Health, Housing & Community Services Department
Public Health Division
(510) 981-5300

Janet Berreman, MD, MPH
Health Officer

Health Advisory

July 16, 2015

Invasive Meningococcal Disease (IMD) among Men Who Have Sex with Men

Please distribute to all providers in your practice

Situation

Clusters of invasive Serogroup C meningococcal disease (IMD) among men who have sex with men (MSM) have been reported in recent months in Chicago, Los Angeles, New York, and various European cities. New cases continue to appear. Characteristics of cases include HIV-positive status and the use of digital apps to meet sexual partners.

The Centers for Disease Control (CDC) recommends increasing vigilance for signs and symptoms of meningococcal disease among MSM, and suggests considering vaccination of individuals who are (1) sexually active MSM infected with HIV and (2) MSM, regardless of HIV status, who regularly have close or intimate contact with multiple partners, or use online "hook-up" apps to identify male sexual partners.

IMD is transmitted by close or intimate personal contact. Individuals who wish to reduce their risk of contracting meningococcal disease should be provided with information regarding vaccination and modification of risk behaviors. Serogroup C is contained in the currently available meningococcal conjugate vaccines; however, vaccination is not 100% effective in preventing IMD.

ACTIONS REQUESTED OF CLINICIANS:

1. **Meningococcal vaccination should be offered to MSM and male-to-female transgender persons, regardless of HIV status, who expect close or intimate contact with MSM currently residing in, or traveling from Chicago.** To achieve protection, vaccination should be completed at least 7-10 days prior to potential exposure. Increased travel and events such as festivals during the summer and fall may increase exposure risk.
2. **Healthcare providers should discuss potential benefits of Meningococcal vaccination** with MSM whose intimate contacts, HIV status, and/or travel may put them at increased risk of IMD.
3. **One dose of meningococcal conjugate vaccine (Menactra® or Menveo®) is recommended for most adults at increased risk of IMD**. **Persons with HIV should receive a 2-dose primary series, administered 8-12 weeks apart, as evidence suggests that persons with HIV may not respond optimally to a single dose**. In addition, vaccine efficacy wanes over time; adults with ongoing increased risk of IMD are recommended to receive a booster dose every 5 years.
4. **REPORT IMMEDIATELY TO Berkeley Public Health** any suspect patient. Do not wait to report until the diagnosis is culture-confirmed; any delay in reporting compromises the ability to identify close contacts and ensure they receive timely antibiotic prophylaxis. Communicable Disease Staff may be reached by phone at **(510) 981-5300** during normal business hours; after hours please call police dispatch at **(510) 981-5911** to contact the Health Officer.

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Post-exposure Prophylaxis

For post-exposure antimicrobial prophylaxis of known contacts of a case of IMD, a one-time dose of 500 mg of ciprofloxacin is generally the first line treatment for adults, and rifampin 10 mg/kg every 12 hours for 2 days is the treatment of choice for most children.
Prophylaxis should be initiated as soon as possible after exposure, but may be effective when begun up to 14 days after the last exposure. Because secondary cases can sometimes occur several weeks or more after exposure to an IMD case, meningococcal vaccination is often recommended in addition to chemoprophylaxis.

Additional Information

Centers for Disease Control and Prevention:

- Meningococcal | Home | CDC

California Department of Public Health:

- Meningococcal Disease
- http://www.cdph.ca.gov/HealthInfo/discond/Documents/MSM_meningococcal_vaccine_health_advisory_April15_2014.pdf

Meningococcal Quick sheet:

- http://www.cdph.ca.gov/programs/immunize/Documents/Meningquicksheet.pdf