low <i>(No information about whether reference standards were interpreted without knowledge of the index tests; however, tests are objective so unlikely that knowledge of results would introduce bias)</i>
Reference standard: applicability	Is there concern that the target condition as defined by the reference standard does not match the review question?	Low
Flow and timing: risk of bias	Was there an appropriate interval between index test(s) and reference standard?	Yes <i>(Index tests and reference standard conducted at the same time)</i>
Flow and timing: risk of bias	Did all patients receive a reference standard?	Yes
Flow and timing: risk of bias	Did patients receive the same reference standard?	Yes
Flow and timing: risk of bias	Were all patients included in the analysis?	Yes
Flow and timing: risk of bias	Could the patient flow have introduced bias?	Low <i>(Index tests and reference standard conducted at the same time, and all patients included in the analysis)</i>

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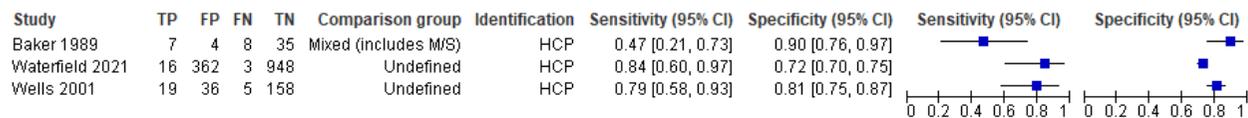
1

## 2 Appendix E Forest plots

### 3 Forest plots for review question: What symptoms and signs, individually or in combination, are associated with 4 meningococcal disease?

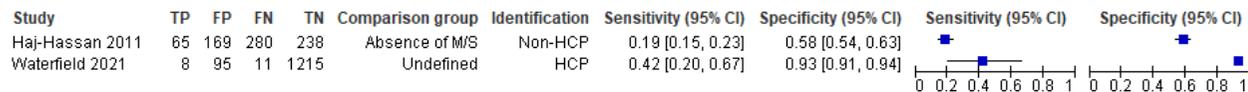
5 This section includes forest plots only for outcomes that include more than one study. Outcomes from single studies are not presented here; the  
6 quality assessment for such outcomes is provided in the GRADE profiles in appendix F.

#### 7 Figure 2: Illness categorisation or appearance for diagnosis of meningococcal disease in babies and children



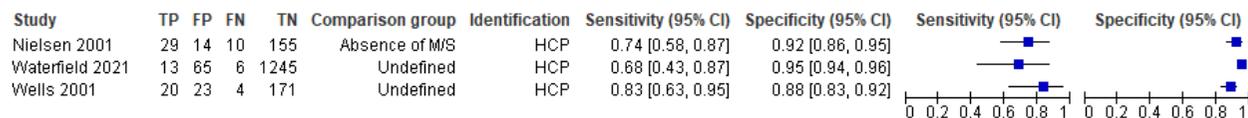
8

#### 9 Figure 3: Pale skin colour for diagnosis of meningococcal disease in babies and children



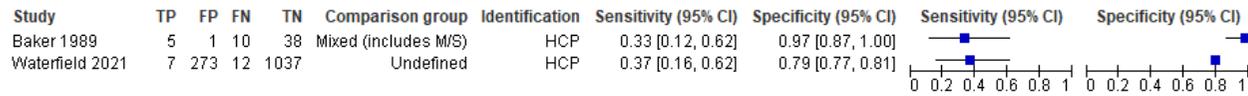
10

#### 11 Figure 4: Purpura (lesions >2 mm in diameter) for diagnosis of meningococcal disease in babies and children



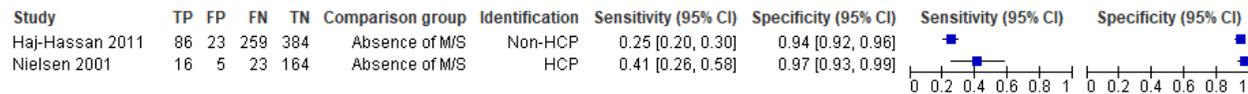
12

1 **Figure 5: Signs of meningism for diagnosis of meningococcal disease in babies and children**



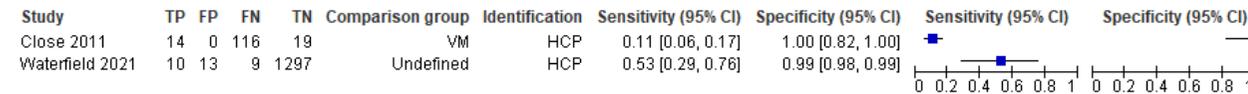
2

3 **Figure 6: Neck pain or stiffness for diagnosis of meningococcal disease in babies and children**



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5 **Figure 7: Reduced consciousness for diagnosis of meningococcal disease in babies and children**



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2 **Appendix F GRADE table**

3 **GRADE tables for review question: What symptoms and signs, individually or in combination, are associated with**  
4 **meningococcal disease?**

5 **Table 5: Illness categorisation or appearance for diagnosis of meningococcal disease in babies and children. Comparison group:**  
6 **nonbacteremic disease (includes viral meningitis)/negative for MD (no further detail). Healthcare professional identification**

No of studies	Study details	No of participants	Effect size (95% CI)	Risk of bias	Inconsistency	Indirectness	Imprecision	Quality of evidence	PPV	NPV
1 (Baker 1989)	Population: Invasive bacterial disease compared to nonbacteremic disease (includes VM) (People aged <21 years with fever >38°C and petechial rash)  Reference standard: Detection of N. meningitidis on blood or CSF culture	54	Sensitivity: 0.47 (0.21 to 0.73)	Serious <sup>1</sup>	No serious	Serious <sup>2</sup>	Serious <sup>3</sup>	VERY LOW	0.64	0.81
			Specificity: 0.90 (0.76 to 0.97)	Serious <sup>1</sup>	No serious	Serious <sup>2</sup>	Serious <sup>3</sup>	VERY LOW		

1 (Waterfield 2021)	Population: MD compared to non-MD (undefined) (Children <18 years presenting to paediatric emergency department with fever ≥38°C, new-onset non-blanching rash or features suggestive of meningococcal infection)  Reference standard: Positive culture or PCR test for N. meningitidis or other bacterial pathogen from a sterile body site (for example, blood or CSF)	1329	Sensitivity: 0.84 (0.60 to 0.97)	Serious <sup>1</sup>	No serious	No serious	Serious <sup>3</sup>	LOW	0.04	1.00
			Specificity: 0.72 (0.70 to 0.75)	Serious <sup>1</sup>	No serious	No serious	No serious	MODERATE		
1 (Wells 2001)	Population: MD compared to non-MD (undefined) (Children ≤15 years presenting to A&E with non-blanching rash)  Reference standard: Blood, CSF or skin culture, gram staining, blood or CSF PCR	218	Sensitivity: 0.79 (0.58 to 0.93)	No serious	No serious	No serious	Serious <sup>3</sup>	MODERATE	0.35	0.97
			Specificity: 0.81 (0.75 to 0.87)	No serious	No serious	No serious	No serious	HIGH		

1 A&E: accident and emergency; CI: confidence interval; CSF: cerebrospinal fluid; MD: meningococcal disease; N. Meningitidis: Neisseria Meningitidis; NPV: negative predictive  
2 value; PCR: positive polymerase chain reaction; PPV: positive predictive value; VM: viral meningitis

3 <sup>1</sup> Serious risk of bias in the evidence contributing to the outcomes as per QUADAS-2

4 <sup>2</sup> 40% of MD population is indirect (27% with meningococcal meningitis alone and 13% with meningitis with other causes)

5 <sup>3</sup> 95% CI crosses 1 decision making threshold

6  
7

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2 **Table 6: Irritable or miserable for diagnosis of meningococcal disease in babies and children. Comparison group: absence of sepsis**  
3 **and meningitis. Non-healthcare professional (parental) identification**

No of studies	Study details	No of participants	Effect size (95% CI)	Risk of bias	Inconsistency	Indirectness	Imprecision	Quality of evidence	PPV	NPV
1 (Haj-Hassan 2011)	Population: MD compared to minor febrile infection (Children aged <16 years with non-fatal MD)	752	Sensitivity: 0.68 (0.63 to 0.73)	Very serious <sup>1</sup>	No serious	No serious	No serious	LOW	0.53	0.64
	Reference standard: Clinical record review (79% confirmed through microbiological techniques)		Specificity: 0.48 (0.43 to 0.53)	Very serious <sup>1</sup>	No serious	No serious	Serious <sup>2</sup>	VERY LOW		

4 *CI: confidence interval; MD: meningococcal disease; NPV: negative predictive value; PPV: positive predictive value*

5 <sup>1</sup> *Very serious risk of bias in the evidence contributing to the outcomes as per QUADAS-2*

6 <sup>2</sup> *95% CI crosses 1 decision making threshold*

7 **Table 7: Duration of illness (<24 hours) for diagnosis of meningococcal disease in babies and children. Comparison group: negative for**  
8 **MD (no further detail). Healthcare professional identification**

No of studies	Study details	No of participants	Effect size (95% CI)	Risk of bias	Inconsistency	Indirectness	Imprecision	Quality of evidence	PPV	NPV
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1 (Waterfield 2021)	Population: MD compared to non-MD (undefined) (Children <18 years presenting to paediatric emergency department with fever ≥38°C, new-onset non-blanching rash or features suggestive of meningococcal infection)  Reference standard: Positive culture or PCR test for N. meningitidis or other bacterial pathogen from a sterile body site (for example, blood or CSF)	1322	Sensitivity: 0.53 (0.29 to 0.76)	Serious <sup>1</sup>	No serious	No serious	Serious <sup>2</sup>	LOW	0.02	0.99
			Specificity: 0.67 (0.64 to 0.70)	Serious <sup>1</sup>	No serious	No serious	No serious	MODERATE		

- 1 *CI: confidence interval; CSF: cerebrospinal fluid; MD: meningococcal disease; N. Meningitidis: Neisseria Meningitidis; MD: meningococcal disease; NPV: negative predictive value;*  
2 *PCR: positive polymerase chain reaction; PPV: positive predictive value*  
3 <sup>1</sup> *Serious risk of bias in the evidence contributing to the outcomes as per QUADAS-2*  
4 <sup>2</sup> *95% CI crosses 1 decision making threshold*

5 **Table 8: Fever >37.5°C for diagnosis of meningococcal disease in babies and children. Comparison group: negative for MD (no further**  
6 **detail). Healthcare professional identification**

No of studies	Study details	No of participants	Effect size (95% CI)	Risk of bias	Inconsistency	Indirectness	Imprecision	Quality of evidence	PPV	NPV
1 (Wells 2001)	Population: MD compared to non-MD (undefined) (Children ≤15 years presenting to A&E with non-blanching rash)	218	Sensitivity: 0.79 (0.58 to 0.93)	No serious	No serious	No serious	Serious <sup>1</sup>	MODERATE	0.18	0.96

	Reference standard: Blood, CSF or skin culture, gram staining, blood or CSF PCR		Specificity: 0.55 (0.47 to 0.62)	No serious	No serious	No serious	Serious <sup>1</sup>	MODERATE		
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1 A&E: accident and emergency; CI: confidence interval; CSF: cerebrospinal fluid; MD: meningococcal disease; NPV: negative predictive value; PCR: positive polymerase chain  
 2 reaction; PPV: positive predictive value  
 3 <sup>1</sup> 95% CI crosses 1 decision making threshold

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5 **Table 9: Fever >38.5°C for diagnosis of meningococcal disease in babies and children. Comparison group: negative for MD (no further  
 6 detail). Healthcare professional identification**

No of studies	Study details	No of participants	Effect size (95% CI)	Risk of bias	Inconsistency	Indirectness	Imprecision	Quality of evidence	PPV	NPV
1 (Wells 2001)	Population: MD compared to non-MD (undefined) (Children ≤15 years presenting to A&E with non-blanching rash)	218	Sensitivity: 0.58 (0.37 to 0.78)	No serious	No serious	No serious	Serious <sup>1</sup>	MODERATE	0.27	0.94
	Reference standard: Blood, CSF or skin culture, gram staining, blood or CSF PCR		Specificity: 0.81 (0.75 to 0.86)	No serious	No serious	No serious	No serious	HIGH		

7 A&E: accident and emergency; CI: confidence interval; CSF: cerebrospinal fluid; MD: meningococcal disease; NPV: negative predictive value; PCR: positive polymerase chain  
 8 reaction; PPV: positive predictive value  
 9 <sup>1</sup> 95% CI crosses 1 decision making threshold

10 **Table 10: Shivers or chills for diagnosis of meningococcal disease in babies and children. Comparison group: negative for MD (no  
 11 further detail). Healthcare professional identification**

No of studies	Study details	No of participants	Effect size (95% CI)	Risk of bias	Inconsistency	Indirectness	Imprecision	Quality of evidence	PPV	NPV
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1 (Waterfield 2021)	Population: MD compared to non-MD (undefined) (Children <18 years presenting to paediatric emergency department with fever ≥38°C, new-onset non-blanching rash or features suggestive of meningococcal infection)  Reference standard: Positive culture or PCR test for N. meningitidis or other bacterial pathogen from a sterile body site (for example, blood or CSF)	1329	Sensitivity: 0.32 (0.13 to 0.57)	Serious <sup>1</sup>	No serious	No serious	Serious <sup>2</sup>	LOW	0.05	0.99
			Specificity: 0.92 (0.90 to 0.93)	Serious <sup>1</sup>	No serious	No serious	No serious	MODERATE		

- 1 *CI: confidence interval; CSF: cerebrospinal fluid; MD: meningococcal disease; N. Meningitidis: Neisseria Meningitidis; MD: meningococcal disease; NPV: negative predictive value;*  
2 *PCR: positive polymerase chain reaction; PPV: positive predictive value*  
3 <sup>1</sup> *Serious risk of bias in the evidence contributing to the outcomes as per QUADAS-2*  
4 <sup>2</sup> *95% CI crosses 1 decision making threshold*

5 **Table 11: Lethargy for diagnosis of meningococcal disease in babies and children. Comparison group: negative for MD (no further**  
6 **detail). Healthcare professional identification**

