CURRENT TOPIC

Hearing impairment after bacterial meningitis: a review

H M Fortnum

Postmeningitic hearing impairment is an important public health problem with implications for both paediatric and audiology services. A recent population study has shown that, by the age of 3 years, the proportion of children with a known bilateral profound hearing impairment who have an acquired impairment is approximately 20%. Of these acquired impairments, 90% are probably due to bacterial meningitis. Furthermore, studies of cohorts of children born in the 1970s and early 1980s indicate that 6% of all childhood hearing impairment is due to bacterial meningitis. Not all children surviving bacterial meningitis suffer permanent sensorineural hearing impairment. How many do, and why are certain children affected but not others? Are there any factors within the illness, within the children, or within the medical treatment that could predict the children at greatest risk? This article reviews the recent literature as a source of answers to these questions and recommends management guidelines in the light of current knowledge of the pathology. (Except where otherwise stated, ‘impairment’ in this article refers to sensorineural hearing impairment, that is permanently raised hearing thresholds and loss of other auditory functions such as frequency resolution, due to damage to the eighth nerve or to the receptor cells of the inner ear.)

Total loss of hearing disrupts the development of communication skills, particularly in young children who have not fully developed speech and language. It can also lead to regression to an earlier stage. This disruption is an important sequela of bacterial meningitis, justifying the effort of early identification to enable appropriate habilitation to begin as soon as possible. Partial hearing impairment and/or unilateral losses also occur and also need to be identified with minimal delay, because these children may also suffer auditory and linguistic disabilities that are only subtly symptomatic. Such children often display behavioural complications and may appear to hear normally. Unaware of what he is missing, a young child will not complain. Crucial stimulation may be missed, which is particularly important at school entry. Parents and teachers should be aware of any degree of impairment, even if it is too mild for hearing aids to be beneficial.

Bacterial meningitis may also cause more widespread damage. If a child is left with multiple handicaps, any hearing impairment is more easily overlooked and difficult to detect. In such children assisting any impairment to hearing may be of even greater benefit than in less complex cases.

What is the incidence of postmeningitic hearing impairment?

From a review of the recent literature, the incidence of hearing impairment in children surviving bacterial meningitis may be as low as 3-5% or as high as 37-2%. The 10-fold range certainly reflects the large sampling errors associated with small samples, but probably also reflects some bias due to case selection and methodology, for example, the type and severity of the hearing impairment included, the timing of assessment after the onset of the illness, the age range of the children, the profile of infecting organisms, and the sophistication of the audiological tests used. Table 1 summarises the recent literature and includes only those studies considered to provide the most trustworthy estimates. The criteria for inclusion of a study were (a) publication in 1977 or later (that is in the last 15 years), (b) sample size over 50 in a consecutive series, (c) a well defined age group including children up to at least 3 years of age, (d) the use of age appropriate audiological testing methods, and (e) audiological testing of more than 80% of the original cases. From the selected papers an overall rate and confidence intervals were computed (weighted by the number of cases in each study) for permanent sensorineural hearing impairment of any degree among survivors of bacterial meningitis. Table 2 gives the results of these calculations for all causes of the illness and for each of the three main infective agents. This synthesis gives an incidence of 9-6%, 10-14 Interpreting the computed confidence intervals, the risk of permanent sensorineural hearing impairment lies between one in 12 and one in eight. This compares with the risk in the background childhood population (<3 years) of approximately one in 600 for any degree of permanent sensorineural hearing loss. Thus the raised relative risk is 50- to 75-fold. However, in countries other than those studied, mainly North America and north west Europe, the contribution of each of the infecting organisms is very different and caution must be used in interpreting and generalising these figures.

For bilateral profound or total impairment the range in reported incidence is between 1% and 4%. Some 10-14 Projected on to an incidence of bacterial meningitis of about 3 per 1000 per year aged 0 to 14 years and a mortality rate of approximately 10% (H M
**Table 1** Incidence of sensorineural hearing impairment after bacterial meningitis

