Our patient is a male child aged 8 years, from a 2nd degree consanguineous marriage, with a history of the influenza-like syndrome in all family members one month before admission. He was admitted for the management of a febrile meningeal syndrome, the history of which goes back to seven days before his admission, with the onset of a non-calculated fever resistant to antipyretics, associated with peri-umbilical pain and stiffness of the neck with the notion of photophobia and constipation. The clinical examination revealed a conscious child, GCS 15/15, very asthenic, fever 39.3 degrees. The neurological examination revealed a stiff neck with a negative brudzinski and kemping sign and no sensory-motor deficit. The skin examination reveals a morbilliform exanthema with an interval of healthy skin made up of non-infiltrated erythematous macules, which fade away within vitro pressure, on the lower and upper limbs and the trunk, sparing the face, the palms, the soles, and the external genitals, associated with the presence of bilateral palmar plantar oedema without desquamation. The mucous membrane examination showed bilateral conjunctivitis, not purulent, and cheilitis with left cervical adenopathy measuring 2 cm, with an inflammatory appearance on ganglionic examination. The rest of the examination was unremarkable. In front of the meningeal syndrome, a lumbar puncture was performed and came back negative. The biological workup revealed a major inflammatory syndrome: the white blood cells were 25 000 with a predominance of PNN at 23 500, the lymphocytes at 1,000, the platelets at 278 000, the sedimentation rate at 100 and the CRP at 272, the ferritinaemia at 725.12, the Pro-BNP was elevated at 1,834, the liver and kidney biological results were normal. Echocardiography revealed myocarditis with mitral leakage, slight hypokinesia of the left ventricle, ejection fraction at 50%, VGTG 40MM, dilated coronary arteries, left common trunk at 4 mm, and IVA at 3 mm with minimal pericardial effusion. Given the current epidemiological context of the clinical symptomatology in our child, the multisystemic inflammatory syndrome was strongly suspected, so a covid19 serology was performed: negative IgM, positive IgG.

Conclusions
Several recent studies have shown the presence of neurological signs in children with multisystemic inflammatory syndrome related to Covid 19 hence the interest in screening to have recommendations based on sound clinical data for better management of patients with this syndrome during this pandemic.