No of studies	Study details	No of participants	Effect size (95% CI)	Risk of bias	Inconsistency	Indirectness	Imprecision	Quality of evidence	PPV	NPV
---------------	---------------	--------------------	----------------------	--------------	---------------	--------------	-------------	---------------------	-----	-----

1 (Waterfield 2021)	Population: MD compared to non-MD (undefined) (Children <18 years presenting to paediatric emergency department with fever ≥38°C, new-onset non-blanching rash or features suggestive of meningococcal infection)  Reference standard: Positive culture or PCR test for N. meningitidis or other bacterial pathogen from a sterile body site (for example, blood or CSF)	1329	Sensitivity: 0.68 (0.43 to 0.87)	Serious <sup>1</sup>	No serious	No serious	Serious <sup>2</sup>	LOW	0.04	0.99
			Specificity: 0.77 (0.74 to 0.79)	Serious <sup>1</sup>	No serious	No serious	No serious	MODERATE		

- 1 *CI: confidence interval; CSF: cerebrospinal fluid; MD: meningococcal disease; N. Meningitidis: Neisseria Meningitidis; MD: meningococcal disease; NPV: negative predictive value;*  
2 *PCR: positive polymerase chain reaction; PPV: positive predictive value*  
3 <sup>1</sup> *Serious risk of bias in the evidence contributing to the outcomes as per QUADAS-2*  
4 <sup>2</sup> *95% CI crosses 1 decision making threshold*

5 **Table 12: Drowsiness for diagnosis of meningococcal disease in babies and children. Comparison group: absence of sepsis and**  
6 **meningitis. Non-healthcare professional (parental) identification**

No of studies	Study details	No of participants	Effect size (95% CI)	Risk of bias	Inconsistency	Indirectness	Imprecision	Quality of evidence	PPV	NPV
1 (Haj-Hassan 2011)	Population: MD compared to minor febrile infection (Children aged <16 years with non-fatal MD)	752	Sensitivity: 0.80 (0.75 to 0.84)	Very serious <sup>1</sup>	No serious	No serious	No serious	LOW	0.66	0.79

	Reference standard: Clinical record review (79% confirmed through microbiological techniques)		Specificity: 0.65 (0.60 to 0.70)	Very serious <sup>1</sup>	No serious	No serious	No serious	LOW		
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1 *CI: confidence interval; MD: meningococcal disease; NPV: negative predictive value; PPV: positive predictive value*  
2 <sup>1</sup> Very serious risk of bias in the evidence contributing to the outcomes as per QUADAS-2

3 **Table 13: Confusion for diagnosis of meningococcal disease in babies and children. Comparison group: absence of sepsis and**  
4 **meningitis. Non-healthcare professional (parental) identification**

No of studies	Study details	No of participants	Effect size (95% CI)	Risk of bias	Inconsistency	Indirectness	Imprecision	Quality of evidence	PPV	NPV
1 (Haj-Hassan 2011)	Population: MD compared to minor febrile infection (Children aged <16 years with non-fatal MD)	616 <sup>1</sup>	Sensitivity: 0.40 (0.34 to 0.47)	Very serious <sup>2</sup>	No serious	No serious	No serious	LOW	0.94	0.71
	Reference standard: Clinical record review (79% confirmed through microbiological techniques)		Specificity: 0.98 (0.96 to 0.99)	Very serious <sup>2</sup>	No serious	No serious	No serious	LOW		

5 *CI: confidence interval; MD: meningococcal disease; NPV: negative predictive value; PPV: positive predictive value*  
6 <sup>1</sup> Analysed in children >1 year (as considered age-specific by authors of the meningococcal paper)  
7 <sup>2</sup> Very serious risk of bias in the evidence contributing to the outcomes as per QUADAS-2

8 **Table 14: Pale skin colour for diagnosis of meningococcal disease in babies and children. Comparison group: absence of sepsis and**  
9 **meningitis/negative for MD (no further detail). Non-healthcare professional (parental)/healthcare professional identification**

No of studies	Study details	No of participants	Effect size (95% CI)	Risk of bias	Inconsistency	Indirectness	Imprecision	Quality of evidence	PPV	NPV
---------------	---------------	--------------------	----------------------	--------------	---------------	--------------	-------------	---------------------	-----	-----

1 (Haj-Hassan 2011)	Population: MD compared to minor febrile infection (Children aged <16 years with non-fatal MD)  Reference standard: Clinical record review (79% confirmed through microbiological techniques)	752	Sensitivity: 0.19 (0.15 to 0.23)	Very serious <sup>1</sup>	No serious	No serious	No serious	LOW	0.28	0.46
			Specificity: 0.58 (0.54 to 0.63)	Very serious <sup>1</sup>	No serious	No serious	No serious	LOW		
1 (Waterfield 2021)	Population: MD compared to non-MD (undefined) (Children <18 years presenting to paediatric emergency department with fever ≥38°C, new-onset non-blanching rash or features suggestive of meningococcal infection)  Reference standard: Positive culture or PCR test for N. meningitidis or other bacterial pathogen from a sterile body site (for example, blood or CSF)	1329	Sensitivity: 0.42 (0.20 to 0.67)	Serious <sup>2</sup>	No serious	No serious	Serious <sup>3</sup>	LOW	0.08	0.99
			Specificity: 0.93 (0.91 to 0.94)	Serious <sup>2</sup>	No serious	No serious	No serious	MODERATE		

1 CI: confidence interval; CSF: cerebrospinal fluid; MD: meningococcal disease; N. Meningitidis: Neisseria Meningitidis; NPV: negative predictive value; PCR: positive polymerase chain reaction; PPV: positive predictive value

- 1 <sup>1</sup> Very serious risk of bias in the evidence contributing to the outcomes as per QUADAS-2  
 2 <sup>2</sup> Serious risk of bias in the evidence contributing to the outcomes as per QUADAS-2  
 3 <sup>3</sup> 95% CI crosses 1 decision making threshold  
 4

5 **Table 15: Unusual skin colour for diagnosis of meningococcal disease in babies and children. Comparison group: negative for MD (no**  
 6 **further detail). Healthcare professional identification**

No of studies	Study details	No of participants	Effect size (95% CI)	Risk of bias	Inconsistency	Indirectness	Imprecision	Quality of evidence	PPV	NPV
1 (Waterfield 2021)	Population: MD compared to non-MD (undefined) (Children <18 years presenting to paediatric emergency department with fever ≥38°C, new-onset non-blanching rash or features suggestive of meningococcal infection)  Reference standard: Positive culture or PCR test for N. meningitidis or other bacterial pathogen from a sterile body site (for example, blood or CSF)	1329	Sensitivity: 0.47 (0.24 to 0.71)	Serious <sup>1</sup>	No serious	No serious	Serious <sup>2</sup>	LOW	0.08	0.99
			Specificity: 0.92 (0.90 to 0.93)	Serious <sup>1</sup>	No serious	No serious	No serious	MODERATE		

- 7 *CI: confidence interval; CSF: cerebrospinal fluid; MD: meningococcal disease; N. Meningitidis: Neisseria Meningitidis; MD: meningococcal disease; NPV: negative predictive value;*  
 8 *PCR: positive polymerase chain reaction; PPV: positive predictive value*  
 9 <sup>1</sup> Serious risk of bias in the evidence contributing to the outcomes as per QUADAS-2  
 10 <sup>2</sup> 95% CI crosses 1 decision making threshold  
 11  
 12

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2 **Table 16: Presence of any rash for diagnosis of meningococcal disease in babies and children. Comparison group: absence of sepsis**  
3 **and meningitis. Non-healthcare professional (parental) identification**

No of studies	Study details	No of participants	Effect size (95% CI)	Risk of bias	Inconsistency	Indirectness	Imprecision	Quality of evidence	PPV	NPV
1 (Haj-Hassan 2011)	Population: MD compared to minor febrile infection (Children aged <16 years with non-fatal MD)	752	Sensitivity: 0.77 (0.73 to 0.82)	Very serious <sup>1</sup>	No serious	No serious	No serious	LOW	0.82	0.82
	Reference standard: Clinical record review (79% confirmed through microbiological techniques)		Specificity: 0.86 (0.82 to 0.89)	Very serious <sup>1</sup>	No serious	No serious	No serious	LOW		

4 *CI: confidence interval; MD: meningococcal disease; NPV: negative predictive value; PPV: positive predictive value*

5 <sup>1</sup> *Very serious risk of bias in the evidence contributing to the outcomes as per QUADAS-2*

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2 **Table 17: Presence of haemorrhagic rash for diagnosis of meningococcal disease in babies and children. Comparison group: viral**  
3 **meningitis. Healthcare professional identification**

No of studies	Study details	No of participants	Effect size (95% CI)	Risk of bias	Inconsistency	Indirectness	Imprecision	Quality of evidence	PPV	NPV
1 (Close 2011)	Population: bacterial meningitis or meningococcal septicaemia compared to viral meningitis (Children aged ≤19 years with a confirmed case of bacterial or viral meningitis, or meningococcal septicaemia)  Reference standard: Any 1 of: bacteria, bacterial antigen, bacterial or viral DNA or RNA identified in CSF; bacteria or viruses obtained from culture of CSF; clinical and/or laboratory diagnosis of meningitis accompanied by microbiological evidence of pathogen from another site, for example blood, throat swab, skin or faeces	172 <sup>1</sup>	Sensitivity: 0.69 (0.61 to 0.76)	Serious <sup>2</sup>	No serious	Serious <sup>3</sup>	No serious	LOW	0.94	0.17
			Specificity: 0.59 (0.33 to 0.82)	Serious <sup>2</sup>	No serious	Serious <sup>3</sup>	Serious <sup>4</sup>	VERY LOW		

- 1 *CI: confidence interval; CSF: cerebrospinal fluid; MD: meningococcal disease; N. Meningitidis: Neisseria Meningitidis; NPV: negative predictive value; PPV: positive predictive*  
 2 *value*  
 3 <sup>1</sup> *Data available for 75% of sample*  
 4 <sup>2</sup> *Serious risk of bias in the evidence contributing to the outcomes as per QUADAS-2*  
 5 <sup>3</sup> *Population may be indirect. Unclear how many people have meningitis only (however, only 80% had N. meningitidis as the cause)*  
 6 <sup>4</sup> *95% CI crosses 1 decision making threshold*  
 7

8 **Table 18: Skin haemorrhages with maximum diameter >1mm for diagnosis of meningococcal disease in babies and children.**  
 9 **Comparison group: absence of sepsis and meningitis. Healthcare professional identification**

No of studies	Study details	No of participants	Effect size (95% CI)	Risk of bias	Inconsistency	Indirectness	Imprecision	Quality of evidence	PPV	NPV
1 (Nielsen 2001)	Population: MD (confirmed or probable case) compared to no invasive bacterial disease (Babies/children aged 1 month-16 years, with haemorrhages in the skin of any size detected at admission or during the stay in hospital, and a rectal temperature >38°C within the 24 hours before inclusion)  Reference standard: Confirmed case: Culture of N. Meningitidis from	208	Sensitivity: 0.95 (0.83 to 0.99)	No serious	No serious	No serious	Serious <sup>1</sup>	MODERATE	0.50	0.99

	blood and/or CSF. Probable case: clinical diagnosis without culture confirmation, but defined by a significant increase in meningococcal antibody titres, or a high antibody titre in a single serum sample drawn during the 2nd or 3rd week after onset of disease, and/or demonstration of serogroup A or C meningococcal capsular polysaccharide in the acute serum sample by counterimmunoelectrophoresis.		Specificity: 0.78 (0.71 to 0.84)	No serious	No serious	No serious	No serious	HIGH		
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1 *CI: confidence interval; CSF: cerebrospinal fluid; MD: meningococcal disease; N. Meningitidis: Neisseria Meningitidis; NPV: negative predictive value; PPV: positive predictive*  
 2 *value*  
 3 *<sup>1</sup> 95% CI crosses 1 decision making threshold*  
 4  
 5

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2 **Table 19: Purpura (lesions >2 mm in diameter) for diagnosis of meningococcal disease in babies and children. Comparison group:**  
3 **absence of sepsis and meningitis/negative for MD (no further detail). Healthcare professional identification**

No of studies	Study details	No of participants	Effect size (95% CI)	Risk of bias	Inconsistency	Indirectness	Imprecision	Quality of evidence	PPV	NPV
1 (Nielsen 2001)	Population: MD (confirmed or probable case) compared to no invasive bacterial disease (Babies/children aged 1 month-16 years, with haemorrhages in the skin of any size detected at admission or during the stay in hospital, and a rectal temperature >38°C within the 24 hours before inclusion)  Reference standard: Confirmed case: Culture of N. Meningitidis from	208	Sensitivity: 0.74 (0.58 to 0.87)	No serious	No serious	No serious	No serious	HIGH	0.67	0.94

	blood and/or CSF. Probable case: clinical diagnosis without culture confirmation, but defined by a significant increase in meningococcal antibody titres, or a high antibody titre in a single serum sample drawn during the 2nd or 3rd week after onset of disease, and/or demonstration of serogroup A or C meningococcal capsular polysaccharide in the acute serum sample by counterimmunoelectrophoresis.		Specificity: 0.92 (0.86 to 0.95)	No serious	No serious	No serious	Serious <sup>1</sup>	MODERATE		
1 (Waterfield 2021)	Population: MD compared to non-MD (undefined) (Children <18 years presenting to paediatric emergency department with fever ≥38°C, new-onset non-blanching rash or features suggestive of	1329	Sensitivity: 0.68 (0.43 to 0.87)	Serious <sup>2</sup>	No serious	No serious	Serious <sup>1</sup>	LOW	0.17	1.00

	meningococcal infection)  Reference standard: Positive culture or PCR test for N. meningitidis or other bacterial pathogen from a sterile body site (for example, blood or CSF)		Specificity: 0.95 (0.94 to 0.96)	Serious <sup>2</sup>	No serious	No serious	No serious	MODERATE		
1 (Wells 2001)	Population: MD compared to non-MD (undefined) (Children ≤15 years presenting to A&E with non-blanching rash)	218	Sensitivity: 0.83 (0.63 to 0.95)	No serious	No serious	No serious	Serious <sup>1</sup>	MODERATE	0.47	0.98
	Reference standard: Blood, CSF or skin culture, gram staining, blood or CSF PCR		Specificity: 0.88 (0.83 to 0.92)	No serious	No serious	No serious	Serious <sup>1</sup>	MODERATE		

