NEDERLANDS INSTITUUT VOOR PRAEVENTIEVE GENEESKUNDE

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LEIDEN, 18th February 1958
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Dr A.B. Sabin
The Children's Hospital Research Foundation
Elland Ave and Bethesda
CINCINNATI 29, OHIO
U.S.A.

Dear Dr Sabin:

Enclosed I am sending you an old reprint on the isolation of Herpes simplex virus from the brains of a young child which has been published in the Dutch Journal of medicine. It is more a clinical than a virological description. Since this case I have recovered Herpes simplex from brains of two other cases of meningo-encephalomyelitis, ~~even from~~ including a young man of 33 years of age, but I have never had the time to publish all these data. You will find a translation of the most important clinical data shut in, but I did not translate the histologic examination of the brain. Might you be interested, I can as yet translate it, but then just let me know.

I was very much interested to learn you had isolated Herpes simplex virus at the end, because from your description I was sure it was not H.E. virus. I received a letter from Stanley mentioning he had read the article and that Dr Betty Aronson in New York had isolated an identical agent from the faeces of a child with acute cerebellar ataxia. Well the future must learn which role this H.E. virus can play in human disease.

With best wishes and kindest regards.

Yours sincerely,

Dr H.A.E. van Tongeren.

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Case history: Child A, born 19-1-1947 fell ill with high fever on 21-12-1950, without further distinct symptoms. On 25-12-1950 it was hospitalized and on admission it behaved slightly strange and it was very ill. Temperature: 102,5 F. It cried very much and was painful on touching. No cyanosis, perhaps a slight dyspnoea, a frequent regular pulse (108) and some rattles in the lungs. Kernig's sign was dubious. It was a normally developed child from healthy parents.
The onset was sudden, with headache, it could not speak, had vomited once (2 days before). Defaecation normal, but on admission rather thin (of consistence). Therapy had been the first 2 days sulfadiazine.
It could hardly sit; neckstiffness slight. Tongue striking red and smooth. Normal fauces and tonsillar region. Urine: normal.

Table 1 is: „Spinal fluid" and Table 2 is: „Bloodcounts."

Neurological examination: Severely ill. Comatous. The whole right arm showed tremors and so now and then the left arm would grasp for the right arm. Pupills: equal, normal reaction to light. Fundus oculi: normal. The eyes showed normal movements. There was neck-stiffness. Tonic spasm of the whole body. Of the arms the biceps-, triceps- and radial-reflex were positive, the flexorreflex as pathological reflex was positive. Hoffmann's reflex negative. No abnormality was found in the abdomen. The abdominal reflexes could only be aroused once. The legs were in tonic spasm (pointing foot). The patellar reflex at times could slightly be observed. Babinski's reflex was negative. The diagnosis encephalitis could be confirmed.
On 28-12-1950. The patient produced watery-thin faeces; it was fed with half water half milk and Vitamin C. On 29-12-1950 it showed Biot's respiration, it rattled. On 30-12-1950 patient was still impos mentis, showed slight convulsions. The faeces was still watery-thin. Pulse and breathing were slightly better. The feet were still in tonic cramp (stretched). The reflexes were negative.
On 31-12-1950: occasionally slight convulsions.
On 1-1-1951: congestion of the papilla with a hemorrhage. Edema of the whole body. The reflexes of the legs were negative, it died at 20.15 u.

Post-mortem examination only revealed a fresh-clear red-injection of the meninges as well as petechiae in the cerebrum, especially on the surface of the hemispheres.