



NEW YORK CITY DEPARTMENT OF  
HEALTH AND MENTAL HYGIENE  
Thomas Farley, M.D., M.P.H.  
*Commissioner*

## 2013 ALERT # 31

### Update on Invasive Meningococcal Disease in Men Who Have Sex with Men

**Please Share this Alert with All Emergency Medicine, Family Medicine, Primary Care Physicians, HIV Specialists, Infectious Disease, and Internal Medicine Staff in Your Facility**

- There have been no new outbreak-related cases of invasive meningococcal disease in men who have sex with men since mid-February 2013, the longest interval since January 2012.
- Providers need to insure that HIV-infected men who have sex with men receive two doses of meningococcal conjugate vaccine to be optimally protected.
- Providers should be aware of early clinical and laboratory findings that might indicate meningococcal septicemia, particularly in HIV-infected men who have sex with men.

August 14, 2013

Dear Providers,

Through your efforts, New York City public and private providers have vaccinated over 16,000 men against meningococcal disease since October 2012. We are pleased to report that there have been no new cases of invasive meningococcal disease (IMD) in men who have sex with men (MSM) since mid-February, the longest interval since January 2012.

Providers should continue to offer meningococcal vaccine to: (a) All HIV-infected MSM, (b) MSM, regardless of HIV status, who regularly have close or intimate contact with men met through an online website, digital application (“app”), or at a bar or party. These are the same groups recommended for vaccination our Health Alert from March 6, 2013 (<https://a816-health29ssl.nyc.gov/sites/NYCHAN/Lists/AlertUpdateAdvisoryDocuments/2013-03%20HAN%20IMD%20in%20MSM.pdf>). The Health Department may issue revised guidance in the future after completion of ongoing studies and confirmation that the outbreak has ended.

Providers and facilities that serve the at-risk populations described above should provide meningococcal vaccine for their patients. Patients can also go to any Health Department immunization (<http://www.nyc.gov/html/doh/html/living/immun-clinics.shtml>) or STD clinic (<http://www.nyc.gov/html/doh/html/living/std-clinics.shtml>) for vaccine. Starting October 29, 2013, pharmacists will be able to administer meningococcal vaccine to adults 18 years and older. The Health Department is having discussions with New York City pharmacies to determine whether they are planning to make this vaccine available and if they will accept insurance.

#### Two doses of meningococcal vaccine for HIV-infected patients

HIV-infected men should receive 2 doses of meningococcal conjugate vaccine, administered at least 8 weeks apart and no less than 6 weeks. Although a large number of people have received one dose of meningococcal vaccine, some HIV-infected persons have not received their second dose. HIV-infected

patients who have not received their second dose should be contacted to return to the office for vaccination.

Since HIV-infected persons should receive an annual influenza vaccine, providers have the opportunity, during the coming months, to evaluate their patient's meningococcal vaccine status at the same time. Initial doses of influenza vaccine will be distributed sometime this month. When you vaccinate your HIV infected patients against influenza, take this opportunity to check if they need their 1<sup>st</sup> or 2<sup>nd</sup> dose of meningococcal vaccine. The meningococcal and influenza vaccines can be administered simultaneously at the same visit, but should be given at different injection sites.

Complete meningococcal vaccination (1 dose for HIV-uninfected, 2 doses for HIV-infected) is believed to provide protection for a minimum of 5 years. Because the purpose of vaccination is to reduce illness and death from this outbreak, no booster shot is currently recommended.

#### Early clues to recognizing impending meningococcal sepsis

The Health Department has determined that there are likely opportunities to improve outcomes by earlier recognition of disease. In some cases, individuals have presented to an emergency department for care and been discharged, only to return within 24 hours in septic shock. After reviewing over 400 IMD cases that have occurred since 2000 in NYC, the Health Department identified criteria that clinicians can use to recognize impending sepsis in adults and, possibly, in children:

- Tachycardia and/or hypotension that is either borderline abnormal or out of proportion to the level of fever and apparent severity of illness
- Low total white blood cell count (< 5.0 K/uL)
- Borderline low platelet count ( $\leq$  150 K/uL)
- Left shift of white cell count differential (> 75% neutrophils plus band forms)

Two or more of the above should prompt clinicians to consider further observation in a healthcare facility and antibiotic treatment.

Additionally, the following patient complaints and physical findings have been associated with IMD:

- Petechiae. A thorough examination of the skin, conjunctiva and pharynx for petechiae, with particularly attention to pressure zones beneath clothes, the palms and the soles is recommended.
- Severe pain in anterior thigh, back, or abdomen.

While the presence of a single finding does not necessarily indicate IMD, the constellation of findings should prompt closer scrutiny and consideration of early antibiotic therapy. Serial vital signs and examinations are critical to assuring that meningococcal infection is recognized and treated promptly. Antibiotic treatment should not be delayed to obtain diagnostic specimens. The Health Department can arrange for PCR testing at the New York State Wadsworth Center Laboratory. Providers should maintain a high index of suspicion for IMD when evaluating any HIV-infected MSM with fever.

To report a suspect or confirmed IMD case or for information about IMD and vaccination, call the “Provider Access Line” at **1-866-692-3641**.

We greatly appreciate our partnership with NYC healthcare providers in addressing this outbreak.

Sincerely,

*Jay K. Varma, MD*

Deputy Commissioner of Disease Control  
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