1 A&E: accident and emergency; CI: confidence interval; CSF: cerebrospinal fluid; MD: meningococcal disease; N. Meningitidis: Neisseria Meningitidis; NPV: negative predictive;  
 2 PCR: positive polymerase chain reaction; PPV: positive predictive value  
 3 <sup>1</sup> 95% CI crosses 1 decision making threshold  
 4 <sup>2</sup> Serious risk of bias in the evidence contributing to the outcomes as per QUADAS-2  
 5  
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2 **Table 20: Petechiae only (without purpura) for diagnosis of meningococcal disease in babies and children. Comparison group: negative**  
3 **for MD (no further detail). Healthcare professional identification**

No of studies	Study details	No of participants	Effect size (95% CI)	Risk of bias	Inconsistency	Indirectness	Imprecision	Quality of evidence	PPV	NPV
1 (Waterfield 2021)	Population: MD compared to non-MD (undefined) (Children <18 years presenting to paediatric emergency department with fever ≥38°C, new-onset non-blanching rash or features suggestive of meningococcal infection)  Reference standard: Positive culture or PCR test for N. meningitidis or other bacterial pathogen from a sterile body site (for example, blood or CSF)	1329	Sensitivity: 0.32 (0.13 to 0.57)	Serious <sup>1</sup>	No serious	No serious	Serious <sup>2</sup>	LOW	0.00	0.83
			Specificity: 0.05 (0.04 to 0.06)	Serious <sup>1</sup>	No serious	No serious	No serious	MODERATE		

4 *CI: confidence interval; CSF: cerebrospinal fluid; MD: meningococcal disease; N. Meningitidis: Neisseria Meningitidis; MD: meningococcal disease; NPV: negative predictive value;*

5 *PCR: positive polymerase chain reaction; PPV: positive predictive value*

6 <sup>1</sup> *Serious risk of bias in the evidence contributing to the outcomes as per QUADAS-2*

7 <sup>2</sup> *95% CI crosses 1 decision making threshold*

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2 **Table 21: More than 20 skin haemorrhages for diagnosis of meningococcal disease in babies and children. Comparison group: absence**  
3 **of sepsis and meningitis. Healthcare professional identification**

No of studies	Study details	No of participants	Effect size (95% CI)	Risk of bias	Inconsistency	Indirectness	Imprecision	Quality of evidence	PPV	NPV
1 (Nielsen 2001)	Population: MD (confirmed or probable case) compared to no invasive bacterial disease (Babies/children aged 1 month-16 years, with haemorrhages in the skin of any size detected at admission or during the stay in hospital, and a rectal temperature >38°C within the 24 hours before inclusion)  Reference standard: Confirmed case: Culture of N. Meningitidis from	208	Sensitivity: 0.74 (0.58 to 0.87)	No serious	No serious	No serious	No serious	HIGH	0.25	0.89

	blood and/or CSF. Probable case: clinical diagnosis without culture confirmation, but defined by a significant increase in meningococcal antibody titres, or a high antibody titre in a single serum sample drawn during the 2nd or 3rd week after onset of disease, and/or demonstration of serogroup A or C meningococcal capsular polysaccharide in the acute serum sample by counterimmunoelectrophoresis.		Specificity: 0.49 (0.41 to 0.57)	No serious	No serious	No serious	Serious <sup>1</sup>	MODERATE		
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1 *CI: confidence interval; CSF: cerebrospinal fluid; MD: meningococcal disease; N. Meningitidis: Neisseria Meningitidis; NPV: negative predictive value; PPV: positive predictive value*

2

3 <sup>1</sup> 95% CI crosses 1 decision making threshold

4

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2 **Table 22: Universal distribution of skin haemorrhages for diagnosis of meningococcal disease in babies and children. Comparison**  
3 **group: absence of sepsis and meningitis. Healthcare professional identification**

No of studies	Study details	No of participants	Effect size (95% CI)	Risk of bias	Inconsistency	Indirectness	Imprecision	Quality of evidence	PPV	NPV
1 (Nielsen 2001)	Population: MD (confirmed or probable case) compared to no invasive bacterial disease (Babies/children aged 1 month-16 years, with haemorrhages in the skin of any size detected at admission or during the stay in hospital, and a rectal temperature >38°C within the 24 hours before inclusion)  Reference standard: Confirmed case: Culture of N. Meningitidis from	208	Sensitivity: 0.92 (0.79 to 0.98)	No serious	No serious	No serious	Serious <sup>1</sup>	MODERATE	0.35	0.97

	blood and/or CSF. Probable case: clinical diagnosis without culture confirmation, but defined by a significant increase in meningococcal antibody titres, or a high antibody titre in a single serum sample drawn during the 2nd or 3rd week after onset of disease, and/or demonstration of serogroup A or C meningococcal capsular polysaccharide in the acute serum sample by counterimmunoelectrophoresis.		Specificity: 0.60 (0.52 to 0.67)	No serious	No serious	No serious	No serious	HIGH		
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- 1 *CI: confidence interval; CSF: cerebrospinal fluid; MD: meningococcal disease; N. Meningitidis: Neisseria Meningitidis; NPV: negative predictive value; PPV: positive predictive*
- 2 *value*
- 3 *<sup>1</sup> 95% CI crosses 1 decision making threshold*
- 4

1

2 **Table 23: Spreading rash for diagnosis of meningococcal disease in babies and children. Comparison group: negative for MD (no further**  
3 **detail). Healthcare professional identification**

No of studies	Study details	No of participants	Effect size (95% CI)	Risk of bias	Inconsistency	Indirectness	Imprecision	Quality of evidence	PPV	NPV
1 (Waterfield 2021)	Population: MD compared to non-MD (undefined) (Children <18 years presenting to paediatric emergency department with fever ≥38°C, new-onset non-blanching rash or features suggestive of meningococcal infection)  Reference standard: Positive culture or PCR test for N. meningitidis or other bacterial pathogen from a sterile body site (for example, blood or CSF)	1329	Sensitivity: 0.63 (0.38 to 0.84)	Serious <sup>1</sup>	No serious	No serious	Serious <sup>2</sup>	LOW	0.04	0.99
			Specificity: 0.76 (0.74 to 0.79)	Serious <sup>1</sup>	No serious	No serious	No serious	MODERATE		

4 *CI: confidence interval; CSF: cerebrospinal fluid; MD: meningococcal disease; N. Meningitidis: Neisseria Meningitidis; MD: meningococcal disease; NPV: negative predictive value;*  
5 *PCR: positive polymerase chain reaction; PPV: positive predictive value*

6 <sup>1</sup> *Serious risk of bias in the evidence contributing to the outcomes as per QUADAS-2*

7 <sup>2</sup> *95% CI crosses 1 decision making threshold*

8 **Table 24: Rash beyond superior vena cava (SVC) for diagnosis of meningococcal disease in babies and children. Comparison group:**  
9 **negative for MD (no further detail). Healthcare professional identification**

No of studies	Study details	No of participants	Effect size (95% CI)	Risk of bias	Inconsistency	Indirectness	Imprecision	Quality of evidence	PPV	NPV
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1 (Wells 2001)	Population: MD compared to non-MD (undefined) (Children ≤15 years presenting to A&E with non-blanching rash)  Reference standard: Blood, CSF or skin culture, gram staining, blood or CSF PCR	218	Sensitivity: 1.00 (0.86 to 1.00)	No serious	No serious	No serious	Serious <sup>1</sup>	MODERATE	0.17	1.00
			Specificity 0.38 (0.31 to 0.45)	No serious	No serious	No serious	No serious	HIGH		

1 A&E: accident and emergency; CI: confidence interval; CSF: cerebrospinal fluid; MD: meningococcal disease; NPV: negative predictive value; PCR: positive polymerase chain  
2 reaction; PPV: positive predictive value; SVC: superior vena cava  
3 <sup>1</sup> 95% CI crosses 1 decision making threshold  
4

5 **Table 25: Petechiae on the trunk below the nipple line for diagnosis of meningococcal disease in babies and children. Comparison**  
6 **group: nonbacteremic disease (includes viral meningitis). Healthcare professional identification**

No of studies	Study details	No of participants	Effect size (95% CI)	Risk of bias	Inconsistency	Indirectness	Imprecision	Quality of evidence	PPV	NPV
1 (Baker 1989)	Population: Invasive bacterial disease compared to nonbacteremic disease (includes VM) (People aged <21 years with fever >38°C and petechial rash)  Reference standard: Detection of N. meningitidis on blood or CSF culture	54	Sensitivity: 0.73 (0.45 to 0.92)	Serious <sup>1</sup>	No serious	Serious <sup>2</sup>	Very serious <sup>3</sup>	VERY LOW	0.41	0.85
			Specificity: 0.59 (0.42 to 0.74)	Serious <sup>1</sup>	No serious	Serious <sup>2</sup>	Serious <sup>4</sup>	VERY LOW		

7 CI: confidence interval; CSF: cerebrospinal fluid; N. Meningitidis: Neisseria Meningitidis; NPV: negative predictive value; PPV: positive predictive value; VM: viral meningitis  
8 <sup>1</sup> Serious risk of bias in the evidence contributing to the outcomes as per QUADAS-2

- 1 <sup>2</sup> 40% of MD population is indirect (27% with meningococcal meningitis alone and 13% with meningitis with other causes)  
 2 <sup>3</sup> 95% CI crosses 2 decision making thresholds  
 3 <sup>4</sup> 95% CI crosses 1 decision making threshold  
 4

5 **Table 26: Petechiae on the lower extremities for diagnosis of meningococcal disease in babies and children. Comparison group:**  
 6 **nonbacteremic disease (includes viral meningitis). Healthcare professional identification**

No of studies	Study details	No of participants	Effect size (95% CI)	Risk of bias	Inconsistency	Indirectness	Imprecision	Quality of evidence	PPV	NPV
1 (Baker 1989)	Population: Invasive bacterial disease compared to nonbacteremic disease (includes VM) (People aged <21 years with fever >38°C and petechial rash)  Reference standard: Detection of N. meningitidis on blood or CSF culture	54	Sensitivity: 0.80 (0.52 to 0.96)	Serious <sup>1</sup>	No serious	Serious <sup>2</sup>	Serious <sup>3</sup>	VERY LOW	0.52	0.90
			Specificity: 0.72 (0.55 to 0.85)	Serious <sup>1</sup>	No serious	Serious <sup>2</sup>	No serious	LOW		

- 7 *CI: confidence interval; CSF: cerebrospinal fluid; N. Meningitidis: Neisseria Meningitidis; NPV: negative predictive value; PPV: positive predictive value; VM: viral meningitis*  
 8 <sup>1</sup> Serious risk of bias in the evidence contributing to the outcomes as per QUADAS-2  
 9 <sup>2</sup> 40% of MD population is indirect (27% with meningococcal meningitis alone and 13% with meningitis with other causes)  
 10 <sup>3</sup> 95% CI crosses 1 decision making threshold  
 11  
 12

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2 **Table 27: Petechiae above the nipple line for diagnosis of meningococcal disease in babies and children. Comparison group:**  
3 **nonbacteremic disease (includes viral meningitis). Healthcare professional identification**

No of studies	Study details	No of participants	Effect size (95% CI)	Risk of bias	Inconsistency	Indirectness	Imprecision	Quality of evidence	PPV	NPV
1 (Baker 1989)	Population: Invasive bacterial disease compared to nonbacteremic disease (includes VM) (People aged <21 years with fever >38°C and petechial rash)  Reference standard: Detection of N. meningitidis on blood or CSF culture	54	Sensitivity: 0.80 (0.52 to 0.96)	Serious <sup>1</sup>	No serious	Serious <sup>2</sup>	Very serious <sup>3</sup>	VERY LOW	0.26	0.57
			Specificity: 0.10 (0.03 to 0.24)	Serious <sup>1</sup>	No serious	Serious <sup>2</sup>	No serious	LOW		

4 *CI: confidence interval; CSF: cerebrospinal fluid; N. Meningitidis: Neisseria Meningitidis; NPV: negative predictive value; PPV: positive predictive value; VM: viral meningitis*

5 <sup>1</sup> *Serious risk of bias in the evidence contributing to the outcomes as per QUADAS-2*

6 <sup>2</sup> *40% of MD population is indirect (27% with meningococcal meningitis alone and 13% with meningitis with other causes)*

7 <sup>3</sup> *95% CI crosses 2 decision making thresholds*

8

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2 **Table 28: Superior vena cava (SVC) distribution of rash for diagnosis of meningococcal disease in babies and children. Comparison**  
3 **group: negative for MD (no further detail). Healthcare professional identification**

No of studies	Study details	No of participants	Effect size (95% CI)	Risk of bias	Inconsistency	Indirectness	Imprecision	Quality of evidence	PPV	NPV
1 (Waterfield 2021)	Population: MD compared to non-MD (undefined) (Children <18 years presenting to paediatric emergency department with fever ≥38°C, new-onset non-blanching rash or features suggestive of meningococcal infection)  Reference standard: Positive culture or PCR test for N. meningitidis or other bacterial pathogen from a sterile body site (for example, blood or CSF)	1329	Sensitivity: 0.32 (0.13 to 0.57)	Serious <sup>1</sup>	No serious	No serious	Serious <sup>2</sup>	LOW	0.01	0.98
			Specificity: 0.63 (0.61 to 0.66)	Serious <sup>1</sup>	No serious	No serious	No serious	MODERATE		

4 *CI: confidence interval; CSF: cerebrospinal fluid; MD: meningococcal disease; N. Meningitidis: Neisseria Meningitidis; MD: meningococcal disease; NPV: negative predictive value;*

5 *PCR: positive polymerase chain reaction; PPV: positive predictive value*

6 <sup>1</sup> *Serious risk of bias in the evidence contributing to the outcomes as per QUADAS-2*