<table>
<thead>
<tr>
<th>Author(s)</th>
<th>Study date</th>
<th>Place</th>
<th>Age</th>
<th>No tested</th>
<th>Organism</th>
<th>Incidence of SNHI of any profound bilateral SNHI (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Salwen et al</td>
<td>1956-80</td>
<td>Sweden</td>
<td>1 month-16 years</td>
<td>181</td>
<td>All</td>
<td>11-6</td>
</tr>
<tr>
<td>Kookiniemi et al</td>
<td>1960-74</td>
<td>Finland</td>
<td>2 months-9 years</td>
<td>101</td>
<td>H influenzae</td>
<td>13-9</td>
</tr>
<tr>
<td>Rosenhall et al</td>
<td>1968-75</td>
<td>Sweden</td>
<td>0-22 years</td>
<td>83</td>
<td>H influenzae</td>
<td>18-1</td>
</tr>
<tr>
<td>Moss</td>
<td>1971-74</td>
<td>UK</td>
<td>1 month-8 years</td>
<td>60</td>
<td>Meningococcus</td>
<td>5-0</td>
</tr>
<tr>
<td>Claesson et al</td>
<td>1971-80</td>
<td>Sweden</td>
<td>0-15 years</td>
<td>128</td>
<td>H influenzae</td>
<td>14-8</td>
</tr>
<tr>
<td>Pomperoy et al</td>
<td>1973-77</td>
<td>USA</td>
<td>1 month-14 years</td>
<td>185</td>
<td>All</td>
<td>9-7</td>
</tr>
<tr>
<td>Dodge et al</td>
<td>1973-77</td>
<td>USA</td>
<td>2 months-14 years</td>
<td>185</td>
<td>All</td>
<td>10-3</td>
</tr>
<tr>
<td>Dawson et al</td>
<td>1975-87</td>
<td>New Zealand</td>
<td>1 month-13 years</td>
<td>143</td>
<td>No steroid</td>
<td>6-3</td>
</tr>
<tr>
<td>Richner et al</td>
<td>to 1977</td>
<td>Switzerland</td>
<td>3 months-8 years</td>
<td>97</td>
<td>H influenzae</td>
<td>15-5</td>
</tr>
<tr>
<td>Edwards and Baker</td>
<td>1977-79</td>
<td>USA</td>
<td>0-16 years</td>
<td>79</td>
<td>Meningococcus</td>
<td>6-3</td>
</tr>
<tr>
<td>Guicafore et al</td>
<td>1978-79</td>
<td>Mexico</td>
<td>1 week-15 years</td>
<td>100</td>
<td>Meningococcus</td>
<td>6-3</td>
</tr>
<tr>
<td>Oszdamer et al</td>
<td>1978-81</td>
<td>USA</td>
<td>3 weeks-3 years</td>
<td>60</td>
<td>H influenzae</td>
<td>6-5</td>
</tr>
<tr>
<td>Vienney et al</td>
<td>1979-82</td>
<td>Switzerland</td>
<td>1 week-16 years</td>
<td>51</td>
<td>Pneumococcus</td>
<td>5-0</td>
</tr>
<tr>
<td>Cartwright et al</td>
<td>1981-86</td>
<td>UK</td>
<td>0-24 years</td>
<td>63</td>
<td>Meningococcus</td>
<td>9-5</td>
</tr>
<tr>
<td>Smith et al</td>
<td>1982-83</td>
<td>West Africa</td>
<td>0-14 years</td>
<td>126</td>
<td>Meningococcus</td>
<td>7-1</td>
</tr>
<tr>
<td>Lebel et al</td>
<td>1984-85</td>
<td>USA</td>
<td>2 months-16 years</td>
<td>178</td>
<td>All</td>
<td>9-6</td>
</tr>
<tr>
<td>Odio et al</td>
<td>1990</td>
<td>Costa Rica</td>
<td>6 weeks-13 years</td>
<td>94</td>
<td>Pneumococcus</td>
<td>2-2</td>
</tr>
</tbody>
</table>

All, all bacteria; SNHI, sensorineural hearing impairment.

**Table 2** Overall rate for incidence of permanent sensorineural hearing impairment after bacterial meningitis as computed from studies included in table 1

