CORRIGENDUM

Corrigendum to “The UK joint specialist societies guideline on the diagnosis and management of acute meningitis and meningococcal sepsis in immunocompetent Adults” [J Infect 72 (2016) 405–438]☆

F. McGill a,b,c,d,x, R.S. Heyderman e,x, B.D. Michael a,f,y, S. Defres a,c,v,x, N.J. Beeching a,b,c,g,x, R. Borrow h,ab, L. Glennie w,ac, O. Gaillemin j,aa, D. Wyncooll q,z, E. Kaczmarsski k,ab, S. Nadel m,n,ac, G. Thwaites p,u,x, J. Cohen t,x, N.W.S. Davies i,y, A. Miller a,l,x, A. Rhodes o,z, R. Read r,s,x, T. Solomon a,b,c,f,y

a Institute of Infection and Global Health, University of Liverpool, UK
b National Institute for Health Research Health Protection Research Unit on Emerging and Zoonotic Infections, UK
c Royal Liverpool and Broadgreen University Hospitals NHS Trust, UK
d Leeds Teaching Hospitals NHS Trust, UK
e Division of Infection & Immunity, University College London, UK
f Walton Centre NHS Foundation Trust, Liverpool, UK
w Liverpool School of Tropical Medicine, UK
ac Institute of Infection and Global Health, University of Liverpool, 8 West Derby Street, Liverpool, L69 7BE, UK. Tel.: +44 0151 795 9606. E-mail address: fmcgill@liv.ac.uk (F. McGill).
x On behalf of the British Infection Association.
y On behalf of the Association of British Neurologists.
z On behalf of the Intensive Care Society.
aa On behalf of the Society for Acute Medicine.
ab On behalf of Public Health England.
ac On behalf of the Meningitis Research Foundation.

DOI of original article: http://dx.doi.org/10.1016/j.jinf.2016.01.007
☆ Endorsed by the Royal College of Emergency Medicine, UK.
* Corresponding author. Institute of Infection and Global Health, Ronald Ross Building, University of Liverpool, 8 West Derby Street, Liverpool, L69 7BE, UK. Tel.: +44 0151 795 9606. E-mail address: fmcgill@liv.ac.uk (F. McGill).
0163-4453/© 2016 The Authors. Published by Elsevier Ltd on behalf of The British Infection Association. This is an open access article under the CC BY-NC-ND license (http://creativecommons.org/licenses/by-nc-nd/4.0/).
The authors regret the following footnote should have been included with Table 6:
In cases where Chloramphenicol is used (known anaphylaxis to penicillins or cephalosporins) the dose may be reduced to 12.5 mg/kg 6 hourly if the patient is recovering, to reduce the risk of a dose-related anaemia.

Table 6 is reproduced again here with the addition of the footnote.
The authors would like to apologise for any inconvenience caused.

<table>
<thead>
<tr>
<th>Aetiology</th>
<th>Antibiotic(s)</th>
<th>Dose</th>
<th>Alternative antibiotic choices</th>
<th>Dose</th>
<th>Duration³</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>Neisseria meningitidis</em></td>
<td>Cefotaxime OR Ceftriaxone</td>
<td>2 g 6 hourly/2 g 12 hourly</td>
<td>Chloramphenicol (if anaphylaxis) OR Benzylpenicillin Chloramphenicol</td>
<td>25 mg/kg 6 hourly 2.4 g 4 hourly</td>
<td>5 days</td>
</tr>
<tr>
<td><em>Streptococcus pneumoniae</em></td>
<td>Cefotaxime OR Ceftriaxone</td>
<td>2 g 6 hourly 2 g 12 hourly</td>
<td>Chloramphenicol</td>
<td>25 mg/kg 6 hourly</td>
<td>10 days (if stable) Up to 14 days if taking longer to respond</td>
</tr>
<tr>
<td>(sensitivities unknown or penicillin resistant, cephalosporin sensitive)</td>
<td>Benzylpenicillin OR Cefotaxime OR Ceftriaxone</td>
<td>2.4 g 4 hourly 2 g 6 hourly/2 g 12 hourly</td>
<td>Chloramphenicol</td>
<td>25 mg/kg 6 hourly</td>
<td>10 days (if stable) Up to 14 days if taking longer to respond</td>
</tr>
<tr>
<td><em>Streptococcus pneumoniae</em></td>
<td>Cefotaxime OR Ceftriaxone</td>
<td>2 g 6 hourly 2 g 12 hourly</td>
<td>Chloramphenicol</td>
<td>25 mg/kg 6 hourly</td>
<td>14 days</td>
</tr>
<tr>
<td>(penicillin sensitive, MIC ≤ 0.06)</td>
<td>Cefotaxime OR Ceftriaxone AND Vancomycin OR Rifampicin</td>
<td>15–20 mg/kg 12 hourly (adjusting according to serum trough levels) 600 mg bd</td>
<td>Chloramphenicol</td>
<td>25 mg/kg 6 hourly</td>
<td>14 days</td>
</tr>
<tr>
<td><em>Listeria monocytogenes</em></td>
<td>Amoxicillin</td>
<td>2 g 4 hourly</td>
<td>Co-trimoxazole</td>
<td>10–20 mg/kg (of the trimethoprim component) in 4 divided doses</td>
<td>21 days</td>
</tr>
<tr>
<td><em>Haemophilus influenzae</em></td>
<td>Cefotaxime OR Ceftriaxone</td>
<td>2 g 6 hourly 2 g 12 hourly</td>
<td>Moxifloxacin</td>
<td>400 mg od</td>
<td>10 days</td>
</tr>
</tbody>
</table>

³ Add in IV Vancomycin 15–20 mg/kg bd or Rifampicin 600 mg bd if penicillin resistance is suspected e.g. patient has recently arrived from a country where penicillin resistant pneumococci is prevalent (if unsure, check with local infectious diseases/microbiology expertise.

³ Treatment durations may need to be extended if patient is not responding.

³ If low risk of *Clostridium difficile* infection and/or requiring outpatient therapy.

³ Serum vancomycin trough concentrations of 15–20 ug/ml should be aimed for.

³ In cases where Chloramphenicol is used (known anaphylaxis to penicillins or cephalosporins) the dose may be reduced to 12.5 mg/kg 6 hourly if the patient is recovering, to reduce the risk of a dose-related anaemia.