7 <sup>2</sup> *95% CI crosses 1 decision making threshold*

8

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2 **Table 29: Duration of rash (<4 hours) for diagnosis of meningococcal disease in babies and children. Comparison group: negative for**  
3 **MD (no further detail). Healthcare professional identification**

No of studies	Study details	No of participants	Effect size (95% CI)	Risk of bias	Inconsistency	Indirectness	Imprecision	Quality of evidence	PPV	NPV
1 (Waterfield 2021)	Population: MD compared to non-MD (undefined) (Children <18 years presenting to paediatric emergency department with fever ≥38°C, new-onset non-blanching rash or features suggestive of meningococcal infection)  Reference standard: Positive culture or PCR test for N. meningitidis or other bacterial pathogen from a sterile body site (for example, blood or CSF)	1233 <sup>1</sup>	Sensitivity: 0.63 (0.38 to 0.84)	Serious <sup>2</sup>	No serious	No serious	Serious <sup>3</sup>	LOW	0.02	0.99
			Specificity: 0.38 (0.35 to 0.41)	Serious <sup>2</sup>	No serious	No serious	No serious	MODERATE		

4 *CI: confidence interval; CSF: cerebrospinal fluid; MD: meningococcal disease; N. Meningitidis: Neisseria Meningitidis; MD: meningococcal disease; NPV: negative predictive value;*

5 *PCR: positive polymerase chain reaction; PPV: positive predictive value*

6 <sup>1</sup> *Data available for 99% of sample*

7 <sup>2</sup> *Serious risk of bias in the evidence contributing to the outcomes as per QUADAS-2*

8 <sup>3</sup> *95% CI crosses 1 decision making threshold*

9

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2 **Table 30: Signs of meningism for diagnosis of meningococcal disease in babies and children. Comparison group: nonbacteremic**  
3 **disease (includes viral meningitis)/negative for MD (no further detail). Healthcare professional identification**

No of studies	Study details	No of participants	Effect size (95% CI)	Risk of bias	Inconsistency	Indirectness	Imprecision	Quality of evidence	PPV	NPV
1 (Baker 1989)	Population: Invasive bacterial disease compared to nonbacteremic disease (includes VM) (People aged <21 years with fever >38°C and petechial rash)  Reference standard: Detection of N. meningitidis on blood or CSF culture	54	Sensitivity: 0.33 (0.12 to 0.62)	Serious <sup>1</sup>	No serious	Serious <sup>2</sup>	Serious <sup>3</sup>	VERY LOW	0.83	0.79
			Specificity: 0.97 (0.87 to 1.00)	Serious <sup>1</sup>	No serious	Serious <sup>2</sup>	Serious <sup>3</sup>	VERY LOW		
1 (Waterfield 2021)	Population: MD compared to non-MD (undefined) (Children <18 years presenting to paediatric emergency department with fever ≥38°C, new-onset non-blanching rash or features suggestive of	1329	Sensitivity: 0.37 (0.16 to 0.62)	Serious <sup>1</sup>	No serious	No serious	Serious <sup>3</sup>	LOW	0.03	0.99

	meningococcal infection)  Reference standard: Positive culture or PCR test for N. meningitidis or other bacterial pathogen from a sterile body site (for example, blood or CSF)		Specificity: 0.79 (0.77 to 0.81)	Serious <sup>1</sup>	No serious	No serious	No serious	MODERATE		
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1 *CI: confidence interval; CSF: cerebrospinal fluid; MD: meningococcal disease; N. Meningitidis: Neisseria Meningitidis; NPV: negative predictive value; PCR: positive polymerase*  
2 *chain reaction; PPV: positive predictive value; VM: viral meningitis*

3 <sup>1</sup> *Serious risk of bias in the evidence contributing to the outcomes as per QUADAS-2*

4 <sup>2</sup> *40% of MD population is indirect (27% with meningococcal meningitis alone and 13% with meningitis with other causes)*

5 <sup>3</sup> *95% CI crosses 1 decision making threshold*

6

7 **Table 31: Neck pain or stiffness for diagnosis of meningococcal disease in babies and children. Comparison group: absence of sepsis**  
8 **and meningitis. Non-healthcare professional (parental)/healthcare professional identification**

No of studies	Study details	No of participants	Effect size (95% CI)	Risk of bias	Inconsistency	Indirectness	Imprecision	Quality of evidence	PPV	NPV
1 (Haj-Hassan 2011)	Population: MD compared to minor febrile infection (Children aged <16 years with non-fatal MD)  Reference standard: Clinical record review (79% confirmed)	752	Sensitivity: 0.25 (0.20 to 0.30)	Very serious <sup>1</sup>	No serious	No serious	No serious	LOW	0.79	0.60

	through microbiological techniques)		Specificity: 0.94 (0.92 to 0.96)	Very serious <sup>1</sup>	No serious	No serious	No serious	LOW		
1 (Nielsen 2001)	Population: MD (confirmed or probable case) compared to no invasive bacterial disease (Babies/children aged 1 month-16 years, with haemorrhages in the skin of any size detected at admission or during the stay in hospital, and a rectal temperature >38°C within the 24 hours before inclusion)  Reference standard: Confirmed case: Culture of N. Meningitidis from blood and/or CSF. Probable case: clinical diagnosis without culture confirmation, but defined by a	208	Sensitivity: 0.41 (0.26 to 0.58)	No serious	No serious	No serious	Serious <sup>2</sup>	MODERATE	0.76	0.88
			Specificity: 0.97 (0.93 to 0.99)	No serious	No serious	No serious	No serious	HIGH		

	significant increase in meningococcal antibody titres, or a high antibody titre in a single serum sample drawn during the 2nd or 3rd week after onset of disease, and/or demonstration of serogroup A or C meningococcal capsular polysaccharide in the acute serum sample by counterimmunoelctrophoresis.									
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1 *CI: confidence interval; CSF: cerebrospinal fluid; MD: meningococcal disease; N. Meningitidis: Neisseria Meningitidis; NPV: negative predictive; PPV: positive predictive value*  
 2 <sup>1</sup> *Very serious risk of bias in the evidence contributing to the outcomes as per QUADAS-2*  
 3 <sup>2</sup> *95% CI crosses 1 decision making threshold*  
 4

5 **Table 32: Photophobia for diagnosis of meningococcal disease in babies and children. Comparison group: absence of sepsis and**  
 6 **meningitis. Non-healthcare professional (parental) identification**

No of studies	Study details	No of participants	Effect size (95% CI)	Risk of bias	Inconsistency	Indirectness	Imprecision	Quality of evidence	PPV	NPV
1 (Haj-Hassan 2011)	Population: MD compared to minor febrile infection (Children aged <16 years with non-fatal MD)  Reference standard: Clinical record review (79% confirmed through microbiological techniques)	752	Sensitivity: 0.21 (0.17 to 0.26)	Very serious <sup>1</sup>	No serious	No serious	No serious	LOW	0.82	0.59
			Specificity: 0.96 (0.94 to 0.98)	Very serious <sup>1</sup>	No serious	No serious	No serious	LOW		

1 *CI: confidence interval; MD: meningococcal disease; NPV: negative predictive value; PPV: positive predictive value*  
 2 <sup>1</sup> *Very serious risk of bias in the evidence contributing to the outcomes as per QUADAS-2*  
 3

4 **Table 33: Headache for diagnosis of meningococcal disease in babies and children. Comparison group: absence of sepsis and**  
 5 **meningitis. Non-healthcare professional (parental) identification**

No of studies	Study details	No of participants	Effect size (95% CI)	Risk of bias	Inconsistency	Indirectness	Imprecision	Quality of evidence	PPV	NPV
1 (Haj-Hassan 2011)	Population: MD compared to minor febrile infection (Children aged <16 years with non-fatal MD)  Reference standard: Clinical record review (79% confirmed through microbiological techniques)	616 <sup>1</sup>	Sensitivity: 0.32 (0.26 to 0.38)	Very serious <sup>2</sup>	No serious	No serious	No serious	LOW	0.38	0.58
			Specificity: 0.64 (0.59 to 0.69)	Very serious <sup>2</sup>	No serious	No serious	No serious	LOW		

6 *CI: confidence interval; MD: meningococcal disease; NPV: negative predictive value; PPV: positive predictive value*  
 7 <sup>1</sup> *Analysed in children >1 year (as considered age-specific by authors of the meningococcal paper)*  
 8 <sup>2</sup> *Very serious risk of bias in the evidence contributing to the outcomes as per QUADAS-2*  
 9

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2 **Table 34: Reduced consciousness for diagnosis of meningococcal disease in babies and children. Comparison group: viral**  
3 **meningitis/negative for MD (no further detail). Healthcare professional identification**

No of studies	Study details	No of participants	Effect size (95% CI)	Risk of bias	Inconsistency	Indirectness	Imprecision	Quality of evidence	PPV	NPV
1 (Close 2011)	Population: bacterial meningitis or meningococcal septicaemia compared to viral meningitis (Children aged ≤19 years with a confirmed case of bacterial or viral meningitis, or meningococcal septicaemia)  Reference standard: Any 1 of: bacteria, bacterial antigen, bacterial or viral DNA or RNA identified in CSF; bacteria or viruses obtained from culture of CSF; clinical and/or laboratory diagnosis of meningitis accompanied by microbiological evidence of pathogen from another site, for example blood, throat swab, skin or faeces	149 <sup>1</sup>	Sensitivity: 0.11 (0.06 to 0.17)	Serious <sup>2</sup>	No serious	Serious <sup>3</sup>	No serious	LOW	1.00	0.14
			Specificity: 1.00 (0.82 to 1.00)	Serious <sup>2</sup>	No serious	Serious <sup>3</sup>	Serious <sup>4</sup>	VERY LOW		

1 (Waterfield 2021)	Population: MD compared to non-MD (undefined) (Children <18 years presenting to paediatric emergency department with fever ≥38°C, new-onset non-blanching rash or features suggestive of meningococcal infection)  Reference standard: Positive culture or PCR test for N. meningitidis or other bacterial pathogen from a sterile body site (for example, blood or CSF)	1329	Sensitivity: 0.53 (0.29 to 0.76)	Serious <sup>2</sup>	No serious	No serious	Serious <sup>4</sup>	LOW	0.43	0.99
			Specificity: 0.99 (0.98 to 0.99)	Serious <sup>2</sup>	No serious	No serious	No serious	MODERATE		

1 *CI: confidence interval; CSF: cerebrospinal fluid; MD: meningococcal disease; N. Meningitidis: Neisseria Meningitidis; NPV: negative predictive value; PCR: positive polymerase*  
2 *chain reaction; PPV: positive predictive value; VM: viral meningitis*

3 <sup>1</sup> *Data available for 65% of sample*

4 <sup>2</sup> *Serious risk of bias in the evidence contributing to the outcomes as per QUADAS-2*

5 <sup>3</sup> *Population may be indirect. Unclear how many people have meningitis only (however, only 80% had N. meningitidis as the cause)*

6 <sup>4</sup> *95% CI crosses 1 decision making threshold*

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2 **Table 35: Signs of shock for diagnosis of meningococcal disease in babies and children. Comparison group: negative for MD (no further**  
3 **detail). Healthcare professional identification**

No of studies	Study details	No of participants	Effect size (95% CI)	Risk of bias	Inconsistency	Indirectness	Imprecision	Quality of evidence	PPV	NPV
1 (Waterfield 2021)	Population: MD compared to non-MD (undefined) (Children <18 years presenting to paediatric emergency department with fever ≥38°C, new-onset non-blanching rash or features suggestive of meningococcal infection)  Reference standard: Positive culture or PCR test for N. meningitidis or other bacterial pathogen from a sterile body site (for example, blood or CSF)	1329	Sensitivity: 0.68 (0.43 to 0.87)	Serious <sup>1</sup>	No serious	No serious	Serious <sup>2</sup>	LOW	0.16	1.00
			Specificity: 0.95 (0.94 to 0.96)	Serious <sup>1</sup>	No serious	No serious	No serious	MODERATE		

4 *CI: confidence interval; CSF: cerebrospinal fluid; MD: meningococcal disease; N. Meningitidis: Neisseria Meningitidis; MD: meningococcal disease; NPV: negative predictive value;*

5 *PCR: positive polymerase chain reaction; PPV: positive predictive value*

6 <sup>1</sup> *Serious risk of bias in the evidence contributing to the outcomes as per QUADAS-2*

7 <sup>2</sup> *95% CI crosses 1 decision making threshold*

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2 **Table 36: Hypotension for diagnosis of meningococcal disease in babies and children. Comparison group: negative for MD (no further**  
3 **detail). Healthcare professional identification**

No of studies	Study details	No of participants	Effect size (95% CI)	Risk of bias	Inconsistency	Indirectness	Imprecision	Quality of evidence	PPV	NPV
1 (Wells 2001)	Population: MD compared to non-MD (undefined) (Children ≤15 years presenting to A&E with non-blanching rash)  Reference standard: Blood, CSF or skin culture, gram staining, blood or CSF PCR	86 <sup>1</sup>	Sensitivity: 0.28 (0.10 to 0.53)	Serious <sup>2</sup>	No serious	No serious	Serious <sup>3</sup>	LOW	0.71	0.84
			Specificity 0.97 (0.90 to 1.00)	Serious <sup>2</sup>	No serious	No serious	No serious	MODERATE		

4 A&E: accident and emergency; CI: confidence interval; CSF: cerebrospinal fluid; MD: meningococcal disease; NPV: negative predictive value; PCR: positive polymerase chain  
5 reaction; PPV: positive predictive value

6 <sup>1</sup> Data only available for 39% of sample

7 <sup>2</sup> Serious risk of bias in the evidence contributing to the outcomes as per QUADAS-2 (due to the proportion of missing data for this factor)

8 <sup>3</sup> 95% CI crosses 1 decision making threshold

9

10 **Table 37: Delayed capillary refill for diagnosis of meningococcal disease in babies and children. Comparison group: negative for MD (no**  
11 **further detail). Healthcare professional identification**

