

## Health Alert: Meningococcal disease (*N. meningitidis*)

Georgia Department of Public Health Requests Reports of  
Suspect Meningococcal Disease Cases

### ACTION STEPS

**Local health departments:** *Please forward to hospitals and clinics in your jurisdiction.*

**Hospitals and clinics:** *Please distribute to infectious disease doctors, infection preventionists, emergency department physicians, intensive care physicians, neurologists, radiologists, primary care providers, and pediatricians.*

### SUMMARY

Since 2023, the Georgia Department of Public Health (DPH) has confirmed 65 reports of invasive meningococcal disease (IMD) across 30 counties in Georgia resulting in 7 deaths. The emergence of antibiotic resistance to ciprofloxacin has been described nationally, including in Georgia. In 2024, DPH encouraged providers to avoid ciprofloxacin as a first-line prophylaxis for close contacts of patients with IMD where feasible, especially in the greater Atlanta area, where most resistant infections have occurred. As of June 2026, resistant strains continue to be identified in Georgia. DPH recommends continued caution when providing ciprofloxacin prophylaxis to close contacts. DPH is working with public health districts to ensure close contacts of IMD patients have received antibiotic prophylaxis and remain up to date with their vaccinations. DPH urges healthcare providers to maintain heightened awareness for patients with meningococcal disease.

### CLINICAL PRESENTATION

The bacterium *Neisseria meningitidis* causes invasive meningococcal disease. It is a highly contagious illness spread primarily through respiratory or throat secretions (saliva or spit). The bacteria spread to people who have had close or lengthy contact with a patient with meningococcal disease. Those at risk include people in the same household, roommates, and anyone with direct contact with the patient's oral secretions, such as a kissing partner. The incubation period of meningococcal disease is typically 3 to 4 days, with a range of 1 to 10 days. Invasive bacterial infection can cause meningitis or meningococemia (meningococcal septicemia). With meningococcal meningitis, the bacteria infect the spinal cord and lining of the brain, causing swelling. Meningitis is characterized by high fever, headache, and stiff neck. Other symptoms may include nausea, vomiting, confusion, sleepiness, and photophobia (sensitivity to light). With meningococemia, the bacteria enter the bloodstream and can cause high fever, low blood pressure, and severe tiredness. Meningococemia is sometimes associated with a characteristic rash caused by bleeding into the skin, which appears as pinpoint spots that do not lose color when pressed or patches of bluish discoloration that look like bruises.

## REPORTING

Invasive meningococcal disease is a [notifiable disease](#) and suspect cases should be reported to the Georgia Department of Public Health immediately (O.C.G.A. §31-12-2). Call your [District Health Office](#) or the DPH Acute Disease Epidemiology Section at 404-657-2588 during business hours Monday through Friday, or 1-866-PUB-HLTH (1-866-782-4584) after-hours on evenings and weekends. Do not await laboratory results before reporting.

## LABORATORY TESTING

Invasive meningococcal disease is diagnosed by culture of *N. meningitidis* from a normally sterile site (e.g., blood, CSF) or purpuric lesions. Meningococcal disease may also be diagnosed by detecting *N. meningitidis*-specific nucleic acid in a specimen obtained from a normally sterile site using a validated polymerase chain reaction (PCR) assay. Although culture remains the gold standard for the diagnosis of meningococcal infections, PCR is useful for detecting *N. meningitidis* in clinical samples, particularly when a patient has been treated with antibiotics prior to specimen collection. Identification of gram-negative diplococci identified in a sterile site specimen strongly suggests *N. meningitidis* but is not confirmatory.

All isolates of *N. meningitidis* recovered from sterile sites should be forwarded to the Georgia Public Health Laboratory (GPHL), Bacteriology Unit. Isolates should be submitted as pure cultures. Consultation with DPH should occur regarding submission of primary cerebrospinal fluid specimens that tested positive by PCR but did not result in a cultured isolate. Please contact DPH Acute Bacterial Core Surveillance Epidemiology Unit at 404-657-2588 during business hours Monday through Friday, or 1-866-PUB-HLTH (1-866-782-4584) if you have any questions or concerns about forwarding isolates or specimens to GPHL.

## VACCINATION

Currently, there are three types of meningococcal vaccines available in the United States:

- 1) Meningococcal conjugate or MenACWY vaccines (Menveo® and MenQuadfi®). These vaccines prevent 4 serogroups of meningococcal disease (A, C, W, Y).
- 2) Serotype B meningococcal or MenB (recombinant) vaccines (Bexsero® and Trumenba®). These vaccines help protect against serogroup B.
- 3) MenABCWY vaccines or pentavalent vaccines (Penbraya™ and Penmenvy). These vaccines help protect against five serogroups of meningococcal disease, A, B, C, W, and Y. Recommended for those receiving MenB and MenACWY vaccinations in the same visit.

The CDC recommends conjugate vaccination (MenACWY) for all preteens and teens at age 11 or 12 with a booster dose at age 16. Children and adults who are at increased risk of meningococcal disease are also recommended to receive this vaccine. Children who are between 2 months and 10 years old should be vaccinated if they have complement component deficiency, take a complement inhibitor, have HIV, have a damaged or removed spleen, or are part of a risk group due to a serotype A, C, W, or Y meningococcal disease outbreak. College freshmen living in residence halls, adults who

are military recruits, and those traveling to countries in which the disease is hyperendemic or epidemic should also be vaccinated. For the serotype B vaccines, it is recommended that these are given as a 2-dose series to people 16 through 23 years old who are not at increased risk of meningococcal disease based on shared clinical decision-making and as a 3-dose series to people who are 10 years and older with increased risk of disease. Certain preteens and teens should get this type of vaccine if they have complement component deficiency, take a complement inhibitor, have a damaged or removed spleen, or are part of a risk group due to a serotype B meningococcal disease outbreak.

Meningococcal vaccines are very effective at protecting those who are vaccinated, but data suggest they do not provide protection on the unvaccinated community through herd immunity. Available data also suggest that booster doses for these vaccines are critical, as protection levels wane in within 5 years of receiving a first dose of MenACWY, or within 2 years of MenB.

### **ACTIONS REQUESTED FOR HEALTHCARE PROVIDERS**

- Consider invasive meningococcal disease in patients presenting with symptoms of meningitis (such as high fever, headache, and stiff neck), sepsis (high fever, low blood pressure, severe tiredness, and characteristic rash), or those who have had close contact with an individual with meningococcal disease.
- Obtain appropriate clinical specimens. Laboratory testing for meningococcal disease is required for confirmation (see Laboratory Testing section above).
- Report suspected cases of invasive meningococcal disease **IMMEDIATELY** by calling your [District Health Office](#) or the DPH Acute Disease Epidemiology Section at 404-657-2588 during business hours Monday through Friday, or 1-866-PUB-HLTH (1-866-782-4584) after-hours on evenings and weekends.
- Ensure patients are up to date on their vaccinations according to CDC's recommended schedules for children and adults. Please refer to CDC's guidance available here: <https://www.cdc.gov/meningococcal/vaccines/index.html>
- Georgia Public Health Departments should ensure antibiotic prophylaxis is provided to all close contacts of an IMD patient to prevent spread of the disease using other first-line medications such as rifampin or ceftriaxone when possible.
- Providers in the community coordinating antibiotic prophylaxis to healthcare facility staff or other close contacts to an IMD patient should also use alternatives to ciprofloxacin, when possible, especially in the greater Atlanta area, and consult their [District Health Office](#) with questions.

**This recommendation will be reviewed annually and updated as needed based on national and state antibiotic resistance trends.**

### **Georgia DPH Contact Information**

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