Online Journal of Health and Allied Sciences
Peer Reviewed, Open Access, Free Online Journal
Published Quarterly : Mangalore, South India : ISSN0972-5997
Volume 12, Issue 3; Jul-Sep2013

Case Report:
Atypical Presentation of Mollaret's Meningitis

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Citation
Hassan M, Amer S, Sklar L, Hassan S. Atypical Presentation of Mollaret's Meningitis. *Online J Health Allied Scs.* 2013;12(3):18. Available at URL:http://www.ojhas.org/issue47/2013-3-18.html

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Submitted: Sep 17, 2013; Accepted: Oct 18, 2013; Published: Nov 15, 2013

Abstract: Mollaret's meningitis is mostly described in the setting of recurrent attacks of fever along with signs and symptoms of meningitis. It resolves spontaneously without any treatment and in most of the cases no causative organism is identified. Here we present an atypical case of mollaret's meningitis in which the patient presented with headache and meningismus in the absence of fever.
Key Words: Mollaret's meningitis; Atypical.

Introduction:
Mollaret's meningitis, first described by Mollaret in 1944 (1), is a rare disease characterized by recurrent episodes of aseptic meningitis. Symptoms, characterized by fever, headache and meningismus, typically resolve spontaneously within 2-5 days without any clinical intervention. The most common etiologic agent is Herpes Simplex Virus type 2 (HSV-2) (2), however HSV-1 has been isolated in some cases and occasionally the etiology is unknown.(3-5) Early diagnosis may prevent prolonged hospital stay, and exposure to unnecessary medications.

Case Report:
We present a case of a 41 years old female with a history of HSV-2, who presented to the emergency department with complains of headache and neck stiffness since four days. Her headaches were generalized and throbbing in nature. She also complained of photophobia, nausea, and vomiting. Physical examination was remarkable for neck stiffness but no focal neurologic deficits. CT head was unremarkable. Having high suspicious for meningitis she received a lumbar puncture and was immediately started on ceftriaxone and acyclovir to cover for possible bacterial and viral meningitis.
Eventually cerebrospinal fluid (CSF) was clear and colorless with 360 WBCs, 11 RBCs, and 94% lymphocytes. CSF glucose was 40mg/dl, and protein was 92mg/dl. CSF was negative for cryptococcal antigen, and VDRL was non reactive. CSF viral and bacterial cultures showed no growth. HSV-2 PCR was found to be positive. CSF findings being consistent with viral meningitis, Ceftriaxone was discontinued.The patient's symptoms resolved completely within 48 hours of symptom onset and the patient was discharged home. The patient was not placed on long-term suppressive therapy and no recurrence has been experienced so far.
Upon review of her medical records, it was noted that the patient had two previous episodes of meningitis, the first in 1999 and the second in 2005. Symptoms from her earlier meningitis episodes lasted approximately a week and subsequently resolved without any residual symptoms. The patient's presentation this time was similar to her prior episodes. There was no evidence of an acute herpes flare up during any of her admissions. She denied any history of genital herpes. However, she stated that she is unsure of her partner's past sexual history. Spinal taps performed during her previous hospitalizations were consistent with aseptic meningitis.

Discussion:
In 1944, Mollaret became the first to describe this syndrome of benign aseptic meningitis (1), and in 1962, Bruyn and colleagues outlined the specific criteria for the diagnosis of Mollaret's (6) which include the following:

1. Recurrent attacks of fever associated with signs and symptoms of meningitis.
2. 2. The attacks are separated by symptom free intervals, which can last for weeks to months.
3. The attacks are accompanied by a CSF comprised of mixed pleocytosis with endothelial cells, lymphocytes, and leukocytes.
4. Each episode remits spontaneously with no residual signs or symptoms.
5. There is an absence of a causative etiological organism.

Our patient's presentation fulfilled each of Bruyns requirements with the exception of recurrent fever criteria. Our patient did not present with a fever, nor did she report having a fever before coming to the hospital. Although rare, Mollaret's meningitis should be considered in all patients with recurrent aseptic

meningitis. This patient's case presentation reveals that the absence of fever should not rule out a diagnosis of Mollaret's meningitis.

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