No of studies	Study details	No of participants	Effect size (95% CI)	Risk of bias	Inconsistency	Indirectness	Imprecision	Quality of evidence	PPV	NPV
1 (Wells 2001)	Population: MD compared to non-MD (undefined) (Children ≤15 years presenting to A&E with non-blanching rash)  Reference standard: Blood,	217	Sensitivity: 0.83 (0.63 to 0.95)	No serious	No serious	No serious	Serious <sup>1</sup>	MODERATE	0.42	0.98
			Specificity 0.85 (0.80 to 0.90)	No serious	No serious	No serious	Serious <sup>1</sup>	MODERATE		

	CSF or skin culture, gram staining, blood or CSF PCR									
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1 A&E: accident and emergency; CI: confidence interval; CSF: cerebrospinal fluid; MD: meningococcal disease; NPV: negative predictive value; PCR: positive polymerase chain  
2 reaction; PPV: positive predictive value

3 <sup>1</sup> 95% CI crosses 1 decision making threshold

4

5 **Table 38: Cold hands or feet for diagnosis of meningococcal disease in babies and children. Comparison group: absence of sepsis and**  
6 **meningitis/negative for MD (no further detail). Non-healthcare professional (parental)/healthcare professional identification**

No of studies	Study details	No of participants	Effect size (95% CI)	Risk of bias	Inconsistency	Indirectness	Imprecision	Quality of evidence	PPV	NPV
1 (Haj-Hassan 2011)	Population: MD compared to minor febrile infection (Children aged <16 years with non-fatal MD)  Reference standard: Clinical record review (79% confirmed through microbiological techniques)	752	Sensitivity: 0.40 (0.35 to 0.46)	Very serious <sup>1</sup>	No serious	No serious	No serious	LOW	0.65	0.62
			Specificity: 0.82 (0.78 to 0.85)	Very serious <sup>1</sup>	No serious	No serious	No serious	LOW		

1 (Waterfield 2021)	Population: MD compared to non-MD (undefined) (Children <18 years presenting to paediatric emergency department with fever ≥38°C, new-onset non-blanching rash or features suggestive of meningococcal infection)  Reference standard: Positive culture or PCR test for N. meningitidis or other bacterial pathogen from a sterile body site (for example, blood or CSF)	1329	Sensitivity: 0.47 (0.24 to 0.71)	Serious <sup>2</sup>	No serious	No serious	Serious <sup>3</sup>	LOW	0.07	0.99
			Specificity: 0.90 (0.88 to 0.92)	Serious <sup>2</sup>	No serious	No serious	Serious <sup>3</sup>	LOW		

- 1 *CI: confidence interval; CSF: cerebrospinal fluid; MD: meningococcal disease; N. Meningitidis: Neisseria Meningitidis; NPV: negative predictive value; PCR: positive polymerase*  
2 *chain reaction; PPV: positive predictive value*  
3 <sup>1</sup> *Very serious risk of bias in the evidence contributing to the outcomes as per QUADAS-2*  
4 <sup>2</sup> *Serious risk of bias in the evidence contributing to the outcomes as per QUADAS-2*  
5 <sup>3</sup> *95% CI crosses 1 decision making threshold*  
6

7 **Table 39: Limb pain for diagnosis of meningococcal disease in babies and children. Comparison group: absence of sepsis and**  
8 **meningitis/negative for MD (no further detail). Non-healthcare professional (parental)/healthcare professional identification**

No of studies	Study details	No of participants	Effect size (95% CI)	Risk of bias	Inconsistency	Indirectness	Imprecision	Quality of evidence	PPV	NPV
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1 (Haj-Hassan 2011)	Population: MD compared to minor febrile infection (Children aged <16 years with non-fatal MD)  Reference standard: Clinical record review (79% confirmed through microbiological techniques)	616 <sup>1</sup>	Sensitivity: 0.38 (0.32 to 0.44)	Very serious <sup>2</sup>	No serious	No serious	No serious	LOW	0.82	0.69
			Specificity: 0.94 (0.91 to 0.96)	Very serious <sup>2</sup>	No serious	No serious	No serious	LOW		
1 (Waterfield 2021)	Population: MD compared to non-MD (undefined) (Children <18 years presenting to paediatric emergency department with fever ≥38°C, new-onset non-blanching rash or features suggestive of meningococcal infection)  Reference standard: Positive culture or PCR test for N. meningitidis or other bacterial pathogen from a sterile body site (for example, blood or CSF)	1329	Sensitivity: 0.32 (0.13 to 0.57)	Serious <sup>3</sup>	No serious	No serious	Serious <sup>4</sup>	LOW	0.08	0.99
			Specificity: 0.95 (0.94 to 0.96)	Serious <sup>3</sup>	No serious	No serious	No serious	MODERATE		

1 CI: confidence interval; CSF: cerebrospinal fluid; MD: meningococcal disease; N. Meningitidis: Neisseria Meningitidis; NPV: negative predictive value; PCR: positive polymerase  
2 chain reaction; PPV: positive predictive value

- 1 <sup>1</sup> Analysed in children >1 year (as considered age-specific by authors of the meningococcal paper)  
 2 <sup>2</sup> Very serious risk of bias in the evidence contributing to the outcomes as per QUADAS-2  
 3 <sup>3</sup> Serious risk of bias in the evidence contributing to the outcomes as per QUADAS-2  
 4 <sup>4</sup> 95% CI crosses 1 decision making threshold  
 5

6 **Table 40: General aching for diagnosis of meningococcal disease in babies and children. Comparison group: absence of sepsis and**  
 7 **meningitis. Non-healthcare professional (parental) identification**

No of studies	Study details	No of participants	Effect size (95% CI)	Risk of bias	Inconsistency	Indirectness	Imprecision	Quality of evidence	PPV	NPV
1 (Haj-Hassan 2011)	Population: MD compared to minor febrile infection (Children aged <16 years with non-fatal MD)  Reference standard: Clinical record review (79% confirmed through microbiological techniques)	752	Sensitivity: 0.37 (0.32 to 0.43)	Very serious <sup>1</sup>	No serious	No serious	No serious	LOW	0.58	0.59
			Specificity: 0.77 (0.72 to 0.81)	Very serious <sup>1</sup>	No serious	No serious	No serious	LOW		

- 8 *CI: confidence interval; MD: meningococcal disease; NPV: negative predictive value; PPV: positive predictive value*  
 9 <sup>1</sup> Very serious risk of bias in the evidence contributing to the outcomes as per QUADAS-2

10 **Table 41: Tachycardia for diagnosis of meningococcal disease in babies and children. Comparison group: negative for MD (no further**  
 11 **detail). Healthcare professional identification**

No of studies	Study details	No of participants	Effect size (95% CI)	Risk of bias	Inconsistency	Indirectness	Imprecision	Quality of evidence	PPV	NPV
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1 (Waterfield 2021)	Population: MD compared to non-MD (undefined) (Children <18 years presenting to paediatric emergency department with fever ≥38°C, new-onset non-blanching rash or features suggestive of meningococcal infection)  Reference standard: Positive culture or PCR test for N. meningitidis or other bacterial pathogen from a sterile body site (for example, blood or CSF)	1329	Sensitivity: 0.79 (0.54 to 0.94)	Serious <sup>1</sup>	No serious	No serious	Serious <sup>2</sup>	LOW	0.02	0.99
			Specificity: 0.55 (0.52 to 0.58)	Serious <sup>1</sup>	No serious	No serious	No serious	MODERATE		

- 1 *CI: confidence interval; CSF: cerebrospinal fluid; MD: meningococcal disease; N. Meningitidis: Neisseria Meningitidis; MD: meningococcal disease; NPV: negative predictive value;*  
2 *PCR: positive polymerase chain reaction; PPV: positive predictive value*  
3 <sup>1</sup> *Serious risk of bias in the evidence contributing to the outcomes as per QUADAS-2*  
4 <sup>2</sup> *95% CI crosses 1 decision making threshold*

5 **Table 42: Respiratory symptoms for diagnosis of meningococcal disease in babies and children. Comparison group: negative for MD (no**  
6 **further detail). Healthcare professional identification**

No of studies	Study details	No of participants	Effect size (95% CI)	Risk of bias	Inconsistency	Indirectness	Imprecision	Quality of evidence	PPV	NPV
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1 (Waterfield 2021)	Population: MD compared to non-MD (undefined) (Children <18 years presenting to paediatric emergency department with fever ≥38°C, new-onset non-blanching rash or features suggestive of meningococcal infection)  Reference standard: Positive culture or PCR test for N. meningitidis or other bacterial pathogen from a sterile body site (for example, blood or CSF)	1329	Sensitivity: 0.42 (0.20 to 0.67)	Serious <sup>1</sup>	No serious	No serious	Serious <sup>2</sup>	LOW	0.02	0.99
			Specificity: 0.69 (0.67 to 0.72)	Serious <sup>1</sup>	No serious	No serious	No serious	MODERATE		

- 1 *CI: confidence interval; CSF: cerebrospinal fluid; MD: meningococcal disease; N. Meningitidis: Neisseria Meningitidis; MD: meningococcal disease; NPV: negative predictive value;*  
2 *PCR: positive polymerase chain reaction; PPV: positive predictive value*  
3 <sup>1</sup> *Serious risk of bias in the evidence contributing to the outcomes as per QUADAS-2*  
4 <sup>2</sup> *95% CI crosses 1 decision making threshold*

5 **Table 43: Tachypnoea for diagnosis of meningococcal disease in babies and children. Comparison group: negative for MD (no further**  
6 **detail). Healthcare professional identification**

No of studies	Study details	No of participants	Effect size (95% CI)	Risk of bias	Inconsistency	Indirectness	Imprecision	Quality of evidence	PPV	NPV
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1 (Waterfield 2021)	Population: MD compared to non-MD (undefined) (Children <18 years presenting to paediatric emergency department with fever ≥38°C, new-onset non-blanching rash or features suggestive of meningococcal infection)  Reference standard: Positive culture or PCR test for N. meningitidis or other bacterial pathogen from a sterile body site (for example, blood or CSF)	1313 <sup>1</sup>	Sensitivity: 0.63 (0.38 to 0.84)	Serious <sup>2</sup>	No serious	No serious	Serious <sup>3</sup>	LOW	0.03	0.99
			Specificity: 0.67 (0.64 to 0.69)	Serious <sup>2</sup>	No serious	No serious	No serious	MODERATE		

- 1 *CI: confidence interval; CSF: cerebrospinal fluid; MD: meningococcal disease; N. Meningitidis: Neisseria Meningitidis; MD: meningococcal disease; NPV: negative predictive value;*
- 2 *PCR: positive polymerase chain reaction; PPV: positive predictive value*
- 3 *<sup>1</sup> Data available for 99% of the sample*
- 4 *<sup>2</sup> Serious risk of bias in the evidence contributing to the outcomes as per QUADAS-2*
- 5 *<sup>3</sup> 95% CI crosses 1 decision making threshold*
- 6

1

2 **Table 44: Difficult/laboured breathing for diagnosis of meningococcal disease in babies and children. Comparison group: absence of**  
3 **sepsis and meningitis. Non-healthcare professional (parental) identification**

No of studies	Study details	No of participants	Effect size (95% CI)	Risk of bias	Inconsistency	Indirectness	Imprecision	Quality of evidence	PPV	NPV
1 (Haj-Hassan 2011)	Population: MD compared to minor febrile infection (Children aged <16 years with non-fatal MD)  Reference standard: Clinical record review (79% confirmed through microbiological techniques)	752	Sensitivity: 0.12 (0.09 to 0.16)	Very serious <sup>1</sup>	No serious	No serious	No serious	LOW	0.44	0.54
			Specificity: 0.87 (0.83 to 0.90)	Very serious <sup>1</sup>	No serious	No serious	Serious <sup>2</sup>	VERY LOW		

4 *CI: confidence interval; MD: meningococcal disease; NPV: negative predictive value; PPV: positive predictive value*

5 <sup>1</sup> *Very serious risk of bias in the evidence contributing to the outcomes as per QUADAS-2*

6 <sup>2</sup> *95% CI crosses 1 decision making threshold*

7

8 **Table 45: Cough for diagnosis of meningococcal disease in babies and children. Comparison group: absence of sepsis and meningitis.**  
9 **Non-healthcare professional (parental)/healthcare professional identification**

No of studies	Study details	No of participants	Effect size (95% CI)	Risk of bias	Inconsistency	Indirectness	Imprecision	Quality of evidence	PPV	NPV
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1 (Haj-Hassan 2011)	Population: MD compared to minor febrile infection (Children aged <16 years with non-fatal MD)  Reference standard: Clinical record review (79% confirmed through microbiological techniques)	752	Sensitivity: 0.02 (0.01 to 0.04)	Very serious <sup>1</sup>	No serious	No serious	No serious	LOW	0.02	0.29
			Specificity: 0.34 (0.30 to 0.39)	Very serious <sup>1</sup>	No serious	No serious	No serious	LOW		
1 (Nielsen 2001)	Population: MD (confirmed or probable case) compared to no invasive bacterial disease (Babies/children aged 1 month-16 years, with haemorrhages in the skin of any size detected at admission or during the stay in hospital, and a rectal temperature >38°C within the 24 hours before inclusion)	208	Sensitivity: 0.15 (0.06 to 0.31)	No serious	No serious	No serious	No serious	HIGH	0.09	0.76
			Specificity: 0.63 (0.55 to 0.70)	No serious	No serious	No serious	No serious	HIGH		

	<p>Reference standard: Confirmed case: Culture of <i>N. Meningitidis</i> from blood and/or CSF.</p> <p>Probable case: clinical diagnosis without culture confirmation, but defined by a significant increase in meningococcal antibody titres, or a high antibody titre in a single serum sample drawn during the 2nd or 3rd week after onset of disease, and/or demonstration of serogroup A or C meningococcal capsular polysaccharide in the acute serum sample by counterimmunoelctrophoresis.</p>								
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1 *CI: confidence interval; CSF: cerebrospinal fluid; MD: meningococcal disease; N. Meningitidis: Neisseria Meningitidis; NPV: negative predictive; PPV: positive predictive value*  
 2 <sup>1</sup> *Very serious risk of bias in the evidence contributing to the outcomes as per QUADAS-2*  
 3

