



HAL
open science

Community-acquired bacterial meningitis in adults: in-hospital prognosis, long-term disability and determinants of outcome in a multicentre prospective cohort

S. Tubiana, E. Varon, C. Biron, M.-C. Ploy, B. Mourvillier, Muhamed-Kheir Taha, M. Revest, C. Poyart, Guillaume Martin-Blondel, M. Lecuit, et al.

► To cite this version:

S. Tubiana, E. Varon, C. Biron, M.-C. Ploy, B. Mourvillier, et al.. Community-acquired bacterial meningitis in adults: in-hospital prognosis, long-term disability and determinants of outcome in a multicentre prospective cohort. *Clinical Microbiology and Infection*, 2020, 26 (9), pp.1192-1200. 10.1016/j.cmi.2019.12.020 . pasteur-02618662

HAL Id: pasteur-02618662

<https://pasteur.hal.science/pasteur-02618662v1>

Submitted on 22 Aug 2022

HAL is a multi-disciplinary open access archive for the deposit and dissemination of scientific research documents, whether they are published or not. The documents may come from teaching and research institutions in France or abroad, or from public or private research centers.

L'archive ouverte pluridisciplinaire **HAL**, est destinée au dépôt et à la diffusion de documents scientifiques de niveau recherche, publiés ou non, émanant des établissements d'enseignement et de recherche français ou étrangers, des laboratoires publics ou privés.



Distributed under a Creative Commons Attribution - NonCommercial 4.0 International License

CLM-19-16143_R3

Community-acquired bacterial meningitis in adults: in-hospital prognosis, long term disability and determinants of outcome in a multicentre prospective cohort

Sarah Tubiana¹, Emmanuelle Varon², Charlotte Biron³, Marie-Cecile Ploy⁴, Bruno Mourvillier⁵, Muhamed-Kheir Taha⁶, Mathieu Revest⁷, Claire Poyart⁸, Guillaume Martin-Blondel⁹, Marc Lecuit¹⁰, Eric Cua¹¹, Blandine Pasquet¹², Marie Preau¹³, Bruno Hoen^{14*}, Xavier Duval^{15*} and the COMBAT study group.

* These authors contributed equally

1 Sarah Tubiana, ST: Paris University, IAME, INSERM, F-75018 Paris, France; Inserm Clinical Investigation Center 1425, Paris, France. sarah.tubiana@aphp.fr

2 Emmanuelle Varon, EV: National Reference Centre for Pneumococci, Centre Hospitalier Intercommunal de Créteil, Créteil, France.

3 Charlotte Biron, CB : Infectious Diseases Department, CHU Hôtel Dieu and INSERM UIC 1413 Nantes University, Nantes, France

4 Marie-Cécile Ploy, MCP : CHU Limoges, Observatoires Régionaux du Pneumocoque, Limoges, France.

5 Bruno Mourvillier, BM: Medical and Infectious Diseases Intensive Care Unit, AP-HP, Bichat Hospital, Paris University, Paris, France.

6 Muhamed-Kheir Taha, MKT: Institut Pasteur, Invasive Bacterial Infections Unit, National Reference Centre for Meningococci and Haemophilus Influenza, Paris, France.

7 Mathieu Revest, MR: Infectious diseases and Intensive care Unit, Inserm U 1230, CHU Rennes, Rennes University, F-35033 Rennes, France

8 Claire Poyart, CP: Department of Bacteriology, University Hospitals Paris Centre-Cochin, French National Center for Streptococci, APHP, France.

9 Guillaume Martin-Blondel, GMB: CHU de Toulouse, Service des Maladies Infectieuses et Tropicales, Toulouse, F-31300 France ; INSERM, UMR1043, Toulouse, F-31300 France.

10 Marc Lecuit, ML: Institut Pasteur, Biology of Infection Unit, Inserm U1117, National Reference Center and WHO Collaborating Center for Listeria, Paris, France. Université de Paris, Hôpital Universitaire Necker-Enfants Malades, Service des Maladies Infectieuses et Tropicales, Institut Imagine, APHP, Paris-France

11 Eric Cua, EC: Infectious Diseases Department, CHU Nice, France

12 Blandine Pasquet, BP: Assistance Publique-Hôpitaux de Paris, Hôpital Bichat, Unité de Recherche Clinique Paris Nord, F-75018 Paris, France.

13 Marie Preau, MP: GRePS, Lyon 2 University, Lyon, France.

14 Bruno Hoen, BH : CHU de Nancy, hôpitaux de Brabois, service de maladies infectieuses et tropicales, 54511 Vandœuvre-lès-Nancy cedex, France.

15 Xavier Duval, XD: Paris University, IAME, INSERM, F-75018 Paris, France; Inserm Clinical Investigation Center 1425, Paris, France; Inserm, F-CRIN, Innovative clinical research network in vaccinology (I-REIVAC), Paris, France

Running title: Outcome of bacterial meningitis

Abstract (250 words)

Objectives. To identify factors associated with unfavorable in-hospital outcome (death or disability) in adults with community-acquired bacterial meningitis (CABM).

Methods. In a prospective multicenter cohort study (COMBAT; February 2013-July 2015), all consecutive cases of CABM in the 69 participating centers in France were enrolled and followed up for 12 months. Factors associated with unfavorable outcome were identified by logistic regression and long-term disability analyzed.

Results. Among the 533 enrolled patients, (*S. pneumoniae* 53.8% (280/520 isolates identified), *N. meningitidis* 21.3% (111/520), others 24.9% (129/520)), case fatality rate was 16.9% (90/533) and unfavorable outcome occurred in 45.0% (225/500). Factors independently associated with unfavorable outcome were: age > 70 years (aOR=4.64; 95%CI [1.93-11.15]), male gender (aOR=2.11; [1.25-3.57]), chronic renal failure (aOR=6.65; [1.57-28.12]), *purpura fulminans* (aOR=4.37; [1.38-13.81]), localized neurological signs (aOR=3.72; [2.29-6.05]), disseminated intravascular coagulation (aOR=3.19; [1.16-8.79]), cerebrospinal fluid (CSF) white-cell count < 1500 cells/ μ L (aOR=2.40; [1.42-4.03]), CSF glucose concentration (0.1-2.5g/L: aOR=1.92; [1.01-3.67]; <0.1g/L: aOR=2.24; [1.01-4.97]), elevated CSF protein concentration (aOR=1.09; [1.03-1.17]), time interval between hospitalization and lumbar puncture > 1 day (aOR=2.94; [1.32-6.54]), and *S. pneumoniae* meningitis (aOR=4.99 ; [1.98-12.56]), or meningitis other than *N. meningitidis* (aOR=4.54; [1.68-12.27]). At twelve months, 26.7% (74/277) had hearing loss, 32.8% (87/265) depressive symptoms, 31.0% (86/277) persistent headache, and 53.4% had a Physical HRQL (142/266) < 25th percentile of the distribution of the score in the general French population (p<0.0001).

Conclusions. The burden of CABM (death, disability, depression, impaired quality of life, and hearing loss) is high. Identification of cases from the first symptoms may improve prognosis.