<table>
<thead>
<tr>
<th>Type of meningitis</th>
<th>Study reference number</th>
<th>No in study</th>
<th>No hearing impaired</th>
<th>Estimate (%)</th>
<th>Range of studies (%)</th>
<th>Computed weighted confidence intervals (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unselected</td>
<td>8, 10, 14, 16, 17, 18, 19, 20</td>
<td>1175</td>
<td>114</td>
<td>9-6</td>
<td>6-3-11-7</td>
<td>7-9 to 11-3</td>
</tr>
<tr>
<td>H influenzae</td>
<td>9, 10, 14, 17, 18, 19, 21, 30, 53</td>
<td>871</td>
<td>88</td>
<td>11-4</td>
<td>5-9-18-1</td>
<td>9-3 to 13-5</td>
</tr>
<tr>
<td>Meningococcal</td>
<td>10, 14, 22, 23, 31, 54</td>
<td>398</td>
<td>38</td>
<td>7-5</td>
<td>5-0-10-5</td>
<td>1-9 to 10-1</td>
</tr>
<tr>
<td>Pneumococcal</td>
<td>10, 14, 18, 19</td>
<td>66</td>
<td>21</td>
<td>3-8</td>
<td>21-4-50-0</td>
<td>20-7 to 42-8</td>
</tr>
</tbody>
</table>

Fortnum, A Davis, and P Ispahani, in preparation, this would amount to 60 to 70 profoundly impaired children each year in England, Scotland, and Wales.

**Table 3** Risk factors for hearing impairment from various studies (study reference numbers in green)

<table>
<thead>
<tr>
<th>Clinical measure</th>
<th>Significantly raised risk of hearing impairment</th>
<th>No raised risk of hearing impairment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Factors within the illness:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low CSF glucose</td>
<td>5, 8, 10, 19, 24, 25, 26</td>
<td>18, 31</td>
</tr>
<tr>
<td>Increased CSF protein</td>
<td>5, 8, 10, 19, 25, 29, 30, 31</td>
<td>18, 31</td>
</tr>
<tr>
<td>Increased CSF white cell count</td>
<td>5, 31</td>
<td>18, 30</td>
</tr>
<tr>
<td>Ataxia or vestibular disturbance</td>
<td>5, 10, 27, 28</td>
<td>18, 30</td>
</tr>
<tr>
<td>Severe neurological deficits</td>
<td>5, 10, 27, 28</td>
<td>18, 30</td>
</tr>
<tr>
<td>Organism:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Meningococcus</td>
<td>18</td>
<td>29, 35</td>
</tr>
<tr>
<td>Pneumococcus</td>
<td>18</td>
<td>5 (&gt;2-5 years)</td>
</tr>
<tr>
<td>Coincident middle ear disease</td>
<td>5, 8, 18</td>
<td></td>
</tr>
<tr>
<td>Hospital &gt;14 days</td>
<td>18</td>
<td></td>
</tr>
<tr>
<td>Seizures</td>
<td>26</td>
<td>10, 18, 14, 35</td>
</tr>
<tr>
<td>Hydrocephalus</td>
<td>26</td>
<td>18</td>
</tr>
<tr>
<td>Subdural effusions</td>
<td>26</td>
<td>10, 18, 53</td>
</tr>
<tr>
<td>CSF pressure</td>
<td>26</td>
<td>5</td>
</tr>
<tr>
<td>Factors within the child:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td>5, 10, 19, 29, 30</td>
<td>5, 10, 18</td>
</tr>
<tr>
<td>Sex</td>
<td>5, 10, 18</td>
<td></td>
</tr>
<tr>
<td>Factors within the treatment:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>More time from symptoms to treatment</td>
<td>5, 14, 30, 35</td>
<td>8, 10, 18</td>
</tr>
<tr>
<td>No steroid treatment compared with steroid treatment</td>
<td>5, 14, 30, 35</td>
<td>20, 48 (meningococcus and H influenzae)</td>
</tr>
<tr>
<td>Partial antibiotic treatment</td>
<td>23</td>
<td></td>
</tr>
<tr>
<td>Delayed CSF sterilisation</td>
<td>25</td>
<td></td>
</tr>
</tbody>
</table>

CSF, cerebrospinal fluid.

Can any factors predict hearing impairment?

**Table 3** lists several factors which have been studied in sufficient numbers of children to give quantitatively stable results, and lists those studies which found an association with the various factors and those which did not. All of these studies are, inevitably, descriptive with data derived from clinical judgments. In terms of the quality of evidence presented, only one of the quoted papers reports relative risk values with confidence intervals.20

**CLINICAL SIGNS**

For those studies that measured it, an initial low concentration of glucose in the cerebrospinal fluid almost universally carried a much raised risk of hearing impairment. The three studies that reported values gave a statistically significant raised risk at concentrations of <0-6 mmol/l,25 <1-1 mmol/l,10 and <2-15 mmol/l.8 The presence of ataxia or vestibular disturbance also indicates a child at a higher risk of hearing impairment.20 27 28 However, this is likely to be a correlated effect rather than a useful causal predictor and is, anyway, difficult to recognise in very young, very sick infants.