4 **Table 46: Sore throat for diagnosis of meningococcal disease in babies and children. Comparison group: absence of sepsis and**  
 5 **meningitis. Non-healthcare professional (parental) identification**

No of studies	Study details	No of participants	Effect size (95% CI)	Risk of bias	Inconsistency	Indirectness	Imprecision	Quality of evidence	PPV	NPV
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1 (Haj-Hassan 2011)	Population: MD compared to minor febrile infection (Children aged <16 years with non-fatal MD)	752	Sensitivity: 0.14 (0.11 to 0.19)	Very serious <sup>1</sup>	No serious	No serious	No serious	LOW	0.20	0.41
	Reference standard: Clinical record review (79% confirmed through microbiological techniques)		Specificity: 0.51 (0.46 to 0.56)	Very serious <sup>1</sup>	No serious	No serious	Serious <sup>2</sup>	VERY LOW		

1 *CI: confidence interval; MD: meningococcal disease; NPV: negative predictive value; PPV: positive predictive value*

2 <sup>1</sup> *Very serious risk of bias in the evidence contributing to the outcomes as per QUADAS-2*

3 <sup>2</sup> *95% CI crosses 1 decision making threshold*

4

5 **Table 47: Sore throat or coryza for diagnosis of meningococcal disease in babies and children. Comparison group: negative for MD (no**  
6 **further detail). Healthcare professional identification**

No of studies	Study details	No of participants	Effect size (95% CI)	Risk of bias	Inconsistency	Indirectness	Imprecision	Quality of evidence	PPV	NPV
1 (Waterfield 2021)	Population: MD compared to non-MD (undefined) (Children <18 years presenting to paediatric emergency department with fever ≥38°C, new-onset non-blanching rash or features suggestive of	1329	Sensitivity: 0.26 (0.09 to 0.51)	Serious <sup>1</sup>	No serious	No serious	Serious <sup>2</sup>	LOW	0.01	0.98

	meningococcal infection)  Reference standard: Positive culture or PCR test for N. meningitidis or other bacterial pathogen from a sterile body site (for example, blood or CSF)		Specificity: 0.49 (0.46 to 0.51)	Serious <sup>1</sup>	No serious	No serious	Serious <sup>2</sup>	LOW		
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1 CI: confidence interval; CSF: cerebrospinal fluid; MD: meningococcal disease; N. Meningitidis: Neisseria Meningitidis; MD: meningococcal disease; NPV: negative predictive value;  
2 PCR: positive polymerase chain reaction; PPV: positive predictive value  
3 <sup>1</sup> Serious risk of bias in the evidence contributing to the outcomes as per QUADAS-2  
4 <sup>2</sup> 95% CI crosses 1 decision making threshold

5

6 **Table 48: Gastrointestinal symptoms for diagnosis of meningococcal disease in babies and children. Comparison group: negative for**  
7 **MD (no further detail). Healthcare professional identification**

No of studies	Study details	No of participants	Effect size (95% CI)	Risk of bias	Inconsistency	Indirectness	Imprecision	Quality of evidence	PPV	NPV
1 (Waterfield 2021)	Population: MD compared to non-MD (undefined) (Children <18 years presenting to paediatric emergency department with fever ≥38°C, new-onset non-blanching rash or features suggestive of	1329	Sensitivity: 0.42 (0.20 to 0.67)	Serious <sup>1</sup>	No serious	No serious	Serious <sup>2</sup>	LOW	0.01	0.99

	meningococcal infection)		Specificity: 0.57 (0.55 to 0.60)	Serious <sup>1</sup>	No serious	No serious	No serious	MODERATE		
	Reference standard: Positive culture or PCR test for N. meningitidis or other bacterial pathogen from a sterile body site (for example, blood or CSF)									

1 *CI: confidence interval; CSF: cerebrospinal fluid; MD: meningococcal disease; N. Meningitidis: Neisseria Meningitidis; MD: meningococcal disease; NPV: negative predictive value;*  
2 *PCR: positive polymerase chain reaction; PPV: positive predictive value*  
3 <sup>1</sup> *Serious risk of bias in the evidence contributing to the outcomes as per QUADAS-2*  
4 <sup>2</sup> *95% CI crosses 1 decision making threshold*  
5

1

2 **Table 49: Nausea or vomiting for diagnosis of meningococcal disease in babies and children. Comparison group: absence of sepsis and**  
3 **meningitis. Non-healthcare professional (parental)/healthcare professional identification**

No of studies	Study details	No of participants	Effect size (95% CI)	Risk of bias	Inconsistency	Indirectness	Imprecision	Quality of evidence	PPV	NPV
1 (Haj-Hassan 2011)	Population: MD compared to minor febrile infection (Children aged <16 years with non-fatal MD)  Reference standard: Clinical record review (79% confirmed through microbiological techniques)	752	Sensitivity: 0.72 (0.67 to 0.77)	Very serious <sup>1</sup>	No serious	No serious	No serious	LOW	0.63	0.73
			Specificity: 0.64 (0.59 to 0.69)	Very serious <sup>1</sup>	No serious	No serious	No serious	LOW		
1 (Nielsen 2001)	Population: MD (confirmed or probable case) compared to no invasive bacterial disease	208	Sensitivity: 0.44 (0.28 to 0.60)	No serious	No serious	No serious	Serious <sup>2</sup>	MODERATE	0.20	0.82

	<p>(Babies/children aged 1 month-16 years, with haemorrhages in the skin of any size detected at admission or during the stay in hospital, and a rectal temperature &gt;38°C within the 24 hours before inclusion)</p> <p>Reference standard: Confirmed case: Culture of N. Meningitidis from blood and/or CSF. Probable case: clinical diagnosis without culture confirmation, but defined by a significant increase in meningococcal antibody titres, or a high antibody titre in a single serum sample drawn during the 2nd or 3rd week after onset of disease, and/or demonstration of serogroup A or C meningococcal capsular polysaccharide in the acute serum sample by counterimmunoelctrophoresis.</p>		<p>Specificity: 0.60 (0.52 to 0.67)</p>	<p>No serious</p>	<p>No serious</p>	<p>No serious</p>	<p>No serious</p>	<p>HIGH</p>		
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1 *CI: confidence interval; CSF: cerebrospinal fluid; MD: meningococcal disease; N. Meningitidis: Neisseria Meningitidis; NPV: negative predictive; PPV: positive predictive value*

2 <sup>1</sup> *Very serious risk of bias in the evidence contributing to the outcomes as per QUADAS-2*

3 <sup>2</sup> *95% CI crosses 1 decision making threshold*

7 **Table 50: Diarrhoea for diagnosis of meningococcal disease in babies and children. Comparison group: absence of sepsis and meningitis. Non-healthcare professional (parental) identification**

No of studies	Study details	No of participants	Effect size (95% CI)	Risk of bias	Inconsistency	Indirectness	Imprecision	Quality of evidence	PPV	NPV
1 (Haj-Hassan 2011)	Population: MD compared to minor febrile infection (Children aged <16 years with non-fatal MD)  Reference standard: Clinical record review (79% confirmed through microbiological techniques)	752	Sensitivity: 0.10 (0.07 to 0.14)	Very serious <sup>1</sup>	No serious	No serious	No serious	LOW	0.30	0.51
			Specificity: 0.80 (0.76 to 0.84)	Very serious <sup>1</sup>	No serious	No serious	No serious	LOW		

9 *CI: confidence interval; MD: meningococcal disease; NPV: negative predictive value; PPV: positive predictive value*

10 <sup>1</sup> *Very serious risk of bias in the evidence contributing to the outcomes as per QUADAS-2*

11 **Table 51: Tummy pain for diagnosis of meningococcal disease in babies and children. Comparison group: absence of sepsis and meningitis. Non-healthcare professional (parental) identification**

No of studies	Study details	No of participants	Effect size (95% CI)	Risk of bias	Inconsistency	Indirectness	Imprecision	Quality of evidence	PPV	NPV
1 (Haj-Hassan 2011)	Population: MD compared to minor febrile infection (Children aged <16 years with non-fatal MD)	616 <sup>1</sup>	Sensitivity: 0.05 (0.03 to 0.08)	Very serious <sup>1</sup>	No serious	No serious	No serious	LOW	0.11	0.53
			Specificity 0.74	Very	No serious	No serious	No serious	LOW		

	Reference standard: Clinical record review (79% confirmed through microbiological techniques)		(0.69 to 0.78)	serious <sup>1</sup>						
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1 *CI: confidence interval; MD: meningococcal disease; NPV: negative predictive value; PPV: positive predictive value*  
 2 <sup>1</sup> *Analysed in children >1 year (as considered age-specific by authors of the meningococcal paper)*  
 3 <sup>2</sup> *Very serious risk of bias in the evidence contributing to the outcomes as per QUADAS-2*  
 4

5 **Table 52: Food refusal for diagnosis of meningococcal disease in babies and children. Comparison group: absence of sepsis and**  
 6 **meningitis/negative for MD (no further detail). Non-healthcare professional (parental)/healthcare professional identification**

No of studies	Study details	No of participants	Effect size (95% CI)	Risk of bias	Inconsistency	Indirectness	Imprecision	Quality of evidence	PPV	NPV
1 (Haj-Hassan 2011)	Population: MD compared to minor febrile infection (Children aged <16 years with non-fatal MD)	752	Sensitivity: 0.58 (0.53 to 0.63)	Very serious <sup>1</sup>	No serious	No serious	No serious	LOW	0.52	0.61
	Reference standard: Clinical record review (79% confirmed through microbiological techniques)		Specificity: 0.56 (0.51 to 0.60)	Very serious <sup>1</sup>	No serious	No serious	No serious	LOW		

1 (Waterfield 2021)	Population: MD compared to non-MD (undefined) (Children <18 years presenting to paediatric emergency department with fever ≥38°C, new-onset non-blanching rash or features suggestive of meningococcal infection)  Reference standard: Positive culture or PCR test for N. meningitidis or other bacterial pathogen from a sterile body site (for example, blood or CSF)	1329	Sensitivity: 0.42 (0.20 to 0.67)	Serious <sup>2</sup>	No serious	No serious	Serious <sup>3</sup>	LOW	0.02	0.99
			Specificity: 0.69 (0.67 to 0.72)	Serious <sup>2</sup>	No serious	No serious	No serious	MODERATE		

- 1 *CI: confidence interval; CSF: cerebrospinal fluid; MD: meningococcal disease; N. Meningitidis: Neisseria Meningitidis; NPV: negative predictive value; PCR: positive polymerase*  
2 *chain reaction; PPV: positive predictive value*  
3 <sup>1</sup> *Very serious risk of bias in the evidence contributing to the outcomes as per QUADAS-2*  
4 <sup>2</sup> *Serious risk of bias in the evidence contributing to the outcomes as per QUADAS-2*  
5 <sup>3</sup> *95% CI crosses 1 decision making threshold*  
6

7 **Table 53: Presence of haemorrhagic rash for diagnosis of meningococcal disease in adults. Comparison group: viral meningitis.**  
8 **Healthcare professional identification**

No of studies	Study details	No of participants	Effect size (95% CI)	Risk of bias	Inconsistency	Indirectness	Imprecision	Quality of evidence	PPV	NPV
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1 (Close 2011)	Population: bacterial meningitis or meningococcal septicaemia compared to viral meningitis (Adults aged >19 years with a confirmed case of bacterial or viral meningitis, or meningococcal septicaemia)  Reference standard: Any 1 of: bacteria, bacterial antigen, bacterial or viral DNA or RNA identified in CSF; bacteria or viruses obtained from culture of CSF; clinical and/or laboratory diagnosis of meningitis accompanied by microbiological evidence of pathogen from another site, for example blood, throat swab, skin or faeces	98 <sup>1</sup>	Sensitivity: 0.31 (0.20 to 0.43)	Serious <sup>2</sup>	No serious	Serious <sup>3</sup>	No serious	LOW	1.00	0.34
			Specificity: 1.00 (0.87 to 1.00)	Serious <sup>2</sup>	No serious	Serious <sup>3</sup>	Serious <sup>4</sup>	VERY LOW		

1 *CI: confidence interval; CSF: cerebrospinal fluid; MD: meningococcal disease; N. Meningitidis: Neisseria Meningitidis; NPV: negative predictive value; PPV: positive predictive value*

2

3 <sup>1</sup> Data available for 63% of sample

4 <sup>2</sup> Serious risk of bias in the evidence contributing to the outcomes as per QUADAS-2

5 <sup>3</sup> Population may be indirect. Unclear how many people have meningitis only (however, only 80% had N. meningitidis as the cause)

6 <sup>4</sup> 95% CI crosses 1 decision making threshold

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2 **Table 54: Reduced consciousness for diagnosis of meningococcal disease in adults. Comparison group: viral meningitis. Healthcare**  
3 **professional identification**

No of studies	Study details	No of participants	Effect size (95% CI)	Risk of bias	Inconsistency	Indirectness	Imprecision	Quality of evidence	PPV	NPV
1 (Close 2011)	Population: bacterial meningitis or meningococcal septicaemia compared to viral meningitis (Adults aged >19 years with a confirmed case of bacterial or viral meningitis, or meningococcal septicaemia)  Reference standard: Any 1 of: bacteria, bacterial antigen, bacterial or viral DNA or RNA identified in CSF; bacteria or viruses obtained from culture of CSF; clinical and/or laboratory diagnosis of meningitis accompanied by microbiological evidence of pathogen from another site, for example blood, throat swab, skin or faeces	95 <sup>1</sup>	Sensitivity: 0.13 (0.06 to 0.23)	Serious <sup>2</sup>	No serious	Serious <sup>3</sup>	No serious	LOW	1.00	0.30
			Specificity: 1.00 (0.87 to 1.00)	Serious <sup>2</sup>	No serious	Serious <sup>3</sup>	Serious <sup>4</sup>	VERY LOW		

- 1 *CI: confidence interval; CSF: cerebrospinal fluid; MD: meningococcal disease; N. Meningitidis: Neisseria Meningitidis; NPV: negative predictive value; PPV: positive predictive*  
 2 *value*  
 3 <sup>1</sup> *Data available for 61% of sample*  
 4 <sup>2</sup> *Serious risk of bias in the evidence contributing to the outcomes as per QUADAS-2*  
 5 <sup>3</sup> *Population may be indirect. Unclear how many people have meningitis only (however, only 80% had N. meningitidis as the cause)*  
 6 <sup>4</sup> *95% CI crosses 1 decision making threshold*