1 **Introduction**

2 Community-acquired adult bacterial meningitis (CABM) is a rare disease with an annual incidence
3 around 2/100 000 inhabitants, affecting all age groups and responsible for high morbidity and
4 mortality [1–3]. The epidemiology of community-acquired bacterial meningitis has changed after the
5 introduction of conjugate vaccines [3–5]. Therapeutic challenges, particularly poor penetration of
6 antibiotics into the cerebrospinal fluid and bacterial strains with decreased susceptibility to
7 antibiotics make management complex. Recent therapeutic improvements have mainly relied on the
8 adjunctive use of dexamethasone, whose indications differ according to guidelines [6–9]. Guidelines
9 also differ regarding the antibiotic treatment of meningitis caused by pneumococci with reduced
10 susceptibility to third-generation cephalosporins; only the French recommendations are
11 recommending very high doses of cephalosporins without the systematic addition of vancomycin [9].

12 Despite meningitis high morbidity and mortality, few large studies have evaluated either the
13 determinants of in-hospital mortality-morbidity or the long-term consequences: disability, quality of
14 life, and depressive symptoms in discharged patients [10–12]. This prospective cohort was designed
15 to describe epidemiological, clinical, and management profiles of adult patients with CABM, with the
16 objective of identifying factors associated with in-hospital unfavorable outcome, and assessing
17 outcome and quality of life one year after diagnosis.

18 **Methods**

19 ***Study design and setting***

20 The COMBAT study is a national prospective multicenter cohort study in which adults with CABM
21 were consecutively enrolled in 69 hospitals between February 2013 and July 2015.

22

23 ***Participants***

24 Eligible patients were adults (age ≥ 18) presenting with a CABM or a *purpura fulminans*. CABM was
25 defined by at least one of the following 1) a CSF culture positive for bacteria; 2) the combination of
26 CSF pleocytosis with a positive blood culture or a positive CSF PCR or antigen test for a meningitis-
27 causing bacterium; or 3) the identification of *Neisseria meningitidis* by culture or specific PCR from a
28 skin biopsy in case of petechiae.

29

30 ***Procedures***

31 In each center, patients were pre-enrolled in the study. Patients or their legal representatives
32 received written information about the study. Only those who gave consent were definitely enrolled.
33 Clinical and microbiological data were prospectively collected and strains were sent to the
34 corresponding national reference centers (see Supplementary Methods). Patients were followed up
35 throughout hospitalization and were contacted by phone twelve months after enrollment. For
36 patients lost to follow-up, vital status was obtained using the French Epidemiology Centre on Medical
37 Causes of Death (CepiDc) database.

38

39

40 ***Variables***

41 Neurological examinations were performed immediately upon enrollment and before discharge. In-
42 hospital outcome was graded at discharge according to the modified Rankin Scale [13,14]. The

43 primary endpoint was unfavorable in-hospital outcome, defined by a score of 2–6 (i.e., slight to
44 severe disability, or death) on the modified Rankin scale at discharge [15].

45 At twelve months, depressive symptoms were assessed using the Center for Epidemiologic Studies
46 Depression (CES-D) scale [16], hearing loss using Hearing Handicap Inventory for the Elderly-
47 screening version (HHIE-S) (see Supplementary Methods). Health-related quality of life (HQRL) was
48 evaluated using the SF-12 Health Survey . Two composite scores can be derived from the SF-12
49 Health Survey: a Physical Component Summary (PCS) and a Mental Component Summary (MCS)
50 HRQL score. An individual was defined as having a “impaired” physical (or mental) HRQL if his PCS
51 (or MCS) was lower than the 25th percentile of the distribution of the score in the general French
52 population of the same age group and gender, using an existing approach to clinically interpret the
53 results [17-18].

54

55 ***Statistical methods***

56 First, a descriptive analysis was performed in the cohort population and according to the most
57 frequent causative microorganism (*S. pneumoniae* and *N. meningitidis*). Categorical variables were
58 summarized as counts (percentage) and frequency distributions were compared with the Chi square
59 test or the Fisher exact test as appropriate. Continuous variables were expressed as median (IQR)
60 and differences were tested with the independent t-test for normally distributed variables or the
61 Mann-Whitney U test otherwise.

62 Second, we searched for factors associated with an unfavorable in-hospital outcome among
63 the following variables: patient’s background characteristics, initial clinical presentation (from
64 symptoms onset to 48 hours after inclusion), biological results at inclusion, causative microorganisms
65 and initial treatments [3,12]. We assessed the linearity of the association between continuous
66 variables and outcome with the Lemeshow goodness of fit and by visual inspection. If there was no
67 linear relationship, the continuous variable was categorized for further analyses. We estimated
68 univariable crude ORs using logistic regression on complete cases. In the multivariate analyses, we

69 used multiple imputations using the SAS statistical software (PROC MI) to impute missing values on
70 all variables of interest. Variables included in the imputation models were those included in the
71 multivariable model and those related to patient clinical course. We used fully conditional
72 specification (FCS) method with linear regression for continuous variables and with discriminant
73 function for categorical variables. We obtained ORs estimates for the multivariate logistic regression
74 model by averaging results across 30 imputed datasets using Rubin's rules [19]. All variables were
75 entered into multivariate model without using any method of selecting variables. Goodness of fit was
76 evaluated by the Hosmer–Lemeshow test and the predicted probabilities validation by c-statistic. The
77 statistical tests were two-tailed; we estimated Wald confidence limits and we deemed p values of
78 less than 0.05 as statistically significant.

79 We also aimed to identify factors associated with unfavorable in-hospital outcome separately
80 for *S. pneumoniae* and *N. meningitidis* and to identify factors associated with in-hospital death. All
81 statistical analyses were performed using SAS version 9.4 software (SAS Institute Inc., Cary, NC).

82

83 ***Ethics and regulatory issues***

84 This study was registered with ClinicalTrials.gov (NCT02916732) and received ethics approval by the
85 Comité de Protection des Personnes Ile de France CPP 4 (IRB 00003835) (2012-16NI), and the French
86 Data Protection Authority (Commission nationale de l'informatique et des libertés) -
87 (EGY/FLR/AR128794).

88 **Results**

89 ***Patient's characteristics***

90 A total of 533 patients with bacterial meningitis were enrolled with median age of 58.4 [42.0-68.5]
91 years male sex accounted for 55.2% (294/533; sex ratio: 1.2) (Figure 1; Table 1). Patients with
92 pneumococcal meningitis were older (median 60.2 years, IQR [48.4–68.3]) than those with
93 meningococcal meningitis (median age 30.0 years, IQR [21.4–56.0]) $p < 0.001$ (Table S1). Risk factors
94 were noted in 353/527 (67.0%) patients and included alcoholism in 83 patients (15.9%), diabetes in
95 77 (14.8%), CSF leak in 66 (12.6%), history of cancer in 54 (10.3%), immunosuppressant drug use in
96 21 (4.0%), or prior splenectomy in 16 patients (3.0%).

