

Según la bibliografía consultada (Medline, Embase), nuestro caso es el primero descrito en Europa y la primera descripción del uso de MALDI-TOF para la identificación de *G. bronchialis*. Este método representa una técnica prometedora para la identificación de patógenos inusuales.

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<http://dx.doi.org/10.1016/j.eimc.2013.02.012>

Should Mollaret's meningitis always be treated with anti-HSV therapy?

¿Deberíamos tratar con antiherpéticos todas las meningitis de Mollaret?

To the Editor,

We have read with interest the letter published in your journal by Muñoz-Sanz et al.¹ They described an infrequent case of recurrent aseptic meningitis treated with aciclovir IV despite the absence of a positive result of HSV-PCR in cerebrospinal fluid (CSF). The patient had a prior history of HSV-2 recurrent meningitis that resolved with antiviral treatment. In addition, while the patient was on chronic suppressive therapy she did not have any further episodes. Withdrawal of chronic therapy was followed by three new episodes of recurrent meningitis. After reinitiating therapy the patient had no further episodes. We would like to add a clinical case to illustrate the appropriateness of their practice.

A 43-year-old male was admitted to our hospital with a history of twelve-days holocranial headaches, fever, photophobia and nausea. The patient referred to have had occasional episodes of headache after sexual intercourse, irritable bowel syndrome and an episode of acute pyelonephritis. The patient sought medical attention and was started on anti-migraine drugs with no improvement being finally referred to our hospital. On physical examination he had neither neck stiffness nor focal neurological signs. Results of CT scan and MRI of the brain were both normal. The CSF white blood cell count was 428 cells/mm (94.4% mononuclear cells), glucose level was 41 mg/dl and the protein level was 101.7 mg/dl. Gram's stain of the CSF did not show microorganisms and the CSF culture was sterile. Serologic studies (HSV, CMV, VZV and HIV) were all IgM and IgG negative and HSV, and enterovirus CSF-PCR were also negative. Antibiotics and antivirals were discontinued and a second lumbar puncture was performed 24 h after, showing persistence of pleocytosis (140 cells/mm with 92.3% mononuclear cells) increase proteins (70 mg/dl) and normal glucose level. In the

following days symptoms gradually decrease and the patient was discharged home with a diagnosis of viral lymphocytic meningitis. During the 1-year follow-up after his hospital admission the patient reported 4 new episodes of fever and migraine. Analytical tests were repeated and results did not show any difference regarding prior results but a positive IgM and IgG for HSV. With the suspicion of Mollaret's meningitis a new lumbar puncture was performed and CSF was sent for pathologic examination showing the presence of large mononuclear cells of irregular nuclei consistent with Mollaret cells. The patient was treated with oral valacyclovir for 10 days. Fever subsided and headache improved. We decided to start on chronic suppressive therapy with no new episodes in the following 12 months. Subsequent serological tests showed HSV IgM negative with HSV IgG positive. The patient decided to stop valacyclovir and after 12 months follow up he had had no further episodes.

As stated by many authors, Mollaret's meningitis should only be referred to recurrent aseptic meningitis with unknown aetiology after throughout studies including molecular techniques.²⁻⁴ *Sensu strictu* our patient had a Mollaret's meningitis; the clinical picture fulfil Bruyn's criteria,⁵ HSV antibodies were detected only after several months of his first episode and HSV PCR was negative. However, symptoms and signs resolved with anti-HSV therapy suggesting a potential role of HSV in the pathogenesis of our patient's clinical picture. It could be argued that antiviral therapy and resolution of symptoms were just a casual association because of the benign nature of the disease, however the rapid improvement of symptoms after initiating therapy and the absence of further episodes makes plausible the existence of a causal relationship.

There are many case reports in the literature where patients presented with many cases of recurrent meningitis, had prolonged hospitalizations, repeated lumbar punctures and MRI or CT scans until HSV DNA is detected in CSF examination⁶⁻⁸ similar to what we and Muñoz-Sanz et al. described.¹ We believe that, provided that anti-HSV therapy is generally well tolerated, with few and known side effects, it is reasonable to start a treatment course with anti-HSV therapy in patients with recurrent aseptic

meningitis irrespective of the positivity of HSV-DNA test in CSF. If initiating therapy is followed by clinical improvement, chronic suppressive therapy should be offered to patients presenting with this disease because it could lead to an avoidance of hospitalization, unnecessary diagnostic tests and therefore a reduction of costs and morbidity associated with many aseptic recurrent meningitis.