7 **Table 55: Reduced general condition for diagnosis of meningococcal disease in undefined age range. Comparison group: negative for**  
 8 **MD (includes non-meningococcal sepsis and meningitis). Healthcare professional identification**

No of studies	Study details	No of participants	Effect size (95% CI)	Risk of bias	Inconsistency	Indirectness	Imprecision	Quality of evidence	PPV	NPV
1 (Borchsenius 1991)	Population: MD compared to non-MD (includes those with bacterial meningitis/septicaemia with causes other than N. meningitidis, other bacterial infections and viral infections). (Patients with suspected systemic meningococcal disease admitted to hospital. Those with meningitis only are included in the review on signs and symptoms of bacterial	120	Sensitivity: 0.47 (0.34 to 0.61)	Very serious <sup>1</sup>	No serious	No serious	Serious <sup>2</sup>	VERY LOW	0.74	0.62

	meningitis)  Reference standard: Method of diagnosis reported for the whole MD group (including those with meningitis alone): MD confirmed with growth of meningococci in blood and/or CSF (for 62%), or based on the clinical picture, meningococcal antigen in CSF, or growth of N. meningitidis in pharyngeal swab specimens (for 38%)		Specificity: 0.84 (0.72 to 0.92)	Very serious <sup>1</sup>	No serious	No serious	Serious <sup>2</sup>	VERY LOW		
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1 CI: confidence interval; CSF: cerebrospinal fluid; MD: meningococcal disease; N. Meningitidis: Neisseria Meningitidis; NPV: negative predictive value; PPV: positive predictive value  
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3 <sup>1</sup> Very serious risk of bias in the evidence contributing to the outcomes as per QUADAS-2  
4 <sup>2</sup> 95% CI crosses 1 decision making threshold  
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2 **Table 56: Cyanosis for diagnosis of meningococcal disease in undefined age range. Comparison group: negative for MD (includes non-**  
3 **meningococcal sepsis and meningitis). Healthcare professional identification**

No of studies	Study details	No of participants	Effect size (95% CI)	Risk of bias	Inconsistency	Indirectness	Imprecision	Quality of evidence	PPV	NPV
1 (Borchsenius 1991)	Population: MD compared to non-MD (includes those with bacterial meningitis/septicaemia with causes other than N. meningitidis, other bacterial infections and viral infections). (Patients with suspected systemic meningococcal disease admitted to hospital. Those with meningitis only are included in the review on signs and symptoms of bacterial	120	Sensitivity: 0.15 (0.07 to 0.27)	Very serious <sup>1</sup>	No serious	No serious	No serious	LOW	1.00	0.55

	meningitis)  Reference standard: Method of diagnosis reported for the whole MD group (including those with meningitis alone): MD confirmed with growth of meningococci in blood and/or CSF (for 62%), or based on the clinical picture, meningococcal antigen in CSF, or growth of N. meningitidis in pharyngeal swab specimens (for 38%)		Specificity: 1.00 (0.94 to 1.00)	Very serious <sup>1</sup>	No serious	No serious	No serious	LOW		
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CI: confidence interval; CSF: cerebrospinal fluid; MD: meningococcal disease; N. Meningitidis: Neisseria Meningitidis; NPV: negative predictive value; PPV: positive predictive value  
<sup>1</sup> Very serious risk of bias in the evidence contributing to the outcomes as per QUADAS-2

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2 **Table 57: Petechiae ( $\leq 4$  mm) for diagnosis of meningococcal disease in undefined age range. Comparison group: negative for MD**  
3 **(includes non-meningococcal sepsis and meningitis). Healthcare professional identification**

No of studies	Study details	No of participants	Effect size (95% CI)	Risk of bias	Inconsistency	Indirectness	Imprecision	Quality of evidence	PPV	NPV
1 (Borchsenius 1991)	Population: MD compared to non-MD (includes those with bacterial meningitis/septicaemia with causes other than N. meningitidis, other bacterial infections and viral infections). (Patients with suspected systemic meningococcal disease admitted to hospital. Those with meningitis only are included in the review on signs and symptoms of bacterial	120	Sensitivity: 0.81 (0.69 to 0.90)	Very serious <sup>1</sup>	No serious	No serious	Serious <sup>2</sup>	VERY LOW	0.81	0.82

	meningitis)  Reference standard: Method of diagnosis reported for the whole MD group (including those with meningitis alone): MD confirmed with growth of meningococci in blood and/or CSF (for 62%), or based on the clinical picture, meningococcal antigen in CSF, or growth of N. meningitidis in pharyngeal swab specimens (for 38%)		Specificity: 0.82 (0.70 to 0.91)	Very serious <sup>1</sup>	No serious	No serious	Serious <sup>2</sup>	VERY LOW		
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- 1 *CI: confidence interval; CSF: cerebrospinal fluid; MD: meningococcal disease; N. Meningitidis: Neisseria Meningitidis; NPV: negative predictive value; PPV: positive predictive value*
- 2
- 3 <sup>1</sup> *Very serious risk of bias in the evidence contributing to the outcomes as per QUADAS-2*
- 4 <sup>2</sup> *95% CI crosses 1 decision making threshold*
- 5
- 6

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2 **Table 58: Ecchymoses (>4 mm) for diagnosis of meningococcal disease in undefined age range. Comparison group: negative for MD**  
3 **(includes non-meningococcal sepsis and meningitis). Healthcare professional identification**

No of studies	Study details	No of participants	Effect size (95% CI)	Risk of bias	Inconsistency	Indirectness	Imprecision	Quality of evidence	PPV	NPV
1 (Borchsenius 1991)	Population: MD compared to non-MD (includes those with bacterial meningitis/septicaemia with causes other than N. meningitidis, other bacterial infections and viral infections). (Patients with suspected systemic meningococcal disease admitted to hospital. Those with meningitis only are included in the review on signs and symptoms of bacterial	120	Sensitivity: 0.46 (0.33 to 0.59)	Very serious <sup>1</sup>	No serious	No serious	Serious <sup>2</sup>	VERY LOW	0.75	0.62

	meningitis)  Reference standard: Method of diagnosis reported for the whole MD group (including those with meningitis alone): MD confirmed with growth of meningococci in blood and/or CSF (for 62%), or based on the clinical picture, meningococcal antigen in CSF, or growth of N. meningitidis in pharyngeal swab specimens (for 38%)		Specificity: 0.85 (0.74 to 0.93)	Very serious <sup>1</sup>	No serious	No serious	Serious <sup>2</sup>	VERY LOW		
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- 1 *CI: confidence interval; CSF: cerebrospinal fluid; MD: meningococcal disease; N. Meningitidis: Neisseria Meningitidis; NPV: negative predictive value; PPV: positive predictive value*
- 2
- 3 <sup>1</sup> *Very serious risk of bias in the evidence contributing to the outcomes as per QUADAS-2*
- 4 <sup>2</sup> *95% CI crosses 1 decision making threshold*
- 5

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2 **Table 59: Neck stiffness for diagnosis of meningococcal disease in undefined age range. Comparison group: negative for MD (includes**  
3 **non-meningococcal sepsis and meningitis). Healthcare professional identification**

No of studies	Study details	No of participants	Effect size (95% CI)	Risk of bias	Inconsistency	Indirectness	Imprecision	Quality of evidence	PPV	NPV
1 (Borchsenius 1991)	Population: MD compared to non-MD (includes those with bacterial meningitis/septicaemia with causes other than N. meningitidis, other bacterial infections and viral infections). (Patients with suspected systemic meningococcal disease admitted to hospital. Those with meningitis only are included in the review on signs and symptoms of bacterial	120	Sensitivity: 0.34 (0.22 to 0.47)	Very serious <sup>1</sup>	No serious	No serious	No serious	LOW	0.43	0.47

	meningitis)  Reference standard: Method of diagnosis reported for the whole MD group (including those with meningitis alone): MD confirmed with growth of meningococci in blood and/or CSF (for 62%), or based on the clinical picture, meningococcal antigen in CSF, or growth of N. meningitidis in pharyngeal swab specimens (for 38%)		Specificity: 0.57 (0.44 to 0.70)	Very serious <sup>1</sup>	No serious	No serious	Serious <sup>2</sup>	VERY LOW		
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1 CI: confidence interval; CSF: cerebrospinal fluid; MD: meningococcal disease; N. Meningitidis: Neisseria Meningitidis; NPV: negative predictive value; PPV: positive predictive value  
2  
3 <sup>1</sup> Very serious risk of bias in the evidence contributing to the outcomes as per QUADAS-2  
4 <sup>2</sup> 95% CI crosses 1 decision making threshold

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2 **Table 60: Reduced consciousness for diagnosis of meningococcal disease in undefined age range. Comparison group: negative for MD**  
3 **(includes non-meningococcal sepsis and meningitis). Healthcare professional identification**

No of studies	Study details	No of participants	Effect size (95% CI)	Risk of bias	Inconsistency	Indirectness	Imprecision	Quality of evidence	PPV	NPV
1 (Borchsenius 1991)	Population: MD compared to non-MD (includes those with bacterial meningitis/septicaemia with causes other than N. meningitidis, other bacterial infections and viral infections). (Patients with suspected systemic meningococcal disease admitted to hospital. Those with meningitis only are included in the review on signs and symptoms of bacterial	120	Sensitivity: 0.42 (0.30 to 0.56)	Very serious <sup>1</sup>	No serious	No serious	Serious <sup>2</sup>	VERY LOW	0.69	0.60

	meningitis)  Reference standard: Method of diagnosis reported for the whole MD group (including those with meningitis alone): MD confirmed with growth of meningococci in blood and/or CSF (for 62%), or based on the clinical picture, meningococcal antigen in CSF, or growth of N. meningitidis in pharyngeal swab specimens (for 38%)		Specificity: 0.82 (0.70 to 0.91)	Very serious <sup>1</sup>	No serious	No serious	Serious <sup>2</sup>	VERY LOW		
--	---	--	----------------------------------	---------------------------	------------	------------	----------------------	----------	--	--

1 CI: confidence interval; CSF: cerebrospinal fluid; MD: meningococcal disease; N. Meningitidis: Neisseria Meningitidis; NPV: negative predictive value; PPV: positive predictive value  
2  
3 <sup>1</sup> Very serious risk of bias in the evidence contributing to the outcomes as per QUADAS-2  
4 <sup>2</sup> 95% CI crosses 1 decision making threshold

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2 **Table 61: Cold extremities for diagnosis of meningococcal disease in undefined age range. Comparison group: negative for MD**  
3 **(includes non-meningococcal sepsis and meningitis). Healthcare professional identification**

No of studies	Study details	No of participants	Effect size (95% CI)	Risk of bias	Inconsistency	Indirectness	Imprecision	Quality of evidence	PPV	NPV
1 (Borchsenius 1991)	Population: MD compared to non-MD (includes those with bacterial meningitis/septicaemia with causes other than N. meningitidis, other bacterial infections and viral infections). (Patients with suspected systemic meningococcal disease admitted to hospital. Those with meningitis only are included in the review on signs and symptoms of bacterial	120	Sensitivity: 0.34 (0.22 to 0.47)	Very serious <sup>1</sup>	No serious	No serious	No serious	LOW	0.83	0.59

	meningitis)  Reference standard: Method of diagnosis reported for the whole MD group (including those with meningitis alone): MD confirmed with growth of meningococci in blood and/or CSF (for 62%), or based on the clinical picture, meningococcal antigen in CSF, or growth of N. meningitidis in pharyngeal swab specimens (for 38%)		Specificity: 0.93 (0.84 to 0.98)	Very serious <sup>1</sup>	No serious	No serious	Serious <sup>2</sup>	VERY LOW		
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1 CI: confidence interval; CSF: cerebrospinal fluid; MD: meningococcal disease; N. Meningitidis: Neisseria Meningitidis; NPV: negative predictive value; PPV: positive predictive value  
2  
3 <sup>1</sup> Very serious risk of bias in the evidence contributing to the outcomes as per QUADAS-2  
4 <sup>2</sup> 95% CI crosses 1 decision making threshold

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2 **Table 62: Body pain for diagnosis of meningococcal disease in undefined age range. Comparison group: negative for MD (includes non-**  
3 **meningococcal sepsis and meningitis). Healthcare professional identification**

No of studies	Study details	No of participants	Effect size (95% CI)	Risk of bias	Inconsistency	Indirectness	Imprecision	Quality of evidence	PPV	NPV
1 (Borchsenius 1991)	Population: MD compared to non-MD (includes those with bacterial meningitis/septicaemia with causes other than N. meningitidis, other bacterial infections and viral infections). (Patients with suspected systemic meningococcal disease admitted to hospital. Those with meningitis only are included in the review on signs and symptoms of bacterial	120	Sensitivity: 0.29 (0.18 to 0.42)	Very serious <sup>1</sup>	No serious	No serious	No serious	LOW	0.68	0.56

	meningitis)  Reference standard: Method of diagnosis reported for the whole MD group (including those with meningitis alone): MD confirmed with growth of meningococci in blood and/or CSF (for 62%), or based on the clinical picture, meningococcal antigen in CSF, or growth of N. meningitidis in pharyngeal swab specimens (for 38%)		Specificity: 0.87 (0.76 to 0.94)	Very serious <sup>1</sup>	No serious	No serious	Serious <sup>2</sup>	VERY LOW		
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- 1 *CI: confidence interval; CSF: cerebrospinal fluid; MD: meningococcal disease; N. Meningitidis: Neisseria Meningitidis; NPV: negative predictive value; PPV: positive predictive value*
- 2
- 3 <sup>1</sup> *Very serious risk of bias in the evidence contributing to the outcomes as per QUADAS-2*
- 4 <sup>2</sup> *95% CI crosses 1 decision making threshold*