97

98 ***Initial clinical presentation from symptoms onset to 48 hours after inclusion***

99 An episode of influenza-like illness prior to meningitis diagnosis was less frequently reported in
100 patients with pneumococcal (91/270; 33.7%) than meningococcal meningitis (56/108; 51.9%)
101 ($p = 0.001$). Antibiotics had been administered during the 48 hours preceding hospital admission to
102 36.2% (188/520) patients (Table 1). Seizures before hospitalization, fever and altered mental status
103 were all more likely to occur in pneumococcal than in meningococcal meningitis (Table 1).

104 Distant foci of infection (otitis or sinusitis $n = 147$, pneumonia $n = 55$ or endocarditis $n = 27$) and
105 localized neurological signs were more frequent in patients with pneumococcal than meningococcal
106 meningitis (54.3% vs 6.3%; $p < 0.0001$ and 39.6% vs 22.5%; $p = 0.0014$ respectively)(Table S1).

107

108 ***Cerebrospinal fluid findings and brain imaging***

109 The median time interval [Q1; Q3] between the meningitis symptom onset and the lumbar puncture
110 was 1 day [1-3]. All CSF laboratory parameters are displayed in Table 1. CSF Gram staining was
111 positive in 366/521 (70.2%) episodes, 228/276 (82.6%) of pneumococcal meningitis, 73/107 (68.2%)
112 of meningococcal meningitis, 12/32 (37.5%) of *Listeria* meningitis and 21/36 (58.3%) of other
113 streptococcal meningitis.

114 Brain imaging was performed on admission before lumbar puncture in 224 (58.9%) patients
115 (see Supplementary Results).

116

117 ***Causative microorganisms***

118 The most common pathogen was *S. pneumoniae* (280 (53.8%) of 520 isolates identified).
119 Pneumococcal serotype was available for 195 (87.8%) of 222 episodes with positive blood or CSF
120 culture (Figure 2) (see Supplementary Results). Four *S. pneumoniae* strains had reduced susceptibility
121 to third-generation cephalosporins (MIC>0.5mg/l) and 21 (8.7%) to amoxicillin (MIC > 0.5 mg/L).

122 *N. meningitidis* was responsible for 111 (21.3%) of which 109 cases (98.2%) with known
123 serogroup. Serogroup B (57 (52.3%) of the 109 episodes) was the most frequent, followed by
124 serogroup C (33.0%), serogroup Y (9.2%), serogroup W (2.8%), and others (2.8%). All strains were
125 susceptible to third-generation cephalosporins and one strain was resistant to rifampicin (MIC > 0.25
126 mg/L).

127 Other streptococci accounted for 37 (7.1%) and *Listeria monocytogenes* for 32 (6.2%) of the
128 520 isolates.

129

130 ***Initial treatment***

131 Overall, 493/533 patients (92.5%) received a third-generation cephalosporin containing initial
132 regimen, either alone in 273 (51.2%) patients or combined with amoxicillin in 125 (23.5%), or
133 combined with amoxicillin plus aminoglycoside in 42 additional patients (7.9%); adjunctive
134 dexamethasone was administered to 376 (71.8 %) of 524 patients, before or together with the
135 antibiotics in 244 (65%) and after antibiotics in 129 (35%) patients with data available.

136

137 ***Clinical course***

138 Complications were noted in 459/533 patients (86.1%). Mechanical ventilation was used in 210
139 (40.6%) of the 517 patients with data available and was more frequent among patients with

140 pneumococcal meningitis (49.4%) than with meningococcal meningitis (30.6%) ($p=0.0008$), as were
141 seizures during hospitalization (Table S1).

142

143 ***In-hospital outcome and factors associated with unfavorable outcome***

144 Overall, case fatality rate was 90 (16.9%) of 533 episodes: 22.5%, 4.5%, 13.5% and 28.1% in
145 pneumococcal, meningococcal, other streptococcal and *Listeria* meningitis, respectively. An
146 unfavorable in-hospital outcome occurred in 225 (45.0%) of 500 episodes with data available: 144
147 (54.3%) of 265 episodes of pneumococcal meningitis, 19 (18.1%) of 105 episodes of meningococcal
148 meningitis, 14 (37.8%) of 37 episodes of meningitis due to other streptococci and 23 (76.7%) of 30
149 episodes of *Listeria* meningitis (Table S1).

150 The following factors were associated with an unfavorable in-hospital outcome: age > 70
151 years (adjusted OR=4.64; 95%CI [1.93-11.15]), male gender (aOR=2.11; 95%CI [1.25-3.57]), chronic
152 renal failure (aOR=6.65; 95%CI [1.57-28.12]), *purpura fulminans* (aOR=4.37; 95%CI [1.38-13.81]),
153 localized neurological signs (aOR=3.72; 95%CI [2.29-6.05]), disseminated intravascular coagulation
154 (aOR=3.19; 95%CI [1.16-8.79]), cerebrospinal fluid white-cell count lower than 1500 cells per μL
155 (aOR=2.40; 95%CI [1.42-4.03]), cerebrospinal fluid glucose concentration (between 0.1-2.5g/L:
156 aOR=1.92; 95%CI [1.01-3.67]; lower than 0.1g/L: aOR=2.24; 95%CI [1.01-4.97]), elevated
157 cerebrospinal fluid protein concentration (aOR=1.09; 95%CI [1.03-1.17]), time interval between
158 hospitalization and lumbar puncture higher than 1 day (aOR=2.94; 95%CI [1.32-6.54]), and meningitis
159 due to *S. pneumoniae* (aOR=4.99 ; 95%CI [1.98-12.56]), or meningitis due to other microorganisms as
160 compared to meningitis due to *N. meningitidis* (aOR=4.54; 95%CI [1.68-12.27]). Adjunctive
161 dexamethasone treatment was not associated with an unfavorable in-hospital outcome (aOR=1.02;
162 95%CI [0.57-1.80]) (Table 2).

163

164 ***Long-term follow-up***

165 At twelve months, 5 additional deaths have occurred. Of the 438 living patients, 284 (64.8%) were
166 successfully contacted by phone (Figure 1; see Supplementary Results). Modified-Rankin score could
167 be determined in 282 of these 284 patients. Overall, 47 patients (16.7% had an unfavorable long-
168 term outcome) with poorer scores in patients with pneumococcal (20.7%) than meningococcal (5.6%)
169 meningitis ($p=0.0045$).

170 Among 265 of the 284 patients with CES-D score available, depressive symptoms were
171 recorded in 87 patients (32.8%) with no significant difference in rates between patients with
172 pneumococcal (33.6%) and meningococcal meningitis (34.3%) ($p=0.92$).

173 Hearing loss was recorded in 74 of the 277 patients (26.7%) with data available and was
174 more frequent in patients with pneumococcal (31.3%) than meningococcal (15.5%) meningitis
175 ($p=0.015$). Overall, 86 (31.0%) of the 277 patients had persistent headache with no significant
176 difference in rates between patients with pneumococcal (27.1%) and meningococcal meningitis (32.9
177 %) ($p=0.40$).

