Antibiotic treatment of suspected neonatal meningitis

Sir,—The annotation on antibiotic treatment of suspected neonatal meningitis seems to demonstrate that optimal treatment of this thankfully rare disorder is still not clear. 1 The suggested array of antibiotic treatment and combined routes of administration may provide cover against a wide range of organisms, but is such treatment in the best interests of every patient? In a sick hypotensive infant who may already have compromised renal function the combination of aminoglycoside and cephalosporin may exacerbate the problem. To state that 'Gentamicin should be used primarily to treat the associated septicaemia' and 'the impression is that cephalosporins are incapable of doing this. Is there any evidence to suggest that co- taxime is ineffective in the treatment of bacteriemia in neonates?

I am concerned by the conviction of the authors in their management proposals. To begin a paragraph stating 'there is no doubt in our minds that intraventricular treatment should be used' and end it with 'there has been no study of intraventricular treatment... and little information on the ventricular drug concentration achieved after systemic treatment alone in dilated ventricles' is perhaps a little rash in view of the finding of enteral therapy increased mortality after intraventricular treatment in the American study.2

The conclusion of McCracken and colleagues was that 'intraventricular therapy cannot be recommended for the routine management of neonatal meningitis caused by Gram negative enteric bacilli'. In the absence of a further randomised multicentre trial it is surely ill advised to recommend the adoption of this invasive and potentially dangerous mode of treatment as the standard treatment in neonatal Gram negative meningitis with ventricular distalation.

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Dr Rennie and Gandy comment:

Thank you for giving us the opportunity to reply to the correspondence referring to our editorial. Opinions regarding the benefits of intraventricular treatment in neonatal Gram negative meningitis are likely to continue to differ for some time: our recommendations constitute what we believe to be the best guidelines for the management of this serious and rare disease. We remain of the opinion, shared with Pearce and Robertson, 1 that a ventricular tap should be performed if the ventricles are large or the infant is failing to respond to treatment after 24 hours. Intraventricular treatment should be given via a Rickham reservoir to babies with ventriculitis. We do not avoid this treatment because of the conclusions of the Neonatal Meningitis Cooperative Study Group because patients were enrolled in this study more than 10 years ago, before the widespread availability of cranial ultrason or the third generation cephalosporins. Much of the discussion pertaining to this work has been well rehearsed before, including the fact that only 20 cases were actually neonates suffering from meningitis.

The combination of cefotaxime with another drug such as gentamicin 1 was suggested because of the evidence in favour of synergism, the improved outlook in granulocytic patients with meningitis, and the fact that endotoxin is likely to be produced after dual treatment, and to combat the emergence of resistance. The advice of our microbiologists has always been to start treatment with a dual regime to obtain rapid bacterial killing. We use a single agent when the baby is improving and sensitivity results are available. Ceftriaxone monotherapy seems promising in adults and may prove useful in the future. This is not only true in the case of meningitis, but is precisely the type of complication that led us to suggest transfer of such cases to centres with intensive care facilities.

Dr Tarlow's suggestion that neonatologists should consider high dose dexamethasone is an interesting one and we are aware of the evidence suggesting a reduction in neurological sequelae in older children, most of whom were suffering from haemorrhagic infection. 3 The use of dexamethasone treatment in neonatal meningitis is planned.4 The dose suggested is large and high dose steroid treatment has proved detrimental in shock. This may be more of a problem for the neonate with Gram negative meningitis than it has been in the general paediatric population.


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