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<http://dx.doi.org/10.1016/j.eimc.2013.02.003>

Evolución favorable en un caso de enfermedad neonatal grave por echovirus 11

Favourable outcome in a case of a severe neonatal disease due to echovirus 11

Sr. Editor:

Los enterovirus humanos (HEV) son virus ARN que pertenecen al género *Enterovirus* incluidos en la familia *Picornaviridae*. Las manifestaciones clínicas descritas por la infección de estos virus durante el período neonatal son muy variadas, produciendo desde cuadros asintomáticos hasta infecciones diseminadas fulminantes. Los factores de riesgo más importantes son: ausencia de anticuerpos neutralizantes, enfermedad materna por el virus previo al parto (sobre todo en la semana previa) o durante el mismo, prematuridad, infección durante los primeros días de vida del neonato, afectación multiorgánica, hepatitis severa y la presencia de viremia en la madre¹. La infección por enterovirus se suele presentar en forma de brotes epidémicos durante las estaciones de verano y otoño. El hombre es el único reservorio conocido y la transmisión en neonatos se produce tanto por vía vertical (transplacentaria o intraparto) como por transmisión horizontal (contacto directo con infectados o fómites)¹. La prevención mediante el lavado de manos sigue siendo la única arma del que disponemos contra esta entidad, aunque están en estudio diferentes alternativas terapéuticas (inmunoglobulinas, nuevos antivirales como el pleconaril), sobre todo en casos graves como son las infecciones neonatales o los pacientes inmunodeprimidos². El diagnóstico etiológico se realiza aislando el virus en cultivos celulares específicos o mediante detección del genoma viral por métodos moleculares (RT-PCR).

En la actualidad, los más de 90 serotipos conocidos de enterovirus se agrupan en 4 especies: HEV-A, -B, -C y -D. El echovirus 11, perteneciente a la especie HEV-B, es uno de los serotipos que con más frecuencia se ha asociado a enfermedad neonatal grave, describiéndose casos de hepatitis fulminante, infecciones del sistema nervioso central, o ambos³⁻⁸.

Presentamos el caso de un varón nacido a finales de julio, pretérmino (36 semanas + 4 días), de madre de 38 años de edad con bolsa rota en las 3 h previas al parto y fiebre periparto con cultivo rectovaginal positivo para *S. agalactiae* a la que se realizó profi-

laxis antibiótica. El parto fue eutócico y el niño recibió lactancia materna exclusiva. A los 4 días de vida ingresó en su hospital de referencia por fiebre de 37,8 °C, sin otros síntomas. Como pruebas iniciales se realizaron cultivos de sangre, orina y LCR, que resultaron negativos, y se inició tratamiento con cefotaxima, ampicilina y aciclovir. Al segundo día de ingreso comienza con letargia y convulsiones tónicas de miembros superiores que ceden con fenobarbital y presenta hepatoesplenomegalia con aumento de transaminasas (GOT: 4.525 UI/l, GPT: 450 UI/l), ascitis, aparición de trombopenia (<50.000 × 10e3/μl) y disminución de la actividad de protrombina en el contexto de fallo hepático agudo, por lo que fue trasladado a nuestro hospital.

Se solicitaron serologías de infecciones connatales (sífilis, toxoplasmosis, rubeola), cultivo de CMV en orina y leche materna, PCR de herpesvirus (WZ, CMV, EBV, VH6) y de enterovirus en sangre, serologías de otros virus como VHA, VIH y parvovirus B19, estudio de metabolopatías, biopsia de glándulas salivares (ante sospecha de hemocromatosis por alteración del metabolismo del hierro con importante aumento del IST [125%] y de la ferritina [91.408 ng/ml]), niveles de paracetamol y punción-aspiración con aguja fina (PAAF) de médula ósea tras aparición de células inmaduras en frotis periféricos más trombopenia, siendo todos los resultados negativos salvo la PCR para HEV en sangre. La muestra clínica fue enviada al Laboratorio de Enterovirus del Centro Nacional de Microbiología, donde el enterovirus se genotipó como echovirus 11.

Con este resultado se completó el estudio con ECG, ecocardiograma y NT-proBNP y troponina I descartando participación miocárdica.

La evolución del paciente fue favorable, pasando a planta al sexto día de ingreso (tabla 1) y siendo dado de alta, tras 16 días de ingreso, sin secuelas y sin presentar otras complicaciones sobreañadidas.

Tabla 1
Evolución analítica del paciente

	Día 1	Día 2	Día 3	Día 5
GOT (UI/l)	7.319	6.580	1.312	484
GPT (UI/l)	1.503	1.647	747	397
Bilirrubina (mg/dl)	4,3	3,8	2,5	2,65
Amonio (μg/dl)	106	111	92	-
Plaquetas (/μl)	29.000	32.000	38.000	41.000
Quick (%)	40	36	51	57