178 At twelve months, 53.4% of patients (142/266) had a Physical HRQL score lower than the
179 25th percentile of the distribution of the score in the general French population ($p<0.0001$) (54.0% of
180 patients (67/124) with *S. pneumoniae* meningitis and 48.6% of patients (34/70) with *N. meningitidis*
181 meningitis ($p<0.0001$ for both)).

182 At twelve months, 29.7% of patients (79/266) had a Mental HRQL score lower than the 25th
183 percentile of the distribution of the score in the general French population ($p=0.077$) (34.7% of
184 patients (43/124) with *S. pneumoniae* meningitis ($p=0.013$) and 28.6% of patients (20/70) with *N.*
185 *meningitidis* meningitis ($p=0.49$)).

186 Among 281 patients who had professional activities before admission, 37.8% had not
187 returned to work and 48% of the 282 patients with data available reported trouble concentrating.

188 Discussion

189 With this prospective multicenter cohort, we confirm the high burden of CABM in terms of in-
190 hospital morbidity and mortality and one-year morbidity, especially for depressive symptoms,
191 impaired health-related quality of life, and hearing loss.

192 COMBAT cohort patients' characteristics closely resemble those reported in other
193 industrialized countries, regarding patients' background characteristics, initial clinical presentation,
194 and distant foci of infections [3]. As expected, patients' characteristics and initial clinical presentation
195 differed between patients with pneumococcal and meningococcal meningitis with higher rates of
196 comorbidities and more severe neurological conditions in patients with pneumococcal meningitis
197 than in those with meningococcal meningitis. However, the highly frequent extra-cerebral
198 localizations in the former could impede diagnosis especially in elderly people with clinical
199 presentation of an endocarditis or pneumonia associated with altered mental status, or conversely
200 suggest possible bacterial meningitis in cases of acute otitis complicated by altered mental status.
201 Among atypical or confusing clinical presentations, consecutive occurrence of an influenza-like illness
202 followed by a febrile neurological picture revealing a bacterial meningitis was frequent, markedly
203 more so in meningococcal meningitis, as previously reported [20,21].

204 Distribution of causative microorganisms was close to those of French surveillance data over
205 the same study period [22] and consistent with that reported in the literature [2,3,5,23] with *S.*
206 *pneumoniae* the most common pathogen followed by *N. meningitidis*. Pneumococcal meningitis due
207 to serotypes in currently available vaccines (7, 13, and 23-valent pneumococcal vaccines)
208 represented more than 60% of all pneumococcal meningitis. Considering the high rate of patients
209 with risk factors who were candidates for vaccination, pneumococcal vaccine coverage was
210 unfortunately low: reported in approximately one third of this population, this rate is nonetheless
211 higher than the 16.4% reported in France in 2011 in a similar population [24].

212 The overall case fatality rate of 16.9% and its variation according to the causative
213 microorganisms are concordant with previous studies [3,25]. Except for meningococcal meningitis,
214 outcome including death and short-term disability was poor in all patients, especially in those with
215 *Listeria monocytogenes* infections. In contrast with some studies, we chose a modified Rankin score
216 over the Glasgow Outcome Scale to measure the degree of disability at discharge, the latter scale
217 being designed to assess independence in the community several months after brain injury, a
218 measure which was not assessable at discharge. Of note, the new “Glasgow Outcome at Discharge
219 Scale (GODS)” has since been published in 2013 [26], after the launch of the current study. Most of
220 the factors independently associated with in-hospital unfavorable outcome, whatever the
221 responsible microorganism, were related to patients’ predisposing conditions such as older age, male
222 gender, and chronic renal failure, or to the initial meningitis presentation, such as localized
223 neurological signs, *purpura fulminans* or disseminated intra-vascular coagulation, features
224 practitioners cannot influence. Among factors modifiable by practitioners, the time interval between
225 hospitalization and lumbar puncture was associated with poor in-hospital outcome. The threshold
226 value above which the prognosis was unfavorable was long (1 day). This corresponded to atypical
227 presentations such as pneumonia in patients with altered mental status, for which the diagnosis of
228 meningitis had been mentioned in a second stage. Adjunctive dexamethasone, treatment extensively
229 used in our cohort, was not found to be independently associated with in-hospital unfavorable
230 outcome (death or disability), contrary to reports in the Netherlands cohort [3]; however, it was
231 associated with a decrease in in-hospital death in the univariate analysis.

232 One of our study’s strengths is the extended survivor follow-up. Whereas modified Rankin
233 score improved in most patients between discharge evaluation and M12 evaluation still concerning
234 16.5 % of the surviving population with an unfavorable outcome at M12, the rate of those suffering
235 from depressive symptoms and headaches was two-fold higher, affecting one-third of patients. It is
236 noteworthy that although M12 motor disability was much less common in meningococcal meningitis
237 patients than in patients with pneumococcal meningitis, the percentage of meningococcal meningitis

238 patients with depressive symptoms, headache and altered physical health-related quality of life was
239 much higher and not significantly different from patients with pneumococcal meningitis. As
240 previously reported, over a quarter of patients reported hearing loss, especially in pneumococcal
241 meningitis subgroup [27]. This underlines the importance of addressing all dimensions of disability in
242 long-term follow-up assessment of meningitis patients.

243 This study suffers from limitations. First, limited 2-year inclusion period did not allow
244 detection of change in *S. pneumoniae* meningitis incidence or serotypes, as shown elsewhere for
245 adults and children, as a consequence of vaccination. Second, the twelve months' evaluation could
246 not be carried out in all survivors. Differences in the patient characteristics of these evaluated and
247 those not does not allow us to impede extrapolation of these characteristics to all survivors.

248 The burden of bacterial meningitis in adults remains particularly high in the early 21st
249 Century despite progress in intensive care. Rapidity of care, especially during pre-hospitalization,
250 following the symptoms onset, could be improved, particularly through development of an
251 educational tool for the general population. Extended survivor's follow-up is essential to refer them
252 towards appropriated rehabilitation care for both pneumococcal meningitis and meningococcal
253 meningitis. Furthermore, broader adherence to vaccination recommendations deserves special
254 attention.

255

256 **Fundings:** This work was supported by French ministry of health, Inserm, SPILF, Pfizer pharmaceutical
257 company which funded also ORP.

258 The study was endorsed by the following professional organisations: Association Pour
259 l'enseignement de la Thérapeutique, Société de Pathologie Infectieuse de Langue Française, Société
260 Française de Microbiologie, Société Nationale Française de Médecine Interne, Société de
261 Réanimation de Langue Française, Société Française de Gériatrie, Société Française d'Anesthésie-
262 Réanimation.

