Commentary

Atypical presentations of well-known diseases have the uttermost importance when they delay the implementation of effective therapies. Herpes encephalitis, as presented by Vachalová and colleagues in this issue of JNRP, serves as an example of such problem.^[1] Both the limitations of diagnostic tests and the importance of clinical suspicion in herpetic encephalitis have been underlined in the literature.^[2] During the past three decades, antiviral drugs have brought a therapeutic improvement that clearly changed outcome in these patients. In that setting, early diagnosis is critical.^[3] Attempts have been made to establish diagnostic guidelines that facilitate management, thus minimizing the ever-present number of patients that does not benefit from early treatment due to atypical manifestations.^[4-6] With their description of cases with confusing initial symptoms, Vachalová and colleagues illustrate this situation, as well as the importance of careful semiology, differential diagnosis, clinical suspicion, and purposeful combination of different tests. Clinical practice has to acknowledge a certain degree of uncertainty. To control this factor, the clinician has to possess a precise, structured, operative knowledge of syndromes, while at the same time, he keeps “in the back of his mind” the possibility of facing an atypical condition.^[7] Even more, while it is a basic ability for any clinician to recognize the definite manifestations of a given disease, he has to be prepared for the myriad of situations surrounding a particular patient that will mislead diagnosis and therapeutics. Sometimes, we encounter more than one simultaneous diagnosis in a patient. Or co-morbidities, the relevance of which has to be pondered, whether they are simple or complex. Or we may have to translate the patient's symptoms, being its expressivity conditioned by his personal or social background. The skill to blend what is relevant of these situations with the information gathered through anamnesis and examination has to be taught during medical training, but it is also the fruit of experience and, sometimes, the fruit of intuition.^[8] In every specialty, common cases are the most frequent,

but sporadic patients dramatically remind us about the challenges of clinical practice.

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References

1. Vachalová I, Kyavar L, Heckmann JG. Pitfalls associated with the diagnosis of Herpes simplex encephalitis. *J Neurosci Rural Pract JNeurosci Rural Pract* 2013;4:176-9.
2. De Tiège X, Héron B, Lebon P, Ponsot G, Rozenberg F. Limits of early diagnosis of herpes simplex encephalitis in children: A retrospective study of 38 cases. *Clin Infect Dis* 2003;36:1335-9.
3. Hughes PS, Jackson AC. Delays in initiation of acyclovir therapy in herpes simplex encephalitis. *Can J Neurol Sci* 2012;39:644-8.
4. Solomon T, Michael BD, Smith PE, Sanderson F, Davies NW, Hart IJ, *et al.* National Encephalitis Guidelines Development and Stakeholder Groups. Management of suspected viral encephalitis in adults-Association of British Neurologists and British Infection Association National Guidelines. *J Infect* 2012;64:347-73.
5. Tyler KL. Herpes simplex virus infections of the central nervous system: Encephalitis and meningitis, including Mollaret's. *Herpes* 2004;11:57A-64.
6. Cinque P, Cleator GM, Weber T, Monteyne P, Sindic CJ, van Loon AM. The role of laboratory investigation in the diagnosis and management of patients with suspected herpes simplex encephalitis: A consensus report. The EU Concerted Action on Virus Meningitis and Encephalitis. *J Neurol Neurosurg Psychiatry* 1996;61:339-45.
7. Livorsi D, Anderson E, Qureshi S, Howard M, Wang YF, Franco-Paredes C. Brainstem encephalitis: An unusual presentation of herpes simplex virus infection. *J Neurol* 2010;257:1432-7.
8. Sexton DJ, McDonald M, Spelman D, Stryjewski M, Yung A, Corey GR. Thirty operating rules for infectious diseases apprentices. *Infect Dis Clin Pract* 2007;15:100-3.

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