Most studies agree that a raised cerebrospinal fluid white cell count8 10 19 25 29 30 or a raised...
cerebrospinal fluid protein concentration is not predictive of hearing impairment.

CAUSATIVE ORGANISM
Different risks have been reported from different organisms, particularly a higher risk of hearing impairment after infection with *Streptococcus pneumoniae*. Where a study has reported differences between organisms this is shown in table 1 and the overall computed incidence rates are shown in table 2. For *Haemophilus influenzae* and meningococcal infections these rates are reliable estimates. The numbers for pneumococcal infections are small and are hence the most open to any selection bias that might have a large effect on the rate, so the apparently higher contingent incidence should be viewed with caution. Permanent sensorineural hearing impairment is not truly organism specific, having been documented for almost all possible causes of bacterial meningitis. There have also been a few documented cases of hearing impairment after viral meningitis, but there has been no comprehensive epidemiological study of this and further research is needed.

AGE
Bacterial meningitis has been documented in children of all ages from neonates to 16 years. It does occur beyond infancy, although the greater vulnerability of very young children to more severe infections may result in a higher proportion of them suffering sequelae of all forms. The fact that some studies have restricted their population by age may explain some of the differences in incidence figures reported in table 1.

In summary, the evidence to date on risk factors indicates that hearing impairment cannot be exclusively predicted by a small number of risk factors. It should be assumed to be a possibility in every case until proved otherwise by thorough audiological testing.

How is the damage mediated?
Hearing impairment after meningitis may have several different causes. Most likely is the effect of suppurative labyrinthitis, due to direct spread of the infection from the subarachnoid space through the cochlear aqueduct. This leads to destruction of sensory structures and no recovery of hearing. On the other hand, a toxic or serous labyrinthitis is thought to be the mechanism responsible for partial and reversible losses. Other possible mechanisms include direct nerve fibre damage and secondary ischaemic damage.

Recent studies of experimental animal models have provided more details of the possible mechanism of the damage. These studies have shown that lysis of bacterial cells by antimicrobial agents produces endotoxin from Gram negative bacteria and lipoteichoic acid from Gram positive bacteria. These lead to the release of cytokines such as tumour necrosis factor and interleukin-1 which initiate a generalised inflammatory response. This inflammation may be responsible for the hair cell damage in the inner ear observed in experimentally infected animals. Roos provides a good review of recent work.

Is the impairment permanent and stable?
The permanence and stability of hearing impairment after bacterial meningitis are important for at least two reasons. Firstly, for the profoundly impaired child one option for rehabilitation now available in a cochlear implant. Postmeningitic children, who have been deafened perilingually or postlingually, are a highly successful group of implantees. Implantation involves insertion of a single or multichannel electrode through the round window into the cochlea with the aim of stimulating the sensory nerve endings. In implantation there is potential risk of destruction of the receptor cells directly or via rupture of membranes separating fluids of different ionic content, leading both to poisoning of the cells and disruption of the primary hydromechanical and chemical properties of the cochlea. If aidable hearing is present, or is likely to return, this procedure is obviously not in the best interests of the child. Thus, any evidence that profound hearing losses may not be permanent has important implications. Rosenhall and Kankkunen report three cases of improvement from bilateral profound losses over periods of 18 months, 4-5 years, and 6 years. However, improvements in hearing after meningitis have more often been reported among cases with less severe hearing losses.

Reports of complete or partial recovery may be due to improvements in the accuracy of testing as the child gets older or to resolution of simultaneously present conductive hearing losses due to fluid in the middle ear, particularly if the first measurement is soon after the infection.

Secondly, any instability in hearing impairment is important as a potential obstacle to a child's development of communication skills. It also has implications for the resources needed in continued follow up of such children. Fluctuations have been documented, again notably by Rosenhall and Kankkunen. Their explanation was a form of endolymphatic hydrops caused by suppurative labyrinthitis. Alternatively, these children may have had coincident middle ear conductive problems. Underlying sensorineural impairments probably do not fluctuate. A few cases of a deterioration in threshold levels between 5 and 12 years after the episode of meningitis have been noted, but attributing these losses solely to the meningitis is questionable.