264 **Acknowledgments:**265 **Combat study group**266 **Principal investigator:** DUVAL Xavier267 **Steering Committee:** HOEN Bruno, MOURVILLIER Bruno, PLOY Marie-Cécile, TUBIANA Sarah, VARON
268 Emmanuelle.269 **Scientific committee:** steering committee and the following members CARON François, BOLLAERT
270 Pierre-Edouard, GAILLOT Olivier, TAHA Muhamed-Kheir, POYART Claire, BONACORSI Stephane,
271 VANDENESCH François, CAMBAU Emmanuelle, LECUIT Marc, GRAVET Alain, FRACHET Bruno, De
272 BROUCKER Thomas, LEVY BRUHL Daniel, RAFFI François.273 **COMBAT Clinical Centers:** ANGUEL Nadia, ARGAUD Laurent, ARISTA Sophie, ARMAND-LEFEVRE
274 Laurence, BALAVOINE Stéphanie, BARADUC Régine, BARNAUD Guilène, BERAUD Guillaume,
275 BERNARD Louis, BERNARS Georges, BERTEI Dominique, BESSEDE Emilie, BILLARD POMARES
276 Typhaine, BIRON Charlotte, BLAND Stéphanie, BOILEAU Julien, BOUBEAU Patrice, BOURDON Sandra,
277 BOUSQUET Aurore, BOYER Sophie, BOZORG-GRAYELI Alexis, BRET Laurent, BRETONNIERE Cédric,
278 BRICAIRE François, BROCAS Elsa, BRUN Michel, BURET Jennifer, BURUCOA Christophe, CABALION
279 Jean, CABON Mathieu, CAMBAU Emmanuelle, CAMUSET Guillaume, CANEVET Christophe, CARON
280 François, CARRICAJÓ Anne, CASTAN Bernard, CAUMES Eric, CAZANAVE Charles, CHABROL Amélie,
281 CHALLAN-BELVAL Thibaut, CHANTEPERDRIX-MARILLIER Vanessa, CHAPLAIN Chantal, CHARLIER-
282 WOERTHER Caroline, CHAUSSADE Hélène CHIROUZE Catherine, CLAIR Bernard, COLOT Julien, CONIL
283 Jean-Marie, CORDEL Hugues, CORMIER Philippe, COUSSON Joël, CRONIER Pierrick, CUA Eric, DAO-
284 DUBREMETZ Anne, DARGERÉ Sylvie, DEGAND Nicolas, DEKEYSER Sophie, DELAUNE Deborah, DENES
285 Eric, DEQUIN Pierre-Francois, DESCAMPS Diane, DESCLOUX Elodie, DESMARETZ Jean-Luc, DIEHL Jean-
286 Luc, DIMET Jérôme, DINH Aurélien, DUVAL Xavier, ESCAUT Lelia, FABE Claude, FAIBIS Frédéric,
287 FLATEAU Clara, FONSALE Nathalie, FORESTIER Emmanuel, FORTINEAU Nicolas, GAGNEUX-BRUNON
288 Amandine, GARANDEAU, GARCIA Magali, GAROT Denis, GAUDRY Stéphanie, GOEHRINGER François,
289 GRAVET Alain, GREGOIRE-FAUCHER Valérie, GROSSET Marine, GUBAVU Camélia, GUEIT Isabelle,
290 GUELON Dominique, GUIMARD Thomas, GUINARD Jérôme, HADOU Tahar, HELENE Jean-Pierre,
291 HENARD Sandrine, HENRY Benoît, HOCHART Anne-Cécile, HOEN Bruno, ILLES Gabriela, JAFFUEL
292 Sylvain, JARRIN Irène, JAUREGUY Françoise, JOSEPH Cédric, JUVIN Marie-Emmanuelle, KAYAL Samer,
293 LACASSIN Flore, LAMAURY Isabelle, LANOTTE Philippe, LAURENS Etienne, LAURICHESSE Henri, LE
294 BRUN Cécile, LE MOING Vincent, LE TURNIER Paul, LECUYER Hervé, LEDRU Sylvie, LEGRIX Céline,
295 LEMAIGNEN Adrien, LEMBLE Chantal, LEMEE Ludovic, LESENS Olivier, LEVAST Marion, LHOMMET
296 Claire, MALES Silvija, MALPOTE Edith, MARTIN-BLONDEL Guillaume, MARX Matthieu, MASSON
297 Raphael, MATRAY Olivier, MBADI Aurore, MECHAI Frédéric, MELLON Guillaume, MERENS Audrey,
298 MEYOHAS Marie Caroline, MICHON Adrien , MOOTIEN YOGANADEN Joy, MORQUIN David, MOULY
299 Stéphanie, MROZEK Natacha, NGUYEN Sophie, NGUYEN Yohan, OGIELSKA Maja, OZIOL Eric, PAGE
300 Bernard, PATRAT-DELON Solène, PATRY Isabelle, PECHINOT André, PICOT Sandrine, PIERREJEAN,
301 PIROTH Lionel, PLASSART Claire, PLESSIS Patrice, PLOY Marie-Cécile, PORTEL Laurent, POUBEAU
302 Patrice, POUPARD Marie, POYART Claire, PRAZUCK Thierry, QUAESAET Luc, RAFFI François,
303 RAMANANTSOA Adriatsiferana, RAPP Christophe, RASKINE Laurent, RAYMOND Josette, REVEST
304 Matthieu, RICHE Agnès, ROBADAY-VOISIN Stéphanie, ROBIN Frédéric, ROMASZKO JP, ROUSSEAU
305 Florence, ROUX Anne-Laure, ROYER Cecile, SAADA Matthieu, SALMON Dominique, SAROUFIM Carlo,
306 SCHMIT Jean Luc, SEBIRE Manuela, SEGONDS Christine, SIVADON-TARDY Valérie, SOISMIER Nathalie,
307 Solen KERNEIS, SON Olivia, SUNDER Simon, SUY Florence, TANDE Didier, TANKOVIC Jacques, VALIN
308 Nadia, VAN GRUNDERBEECK Nicolas, VANDENESCH François, VARON Emmanuelle, VERDON Renaud,
309 VERGNAUD Michel, VERNET-GARNIER Véronique, VIDAL Magali, VITRAT Virginie, VITTECOQ Daniel,
310 VUOTTO Fanny.

311

312 **Coordination and statistical analyses (Clinical trial unit, Hôpitaux Universitaires Paris Nord Val de**
313 **Seine, AP-HP, Paris)**: GORENNE Isabelle, LAOUENAN Cédric, MARCAULT Estelle, MENTRE France,
314 PASQUET Blandine, ROY Carine, TUBIANA Sarah.

315 **Scientific partnership**: SPLIF, CMIT, SRLF, SFM, REIVAC, SFORL, APNET, SPF

316 **Partners**: ORP (MC PLOY), GPIP/ACTIV (Corinne Levy)

317

318 **ClinicalTrial. Gov identification number**: NCT01730690

319

320 **Conflicts of interest**: Authors have no commercial or other associations that might pose a

321 conflict of interest.