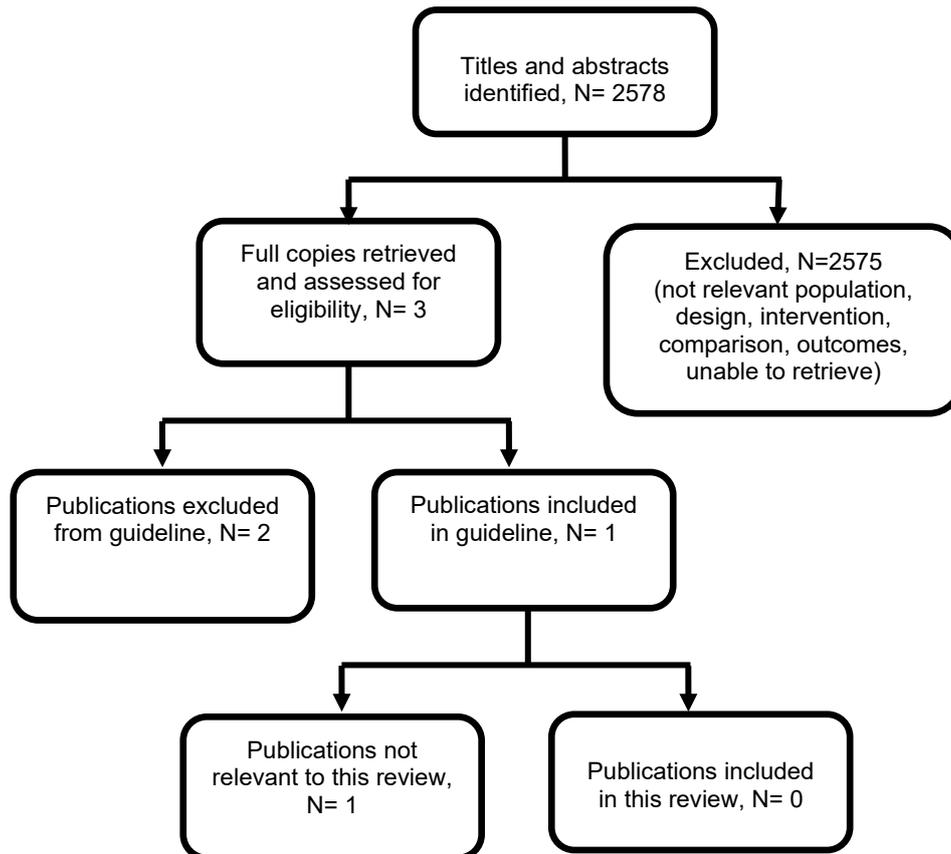
1 **Appendix F Economic evidence study selection**

2 **Study selection for: What symptoms and signs, individually or in combination,**  
3 **are associated with meningococcal disease?**

4 A global economic search was undertaken for the whole guideline, but no economic  
5 evidence was identified which was applicable to this review question (see Figure 8).

6 **Figure 8: Study selection flow chart**

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1 **Appendix G Economic evidence tables**

2 **Economic evidence tables for review question: What symptoms and signs,**  
3 **individually or in combination, are associated with meningococcal disease?**

4 No evidence was identified which was applicable to this review question.

5

1 **Appendix H Economic model**

2 **Economic model for review question: What symptoms and signs, individually**  
3 **or in combination, are associated with meningococcal disease?**

4 No economic analysis was conducted for this review question.

5

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## 2 Appendix I Excluded studies

3 **Excluded studies for review question: What symptoms and signs, individually**  
4 **or in combination, are associated with meningococcal disease?**

5 **Excluded diagnostic and prognostic studies**

6 **Table 63: Excluded studies and reasons for their exclusion**

Study	Reason for exclusion
Ali, S., Hovenden, J.L., Symon, D.N.K., Review of meningococcal infection in children at a United Kingdom hospital, <i>Acta Microbiologica et Immunologica Hungarica</i> , 56, 81-87, 2009	Study design not of interest for review [Case series]
Aponso, D., Bullen, C., Presenting features of meningococcal disease, public health messages and media publicity: are they consistent?, <i>New Zealand Medical Journal</i> , 114, 83-85, 2001	Study design not of interest for review [Prevalence study on signs and symptoms of meningococcal disease. No comparison with those without meningococcal disease.]
Burman, L.A., Norrby, R., Trollfors, B., Invasive pneumococcal infections: incidence, predisposing factors, and prognosis, <i>Reviews of Infectious Diseases</i> , 7, 133-142, 1985	Study design not of interest for review [Case series]
Campbell, H., Andrews, N., Parikh, S., Ribeiro, S., Gray, S., Lucidarme, J., Ramsay, M.E., Borrow, R., Ladhani, S.N., Variable clinical presentation by the main capsular groups causing invasive meningococcal disease in England, <i>Journal of Infection</i> , 80, 182-189, 2020	Comparison not of interest for review [Comparison between different serogroups of meningococcal disease. Serogroups B, Y, and W]
De Greeff, S.C., De Melker, H.E., Schouls, L.M., Spanjaard, L., Van Deuren, M., Pre-admission clinical course of meningococcal disease and opportunities for the earlier start of appropriate intervention: a prospective epidemiological study on 752 patients in the Netherlands, 2003-2005, <i>European Journal of Clinical Microbiology and Infectious Diseases</i> , 27, 985-992, 2008	Study design not of interest for review [Prevalence data for signs and symptoms in meningococcal disease. No comparison with those without meningococcal disease]
Dubey, Himanshu, Oster, Philipp, Fazeli, Mir Sohail et al. (2022) Risk Factors for Contracting Invasive Meningococcal Disease and Related Mortality: A Systematic Literature Review and Meta-analysis. <i>International journal of infectious diseases: IJID : official publication of the International Society for Infectious Diseases</i> 119: 1-9	Systematic review - included studies failed to meet inclusion criteria
Evans-Jones, L.G., Whittle, H.C., Onyewotu, I.I., Egler, L.J., Greenwood, B.M., Comparative study of group A and group C meningococcal infection, <i>Archives of Disease in Childhood</i> , 52, 320-323, 1977	Country not of interest for review [Not a high-income OECD country (Nigeria)]
Fijnvandraat, K., Derkx, B., Peters, M., Bijlmer, R., Sturk, A., Prins, M.H., van Deventer, S.J. and ten Cate, J.W., Coagulation activation and tissue necrosis in meningococcal septic shock: severely reduced protein C levels predict a high mortality, <i>Thrombosis and Haemostasis</i> , 73, 15-	Outcome not of interest for review [Risk factors associated with adverse outcomes in meningococcal disease]

Study	Reason for exclusion
20, 1995	
Geishofer, G., Binder, A., Müller, M., Zöhrer, B., Resch, B., Müller, W., Faber, J., Finn, A., Endler, G., Mannhalter, C. and Zenz, W., 4G/5G promoter polymorphism in the plasminogen-activator-inhibitor-1 gene in children with systemic meningococcaemia, <i>European Journal of Pediatrics</i> , 164, 486-90, 2005	Study design not of interest for review [Case-control study]
Granier, S., Owen, P., Stott, N.C.H., Recognizing meningococcal disease: the case for further research in primary care, <i>British Journal of General Practice</i> , 48, 1167-1171, 1998	Study design not of interest for review [Systematic review doesn't include individual study quality assessment. Studies included in this review were assessed for potential inclusion]
Guiddir, T., Gros, M., Hong, E., Terrade, A., Denizon, M., Deghmane, A.E. and Taha, M.K., Unusual initial abdominal presentations of invasive meningococcal disease, <i>Clinical Infectious Diseases</i> , 67, 1220-1227, 2018	Outcome not of interest for review [Fatality rate with abdominal pain vs no abdominal pain in invasive meningococcal disease]
Healy, C.M., Butler, K.M., Smith, E.O.B., Hensey, O.P., Terence, B., Moloney, A.C., MacMahon, P., Cosgrove, J. and Cafferkey, M.T., Influence of serogroup on the presentation, course, and outcome of invasive meningococcal disease in children in the Republic of Ireland, 1995-2000, <i>Clinical Infectious Diseases</i> , 34, 1323-1330, 2002	Comparison not of interest for review [Comparison between different serogroups of meningococcal disease. Serogroup b vs c meningococcal disease]
Inkelis, S.H., O'Leary, D., Wang, V.J., Malley, R., Nicholson, M.K., Kuppermann, N., Extremity pain and refusal to walk in children with invasive meningococcal disease, <i>Pediatrics</i> , 110(1), e3, 2002	Study design not of interest for review [Prevalence data on signs and symptoms of meningococcal disease. No comparison with those without meningococcal disease]
Kuppermann, N., Malley, R., Inkelis, S.H. and Fleisher, G.R., Clinical and hematologic features do not reliably identify children with unsuspected meningococcal disease, <i>Pediatrics</i> , 103(2), e20, 1999	No signs and symptoms of interest for review [Mean temperature as continuous outcome as opposed to presence or absence of fever]
Leonard, P.A., Beattie, T.F., Presenting features of paediatric meningococcal disease-a five year experience from a paediatric accident and emergency department, <i>Health Bulletin</i> , 58, 148-151, 2000	Study design not of interest for review [Prevalence data on signs and symptoms of meningococcal disease. No comparison with those without meningococcal disease]
Loenenbach, A.D., van der Ende, A., de Melker, H.E., Sanders, E.A., Knol, M.J., The clinical picture and severity of invasive meningococcal disease serogroup W compared with other serogroups in the Netherlands, 2015–2018, <i>Clinical Infectious Diseases</i> , 70, 2036-2044, 2020	Comparison not of interest for review [Comparison between different serogroups of meningococcal disease]
Marzouk, O., Thomson, A.P., Sills, J.A., Hart, C.A., Harris, F., Features and outcome in meningococcal disease presenting with maculopapular rash, <i>Archives of disease in childhood</i> , 66, 485-487, 1991	Study design not of interest for review [Prevalence data on different types of rash in meningococcal disease. No comparison with those without meningococcal disease]
Parikh, S.R., Campbell, H., Gray, S.J., Beebeejaun, K., Ribeiro, S., Borrow, R., Ramsay, M.E., Ladhani, S.N., Epidemiology, clinical presentation, risk factors, intensive care	Study design not of interest for review [Prevalence data on signs and symptoms of meningococcal disease. No comparison with those without meningococcal disease]

Study	Reason for exclusion
admission and outcomes of invasive meningococcal disease in England, 2010–2015, <i>Vaccine</i> , 36, 3876-3881, 2018	
Paul, V.K., Verma, I.C., Deorari, A.K., Clinical aspects of meningococcal infections, <i>Indian Journal of Pediatrics</i> , 55, 207-217, 1988	Study design not of interest for review [Case series]
Schildkamp, R.L., Lodder, M.C., Bijlmer, H.A., Dankert, J., Scholten, R.J., Clinical manifestations and course of meningococcal disease in 562 patients, <i>Scandinavian Journal of Infectious Diseases</i> , 28, 47-51, 1996	Comparison not of interest for review [Compares signs and symptoms in meningococcal meningitis vs meningococcal disease vs meningococcal sepsis. No comparison with those without meningococcal meningitis/disease]
Sørensen, H.T., Møller-Petersen, J., Krarup, H.B., Pedersen, H., Hansen, H., Hamburger, H., Diagnostic problems with meningococcal disease in general practice, <i>Journal of Clinical Epidemiology</i> , 45, 1289-1293, 1992	Comparison not of interest for review [Compares signs and symptoms in those with a correct referral diagnosis from GP of meningococcal disease (meningitis/sepsis) or CNS infection vs those that the referring GP thought did not have MD /CNS infection (incorrect diagnosis). No comparison with those without meningococcal meningitis/disease]
Stinson, C., Burman, C., Presa, J., Abalos, M., Atypical presentation of invasive meningococcal disease caused by serogroup W meningococci, <i>Epidemiology &amp; Infection</i> , 148, e12, 2020	Study design not of interest for review [Literature review. Studies included in this review were assessed for potential inclusion]
Stovall, S.H., Schutze, G.E., 2002, Meningococcal infections in children from Arkansas, <i>Pediatric Infectious Disease Journal</i> , 21, 366-370, 2002	Study design not of interest for review [Prevalence data on signs and symptoms of meningococcal infections. No comparison with those without meningococcal disease]
Thompson, M.J., Ninis, N., Perera, R., Mayon-White, R., Phillips, C., Bailey, L., Harnden, A., Mant, D., Levin, M., Clinical recognition of meningococcal disease in children and adolescents, <i>Lancet</i> , 367, 397-403, 2006	Study design not of interest for review [Prevalence data on signs and symptoms of meningococcal disease. No comparison with those without meningococcal disease]
Toejum, T., Nilsson, F., Bruun, J.N., Haneberg, B., The early phase of meningococcal disease, <i>NIPH Annals</i> , 6, 175-181, 1983	Study design not of interest for review [Case control study]
Voss, L., Lennon, D., Sinclair, J., The clinical features of paediatric meningococcal disease Auckland, 1985-87, <i>New Zealand Medical Journal</i> , 102, 243-245, 1989	Study design not of interest for review [Prevalence data for signs and symptoms of meningococcal disease. No comparison with those without meningococcal disease]
Wang, V.J., Kuppermann, N., Malley, R., Barnett, E.D., Meissner, H.C., Schmidt, E.V., Fleisher, G.R., Meningococcal disease among children who live in a large metropolitan area, 1981–1996, <i>Clinical Infectious Diseases</i> , 32, 1004-1009, 2001	Study design not of interest for review [Epidemiological study (no details on signs and symptoms or risk factors with meningococcal disease)]
Wong, V.K., Hitchcock, W., Mason, W.H., Meningococcal infections in children: a review of 100 cases, <i>Pediatric Infectious Disease Journal</i> , 8, 224-227, 1989	Study design not of interest for review [Prevalence data for signs and symptoms of meningococcal infections. No comparison with those without meningococcal disease]

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## 2 Excluded economic studies

3 No economic evidence was identified for this review.

4

- 1 **Appendix J Research recommendations – full details**
- 2 **Research recommendations for review question: What symptoms and signs,**
- 3 **individually or in combination, are associated with meningococcal disease?**
- 4 No research recommendations were made for this review question.