Can we reduce the risk?
There have been recent advances in both the prevention and treatment of bacterial meningitis. The potential value of immunisation has been acknowledged and researched for many years and in October 1992 immunisation for *H influenzae* infections will become a reality in the UK. The new *H influenzae* b vaccine, given to children at the time of the standard triple
Hearing impairment after bacterial meningitis: a review

Vac
tic (diphtheria, pertussis, and tetanus) is intended to prevent the maj
erity of cases. An estimate of the potential health gain may be
made by projecting the optimistic assumptions of 100% uptake and 100% effectiveness onto
figures from a recent 10 year retrospective study (H M Fortnum, A Davis and P Ispahani, in
preparation) in Nottingham District Health Authority (1989: total child population 0 to 14
years=113603, 18% of all age total). Such a vaccine given at 3 months of age might have
prevented 78 cases of meningitis over 10 years including one death and three cases of per
manent hearing impairment (one profun bilateral and two severe to profound uni
eral). It would not have prevented six cases in children aged less than 4 months,
two of whom died. Projecting these figures on to the population of England, Scotland,
and Wales, a vaccine might prevent up to 700 cases of meningitis due to H influenzae per year.
Applying the overall incidence rate from table 2 would predict a consequent reduction of 65 to
95 children per year with permanent hearing loss but these figures may not truly represent
the UK population in the 1990s and should be used with caution.

The role of factors within treatment is un

certain. In the past the discussion has mainly concentrated on the question of appropriate antibiotics\(^\text{35}, 36\) and delay to treatment. Well conducted studies have found both for and against an increased risk if treatment is delayed more than 48 hours (table 3). It is likely that this conflicting evidence is the result of the involvement of other factors, as it is generally accepted that any damage to hearing occurs early in the infection.\(^\text{6}, 10, 17, 24, 47\)

More recently, in the search for effective treatment, steroids have received much attention. If given at the same time as antibiotics, dexamethasone lessens the inflammatory response\(^\text{37}\) and may block much of the cochlear damage.\(^\text{36}\) Three studies reported a lesser risk of neurological sequelae in steroid
treated children,\(^\text{19}, 20, 46\) but only two of the three found a lesser risk of hearing impair

ment.\(^\text{19}, 48\) Other studies have reported benefit from the use of non-steroidal anti-inflammatory agents.\(^\text{49}, 50\) A benefit becomes surgically

confer less benefit.\(^\text{39}\) Thus the window of four to six weeks reconciles the increased resource implications of referral too early with the dangers of referral too late.

The professional responsibility for initiating referral of the child for hearing assessment has
to lie with the paediatrician responsible for the child in hospital. It is an obligation of the
paediatric service to ensure that a fail-safe administrative system exists to make certain that
referral actually occurs. Any subsequent non-attendance should be followed up with
close cooperation between the general paediatric and audiology services.

Assessment of the hearing of young children is not easy. It requires great skill and patience
particularly to detect mild or unilateral impair

ments and particularly in younger children. Conventional pure tone audiometry can be
reliably used in children over the age of 3 or 4 years with minimal modification, but 80% of
bacterial meningitis occurs before age 3. Accurate testing of younger children is possible
if the relevant skills are available. Usually this will require referral to a subregional or regional
centre specialising in paediatric audiology.

Assessing the importance of the potential problem to the parents will help to ensure attendance.
On no account should the child's hearing be tested by informal and imprecise methods in an
outpatient clinic or at the bedside, as this could give an incorrect result and a false sense of
security. Neonates and very young infants should have their hearing assessed with brainstem
auditory evoked potentials.

This article has concentrated on bacterial meningitis but the question often arises of the
possibility of hearing impairment after viral meningitis. This is a more difficult link to study
but without further research proves otherwise, any child with encephalitis, or ill enough with viral
meningitis to merit hospital admission, should also have a formal assessment of hearing after
discharge. This should also apply to any child

with viral meningitis treated outside hospital, even some time before, where there is concern
over hearing, speech or balance. There will also be children known to have had meningitis
before the introduction of fail-safe mechanisms of referral. If concern is expressed over the
hearing or speech of such children, the possibility of meningitic damage should be considered and
referral made for audiological assessment to exclude this cause before other aetologies are
sought.