322

323

324 References

- 325 1. Brouwer MC, Tunkel AR, van de Beek D. Epidemiology, diagnosis, and antimicrobial treatment
326 of acute bacterial meningitis. *Clin Microbiol Rev* **2010**; 23:467–492.
- 327 2. Brouwer MC, van de Beek D. Epidemiology of community-acquired bacterial meningitis. *Curr*
328 *Opin Infect Dis* **2018**; 31:78–84.
- 329 3. Bijlsma MW, Brouwer MC, Kasanmoentalib ES, et al. Community-acquired bacterial meningitis
330 in adults in the Netherlands, 2006–14: a prospective cohort study. *Lancet Infect Dis* **2016**;
331 16:339–347.
- 332 4. McIntyre PB, O’Brien KL, Greenwood B, van de Beek D. Effect of vaccines on bacterial
333 meningitis worldwide. *Lancet Lond Engl* **2012**; 380:1703–1711.
- 334 5. Polkowska A, Toropainen M, Ollgren J, Lyytikäinen O, Nuorti JP. Bacterial meningitis in Finland,
335 1995–2014: a population-based observational study. *BMJ Open* **2017**; 7:e015080.
- 336 6. van Ettekovén CN, van de Beek D, Brouwer MC. Update on community-acquired bacterial
337 meningitis: guidance and challenges. *Clin Microbiol Infect Off Publ Eur Soc Clin Microbiol Infect*
338 *Dis* **2017**; 23:601–606.
- 339 7. van de Beek D, Cabellos C, Džupova O, et al. ESCMID guideline: diagnosis and treatment of
340 acute bacterial meningitis. *Clin Microbiol Infect Off Publ Eur Soc Clin Microbiol Infect Dis* **2016**;
341 22 Suppl 3:S37–62.
- 342 8. Tunkel AR, Hartman BJ, Kaplan SL, et al. Practice guidelines for the management of bacterial
343 meningitis. *Clin Infect Dis Off Publ Infect Dis Soc Am* **2004**; 39:1267–1284.
- 344 9. Société de Pathologie Infectieuse de Langue Française, Collège des Universitaires des Maladies
345 Infectieuses et Tropicales (CMIT), Association Pédagogique Nationale pour l’Enseignement de la
346 Thérapeutique (APNET), et al. [Management of acute community-acquired bacterial
347 meningitides, except in newborn infants. Short text. November 2008. Société de Pathologie
348 Infectieuse de Langue Française]. *Rev Neurol (Paris)* **2009**; 165 Spec No 3:F205–216.
- 349 10. Borg J, Christie D, Coen PG, Booy R, Viner RM. Outcomes of meningococcal disease in
350 adolescence: prospective, matched-cohort study. *Pediatrics* **2009**; 123:e502–509.
- 351 11. van de Beek D, Schmand B, de Gans J, et al. Cognitive impairment in adults with good recovery
352 after bacterial meningitis. *J Infect Dis* **2002**; 186:1047–1052.
- 353 12. Weisfelt M, Hoogman M, van de Beek D, de Gans J, Dreschler WA, Schmand BA.
354 Dexamethasone and long-term outcome in adults with bacterial meningitis. *Ann Neurol* **2006**;
355 60:456–468.
- 356 13. Rankin J. Cerebral vascular accidents in patients over the age of 60. II. Prognosis. *Scott Med J*
357 **1957**; 2:200–215.
- 358 14. Banks JL, Marotta CA. Outcomes validity and reliability of the modified Rankin scale:
359 implications for stroke clinical trials: a literature review and synthesis. *Stroke* **2007**; 38:1091–
360 1096.

- 361 15. Nguyen THM, Tran THC, Thwaites G, et al. Dexamethasone in Vietnamese adolescents and
362 adults with bacterial meningitis. *N Engl J Med* **2007**; 357:2431–2440.
- 363 16. Vilagut G, Forero CG, Barbaglia G, Alonso J. Screening for Depression in the General Population
364 with the Center for Epidemiologic Studies Depression (CES-D): A Systematic Review with Meta-
365 Analysis. *PloS One* **2016**; 11:e0155431.
- 366 17. Gandek B, Ware JE, Aaronson NK, et al. Tests of data quality, scaling assumptions, and reliability
367 of the SF-36 in eleven countries: results from the IQOLA Project. *International Quality of Life*
368 *Assessment. J Clin Epidemiol* **1998**; 51:1149–1158.
- 369 18. Carrieri P, Spire B, Duran S, et al. Health-related quality of life after 1 year of highly active
370 antiretroviral therapy. *J Acquir Immune Defic Syndr* 1999 **2003**; 32:38–47.
- 371 19. Donald B. Rubin. *Multiple Imputation for Nonresponse in Surveys*. New York: Wiley, 1987.
- 372 20. Harrison LH, Armstrong CW, Jenkins SR, et al. A cluster of meningococcal disease on a school
373 bus following epidemic influenza. *Arch Intern Med* **1991**; 151:1005–1009.
- 374 21. Bacterial meningitis after influenza. *Lancet Lond Engl* **1982**; 1:804.
- 375 22. Hoen B, Varon E, de Debroucker T, et al. Management of acute community-acquired bacterial
376 meningitis (excluding newborns). Long version with arguments. *Med Mal Infect* **2019**; 49:405–
377 441.
- 378 23. Castelblanco RL, Lee M, Hasbun R. Epidemiology of bacterial meningitis in the USA from 1997
379 to 2010: a population-based observational study. *Lancet Infect Dis* **2014**; 14:813–819.
- 380 24. Guthmann JP. Publié le 22/12/2011 Maladies infectieuses Enquête nationale de couverture
381 vaccinale, France, janvier 2011 Couverture vaccinale contre la grippe saisonnière dans les
382 groupes cibles et mesure de l'efficacité vaccinale. Couverture vaccinale par les vaccins
383 diphtérie-tétanos-poliomyélite (dTP) et antipneumococcique chez les personnes âgées de 65
384 ans et plus. France: Institut de veille sanitaire, 2011.
- 385 25. Bodilsen J, Dalager-Pedersen M, Schønheyder HC, Nielsen H. Time to antibiotic therapy and
386 outcome in bacterial meningitis: a Danish population-based cohort study. *BMC Infect Dis* **2016**;
387 16:392.
- 388 26. McMillan TM, Weir CJ, Ireland A, Stewart E. The Glasgow Outcome at Discharge Scale: an
389 inpatient assessment of disability after brain injury. *J Neurotrauma* **2013**; 30:970–974.
- 390 27. Heckenberg SGB, Brouwer MC, van der Ende A, Hensen EF, van de Beek D. Hearing loss in
391 adults surviving pneumococcal meningitis is associated with otitis and pneumococcal serotype.
392 *Clin Microbiol Infect Off Publ Eur Soc Clin Microbiol Infect Dis* **2012**; 18:849–855.

