Ante la positividad de la PCR para CMV, se realizó el diagnóstico de papilitis por CMV. En un estudio[5] que evalúa la PCR para el diagnóstico de uveítis infecciosa en el segmento posterior, se concluye que cuando hay afectación del nervio óptico es más probable que el resultado sea positivo. Sin embargo, el 71% de los pacientes presentaban inflamación de la cámara anterior y ninguno presentaba una papilitis aislada.

También se ha estudiado el análisis mediante PCR de humor acuoso en pacientes con retinitis por CMV, confirmando la alta sensibilidad y especificidad de esta prueba en diferentes estudios, aunque en muchos no se precisa si existe inflamación de la cámara anterior[6–8]. Este es el primer caso hasta la fecha de papilitis aislada en el que el análisis de humor acuoso determinó la causa de la infección.

La afectación retiniana por CMV es causa de ceguera en pacientes con síndrome de la inmunodeficiencia adquirida, sin embargo, existen pocos casos descritos en niños con LLA[3,9]. Nuestra paciente no presentaba retinitis, sino una papilitis aislada; no se ha descrito papilitis en ningún niño con LLA.

Dada la baja incidencia de papilitis por CMV en la población pediátrica, nos parece importante dar a conocer esta manifestación para tenerla en cuenta en el diagnóstico diferencial de la infiltración leucémica. El análisis de humor acuoso es una técnica de utilidad para establecer este diagnóstico y realizar un tratamiento adecuado.

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Acute abdominal pain as the initial manifestation of meningococcemia in adult patient

Dolor abdominal agudo como manifestación inicial de meningococemia en un paciente adulto

Acute abdominal pain as the initial presentation of a *Neisseria meningitidis* infection is very uncommon. It is more frequent in the pediatric age, but very rare in adult population. Here we present a case of meningococcemia. The patient was a 91-year-old woman admitted to the hospital due to pain in the epigastrium and right flank, nausea and a one-day history of distemper. She had a history of a right hemicolectomy, due to a neoplasm of the right colon. On admission the physical examination showed the following: temperature of 38.3 °C, blood pressure of 166/71 mmHg. The patient was conscious and oriented, without neck stiffness. In the analysis, the following data were highlighted: polymorphonuclears (PMNs) 86.5%, lymphocytes (LYM) 7.9%: CD4/217 mm^3, CD8 113/mm^3, creatinine 1.42 mg/dL, estimated glomerular filtration rate 34.54 mL/min, C-reactive protein 0.58 mg/dL, AST and ALT level were elevated. In the urine analysis, she had positive nitrites and 61 leukocytes/μL. Negative serology for influenza A, B. An abdominal ultrasound was performed, where only a discrete bilateral pleural effusion was observed. Gram-negative diplococcus were detected in blood cultures, subsequently identified by PCR technique as *N. meningitidis* (finally identified as serogroup Y). Lumbar puncture was performed and the cerebrospinal fluid showed the following: glucose 167 mg; proteins 114.2 mg/dL; red cells 4/mm; leukocytes 7/mm (PMNs 14.3%, LYM 85.7%). The initial antibiotic therapy was adjusted to ceftriaxone. The patient presented a clinical worsening 24 h after hospital admission, and finally died 72 h after admission.

N. meningitidiss is a Gram-negative, oxidase-positive, aerobic bacterium. The different strains are classified into serogroups according to the polysaccharides of the capsule, the most frequent being two A, B, C, Y and W-135. The mortality rate is 20% for meningococcemia despite treatment with antimicrobials. The immune system plays an important role in protecting the host from meningococcal disease, and diseases associated with inmunocompromised conditions like human immunodeficiency virus, antecedent infection, have been reported as some of the significant risk factors.[1] In our case the patient presented a low CD4 count as well as hypogammaglobulinemia, suggesting that immunosenescence could have been a contributing factor.[2] The initial symptoms at the onset of the disease can vary in time and frequency, being abdominal pain an infrequent symptom of early appearance, that can occur in isolation, as well as in the context of a meningococcal sepsis.[3] The pain is usually located in the right hemiabdomen which can make it difficult to differentiate from other pathologies. Leading to surgical intervention and subsequent delay in the proper management of this entity, explaining the high morbidity and mortality rates.[4]

Recently, 105 cases of unusual initial abdominal presentations of meningococcemia were described in France. Abdominal presentations represented 1% of all meningococcemias and 64% of

them started with abdominal pain as the initial symptom in the first 24 h. Since 2014 it seems that abdominal presentations have increased related to the spread of NmW/CC11 isolates of the South American-UK strain.[5] It seems reasonable that meningococcemia is considered in the differential diagnosis of abdominal pain in patients were imaging studies do not show clear findings explaining the patient's symptoms, even in very old patients.

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