Recommendations

All children recovering from bacterial meningitis should be referred for audiological assessment
before discharge from hospital.\(^\text{51}\) For administrative and motivational reasons immediate cross
referrals are more likely than later ones to result in an appointment actually being made. The
appointment should take place about four to six weeks later. If a child is seen too early an
associated conductive loss may be identified, requiring further follow up before the possibility
of an underlying sensorineural impairment can be discounted. However, if the appointment is
made later the impact of the acute life threaten

ing disease on the parents may have lessened and they may not think it important enough to bring the child for the appointment. In this way

a significant degree of hearing impairment could go undetected until the child meets a circumstance where unimpaired auditory input
becomes a higher priority (for example at school entry). Also a non-attended appointment at a
specialist centre is a waste of scarce resources.

Another reason for minimising the delay to referral, and therefore to assessment and identi

fication of any hearing impairment, is the process of ossification of the cochlea that can
occur within a few months of meningitis. This process is important in profound hearing losses
because if ossification has progressed too far an extracochlear implant becomes surgically very
difficult to insert\(^\text{35}\) and extracochlear implants confer less benefit.\(^\text{39}\) Thus the window of four to six weeks reconciles the increased resource implications of referral too early with the dangers of referral too late.

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sought.
Summary

The recent literature reports the incidence of permanent sensorineural hearing impairment in children surviving bacterial meningitis to be approximately 10%. The question of why some children surviving bacterial meningitis suffer a hearing impairment while others recover completely remains unanswered. Very few of the factors so far studied have any predictive power. Knowledge of those that do, for example low concentrations of cerebrospinal fluid glucose, may improve our understanding of the pathological mechanisms involved and ultimately possibly lead to methods of prevention, but at present do not allow useful prediction of those who will be affected.

The role of steroids and non-steroidal anti-inflammatory agents needs further investigation. These may yet prove to be useful interventions to prevent mortality and morbidity caused by bacterial meningitis. The best hope of preventing serious sequelae of bacterial meningitis is primary prevention and timely vaccination offers the most promising solution. Further research will not only double the range of causative organisms covered. Up to date epidemiological studies of the UK population are needed to enable an accurate assessment of the extent of the problem and the potential health gain from advances in prevention or treatment.

Children will continue to suffer bacterial meningitis. Most will survive but some of them will be left with impaired hearing. Such children must be identified as quickly as possible to ensure the timely secondary prevention of disability or handicap.

My thanks go to Professor Mark Haggard, Professor David Hull, Dr Adrian Davis, and Dr Michael Tarlow for constructive comments on an earlier draft of this paper.

Hearing impairment after bacterial meningitis: a review


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**Turning off the bilirubin tap**

If there's too much water in your bucket you can syphon it off, enlarge the hole in the bucket, make new holes, or turn off the tap. Treatment of hyperbilirubinaemia has been aimed at syphoning (exchange transfusion), enlarging the hole (enzyme induction), or creating new holes (phototherapy) but little attention has been paid to the possibility of turning off the tap, although some children have been given a new bucket.

In the production of bilirubin from haem the rate-limiting enzyme is haem oxygenase and this enzyme is inhibited by tin-containing porphyrin molecules which act as competitive, non-metabolised inhibitors. Tin protoporphyrin is one such molecule but tin mesoporphyrin is apparently more potent.

A report from the Rockefeller University Hospital in New York (Richard A Galbraith and colleagues, *Pediatrics* 1992;89:175–82) describes the effect of giving tin mesoporphyrin to two 17 year olds with Crigler-Najjar disease type I. The study was complex and difficult to interpret because phototherapy and repeated plasmapheresis were continued at the same time and patients were estimated to have a very large tissue load of bilirubin. Nevertheless there seemed to be some effect from the tin mesoporphyrin in so far as mean serum bilirubin concentrations were lower during this treatment and the rebound increase in serum bilirubin after plasmapheresis was slower. Both of the patients had shown recent neurological deterioration, which appeared not to progress during the treatment.

These studies seem to be of more theoretical than practical interest. Long term treatment with phototherapy has been practised in Crigler-Najjar disease for at least 20 years. It is very difficult to maintain, home phototherapy being fraught with severe practical and psychological problems, and neurological deterioration during the teenage years has been described by several authors. Liver transplantation in childhood has been performed in various centres on patients with this disease and currently seems to be the most attractive option. A major drawback of the haem oxygenase inhibitors is severe photosensitivity, although otherwise they seem to be non-toxic.

The idea of turning off the bilirubin tap seems an attractive one but at present its application seems likely to be very limited in practice.