393

394 **Figure 1:** Study flow chart

395

396 **Figure 2:** Distribution of *S. pneumoniae* serotypes (%) in the COMBAT study (N=195)

397 **Note:**

398 *Green bars correspond to the additional serotypes included in the 13-valent vaccine as compared to those*
399 *included in the 7-valent*

400 *Orange bars correspond to serotypes include in the 7-valent vaccine; 19 (9.8%) of meningitis cases were due to*
401 *a pneumococcal serotype included in the 7-valent vaccine*

402
403 *Purple bars correspond to serotype include only in the polysaccharide 23-valent vaccine; 119 (61.0%) of*
404 *meningitis were due to a pneumococcal serotype included in the 23-valent polysaccharide vaccine*

405
406 *Blue bars correspond to serotypes non-included in any current vaccines*
407

408

Pre-enrolled patients N=590

Excluded patients N=57

Age < 18 years:	N=3
Declined consent:	N=38
Healthcare-related meningitis:	N=5
>1 inclusion for the same meningitis episode:	N=8
Unmet any inclusion criteria:	N=3

Enrolled patients N=533

In-hospital death: N=90

Patients alive at discharge N=443

Death after discharge: N=5
Lost to follow-up: N=154

Alive patients with 12-month phone call follow-up N=284

%

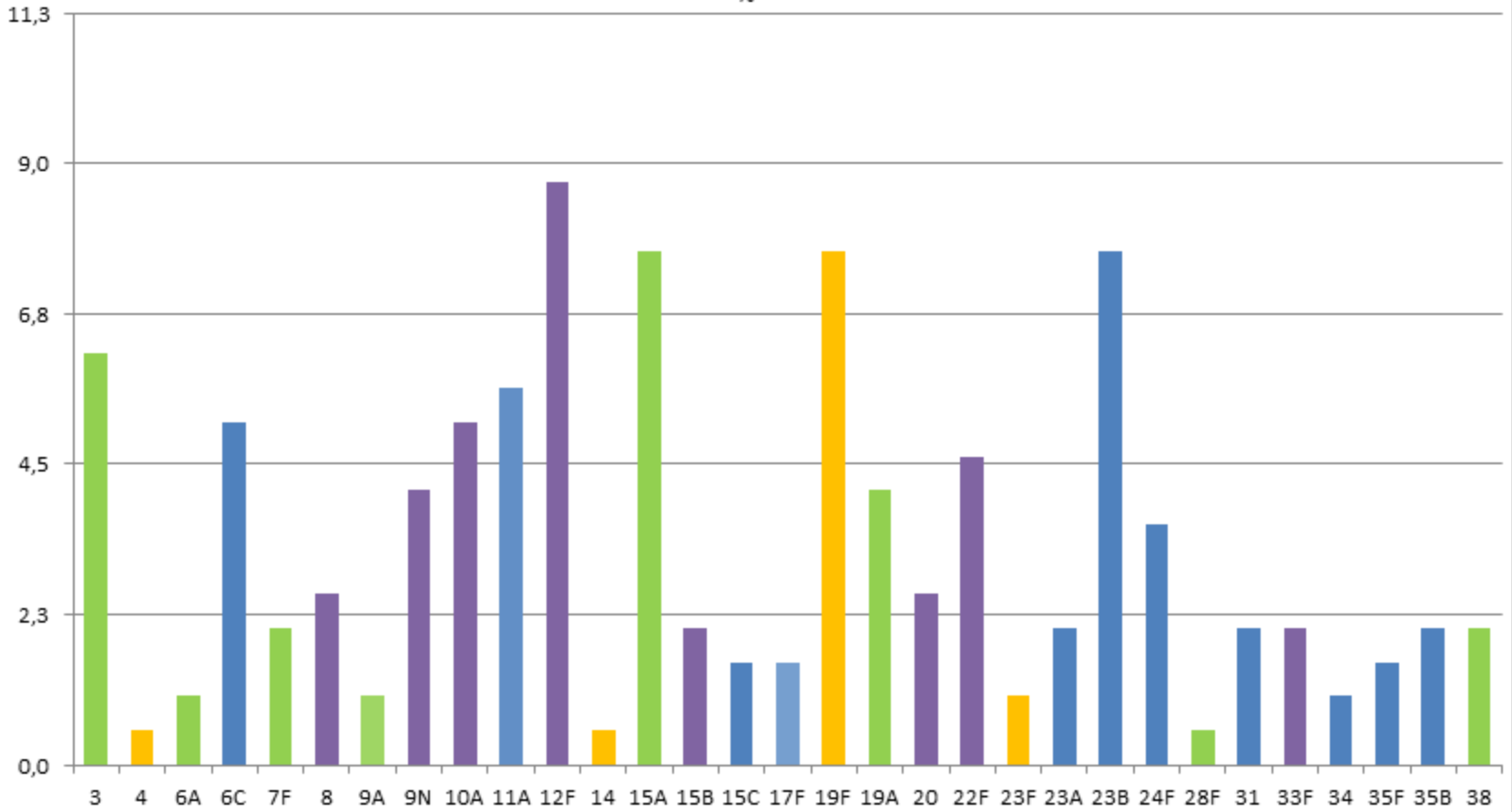


Table 1: Characteristics of the study population, COMBAT study (N=533)

	n /N (%)
Background characteristics	
Age, Median [IQR]	58.4 [42.0-68.5]
Male/female Ratio	1.2
≥ 1 risk factor for meningitis	353/527 (67.0)
Alcoholism	83/522 (15.9)
Diabetes	77/522 (14.8)
CSF leak	66/522 (12.6)
History of cancer (< 5 years)	54 /525 (10.3)
History of cardiac failure	31/524 (5.9)
Immunosuppressant drug use	21/526 (4.0)
History of chronic renal failure	21/523 (4.0)
History of splenectomy	16 /525 (3.0)
Initial clinical presentation from symptoms onset to 48 hours after inclusion	
Episode of influenza-like illness within 15 preceding days	190/513 (37.0)
Admission in intensive care unit	417/527 (79.1)
Pre-treatment with antibiotics	188/520 (36.2)
Body temperature (Median [IQR])	38.5 [37.7-39.3]
Seizures before hospitalization	37/518 (7.1)
Altered mental status	373/523 (71.3)
Headache	361/511 (70.6)
Neck stiffness	325/515 (63.1)
Nausea	263/515 (51.1)
Distant foci of infection	205/533 (38.5)
Localized neurological signs	183/533 (34.3)
Purpura	49/524 (9.4)
Cerebrospinal fluid findings	
White cells count (cells per mm ³)	1530.0 [332.0-5000.0]
% of neutrophils (Median [IQR])	92.0 [80.0-96.0]
Protein (g/L)	4.1 [2.1-6.7]
Glucose (mM)	0.6 [0.1-2.5]
Positive Gram Stain	366/521 (70.2)

	n /N (%)
Causative microorganisms	
<i>Streptococcus pneumoniae</i>	280/520 (53.8)
<i>Neisseria meningitidis</i>	111/520 (21.3)
Other streptococci	37/520 (7.1)
<i>Listeria monocytogenes</i>	32/520 (6.2)
<i>Haemophilus influenzae</i>	25/520 (4.8)
<i>Staphylococcus aureus</i>	11/520 (2.1)
<i>Escherichia coli</i>	7/520 (1.3)
<i>Mycobacterium tuberculosis</i>	2/520 (0.4)
Others	15/520 (2.9)
Clinical course	
≥ 1 complication	459/533(86.1)
Assisted ventilation	210/517 (40.6)
Coma (Glasgow score <8)	134/523 (25.6)
Increased fever	83 /509 (16.3)
Seizures	64/525 (12.2)
Ventriculitis	46/523 (8.8)
In-hospital outcome (modified Rankin score)	
Death (6)	90/533 (16.9)
Major disability (5)	14/410 (3.4)
Moderately severe disability (4)	27/410 (6.6)
Moderate disability (3)	40/410 (9.8)
Mild disability (2)	54/410 (13.2)
Low disability (1)	107/410 (26.1)
No disability (0)	168/410 (41.0)
Unfavorable outcome*	225/500 (45.0)

Data are median (IQR) or n/N (%)

*Data available for 500 patients; unfavorable outcome was defined as a modified Rankin score of 2–6

Table 2: Factors associated with an in-hospital unfavorable outcome (death or disability), COMBAT study (N=500)

	Unfavorable outcome N=225 N (%)	Favorable outcome N=275 N (%)	Univariable odds ratio for unfavorable outcome [95%CI]	Multivariable odds ratio for unfavorable outcome [95%CI]	p value of multivariable analysis
Background characteristics					
Age (years)					
18-39	24/225 (10.7)	94/275 (34.2)	1	1	
40-70	119/225 (52.9)	147/275 (53.5)	3.17 [1.91-5.28]	1.79 [0.87-3.67]	0.1144
>70	82/225 (36.4)	34/275 (12.4)	9.45 [5.18-17.22]	4.64 [1.93-11.15]	0.0006
Men sex	135/225 (60.0)	142/275 (51.6)	1.41 [0.98-2.01]	2.11 [1.25-3.57]	0.0054
Alcoholism	48/219 (21.9)	32/275 (11.6)	2.13 [1.31-3.47]	1.18 [0.62-2.25]	0.6163
Immunosuppressant drug use	12/223 (5.4)	9/275 (3.3)	1.68 [0.70-4.06]	0.47 [0.14-1.64]	0.2391
History of Cancer (< 5 years)	34/222 (15.3)	17/275 (6.2)	2.75 [1.49-5.06]	1.46 [0.63-3.37]	0.3779
Diabetes	45/220 (20.5)	24/274 (8.8)	2.68 [1.57-4.56]	1.93 [0.93-4.01]	0.0767
History of cardiac failure	21/221 (9.5)	10/275 (3.6)	2.78 [1.28-6.04]	0.80 [0.29-2.20]	0.6619
History of chronic renal failure	17/220 (7.7)	3 /275 (1.1)	7.59 [2.20-26.25]	6.65 [1.57-28.12]	0.0100
Initial clinical presentation from symptoms onset to 48 hours after inclusion					
Nausea or vomiting	83/213 (39.0)	162/274 (59.1)	0.44 [0.31-0.64]	0.99 [0.58-1.69]	0.9831
Headache	118/210 (56.2)	224/273 (82.1)	0.28 [0.19-0.42]	0.65 [0.37-1.15]	0.1417
Seizures	47/218 (21.6)	31/275 (11.3)	2.16 [1.32-3.55]	1.43 [0.75-2.72]	0.2800
Otitis or sinusitis	57/221 (25.8)	73/272 (26.8)	0.95 [0.63-1.42]	0.79 [0.45-1.38]	0.4063
Pneumonia	36/221 (16.3)	16/272 (5.9)	3.11 [1.68-5.78]	2.00 [0.88-4.51]	0.0964
<i>Purpura fulminans</i>	16/225 (7.1)	25/275 (9.1)	0.77 [0.40-1.47]	4.37 [1.38-13.81]	0.0120
Triad of fever, neck stiff ness, altered mental status	60/223 (26.9)	75/275 (27.3)	0.99 [0.66-1.45]	1.03 [0.61-1.75]	0.9076
Localized neurological signs	117/225 (52.0)	61/275 (22.2)	3.80 [2.58-5.59]	3.72 [2.29-6.05]	<.0001
Biological results at inclusion					
C-reactive protein ≥ 200 mg/L	93/177 (52.5)	100/237 (42.2)	1.52 [1.03-2.24]	1.29 [0.75-2.23]	0.3565
Blood leucocytes ≥10 000 mm ³	140/216 (64.8)	207/267 (77.5)	0.53 [0.36-0.80]	0.70 [0.40-1.22]	0.2097
Disseminated intra-vascular coagulation	21/219 (9.6)	12/273 (4.4)	2.31 [1.11-4.80]	3.19 [1.16-8.79]	0.0250
CSF glucose concentration (g/L)					

	Unfavorable outcome N=225 N (%)	Favorable outcome N=275 N (%)	Univariable odds ratio for unfavorable outcome [95%CI]	Multivariable odds ratio for unfavorable outcome [95%CI]	p value of multivariable analysis
<0.1	57/202 (28.2)	50/258 (19.4)	1.72 [1.01-2.94]	2.24 [1.01-4.97]	0.0482
0.1-2.5	100/202 (49.5)	140/258 (54.3)	1.08 [0.68-1.70]	1.92 [1.01-3.67]	0.0469
>2.5	45/202 (22.3)	68/258 (26.4)	1	1	
CSF Protein (g/L) (Mean (std))*	6.2 (5.3)	4.3 (4.5)	1.11 [1.05-1.16]	1.09 [1.03-1.17]	0.0066
CSF white cell count < 1500 cells/ mm ³	135/219 (61.6)	96/268 (35.8)	2.88 [1.99-4.17]	2.40 [1.42-4.03]	0.0010
CSF % polymorphonuclear cells (Mean (std))**	82.1 (21.4)	86.8 (18.6)	0.89 [0.81-0.98]	0.99 [0.87-1.13]	0.8691
Causative microorganisms					
<i>N. meningitidis</i>	19/223 (8.5)	86/264 (32.6)	1	1	
<i>S. pneumoniae</i>	144/223 (64.6)	121/264 (45.8)	5.39 [3.10-9.36]	4.99 [1.98-12.56]	0.0007
Other microorganisms	60/223 (26.9)	57/264 (21.6)	4.76 [2.58-8.81]	4.54 [1.68-12.27]	0.0028
Initial treatment					
Time interval between hospitalization and lumbar puncture (Day)					
0	125/221 (56.6)	207/274 (75.5)	1	1	1
1	54/221 (24.4)	53/274 (19.3)	1.69 [1.09-2.62]	1.24 [0.68-2.26]	0.4788
>1	42/221 (19.0)	14/274 (5.1)	4.97 [2.61-9.46]	2.94 [1.32-6.54]	0.0083
Pre-treatment with antibiotics	88/217 (40.6)	92/274 (33.6)	1.35 [0.93-1.95]	0.89 [0.53-1.47]	0.6442
Dexamethasone use	153/221 (69.2)	208/272 (76.5)	0.69 [0.46-1.03]	1.02 [0.57-1.80]	0.9544

CSF=cerebrospinal fluid.

* odds ratio for a 1 g/L increase.

** odds ratio for 10 percent increase.

In univariate analysis, percentage of missing value ranged from 0.0% to 3.6% excepted for C-reactive protein (17.2%), CSF glucose concentration (8.0%) and CSF polymorphonuclear cells (6.8%). The multivariable analysis used an imputed dataset with 30 imputation rounds, all variables in the table were entered in the multivariable logistic regression model simultaneously