1962

CASE 2

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The patient, a 10 year old male, was the product of a normal pregnancy and delivery. He was in good health and displayed normal development until 8 months of age, but on the day following his second diphtheria, pertussis and tetanus immunization the patient developed a fever of 102° and had several generalized motor seizures.

General physical and neurological examinations were entirely within normal limits. Laboratory examinations, including urinalysis, white count, hemoglobin, sedimentation rate, spinal tap, and cerebrospinal fluid revealed no significant abnormalities. Bilateral subdural taps were negative. Seizures were poorly controlled with phenobarbital and diphenylhydantoin.

At the age of 5 years the patient was obviously macrocephalic with a head circumference of 55.5 cm. Psychological examination at that time disclosed an I.Q. of 37. He displayed gradual intellectual deterioration, dying at the age of 10 years from an overwhelming pneumonia.

At autopsy the head appeared markedly enlarged with a circumference of 59 cm. The brain weighed 1890 gms. The brain was obviously enlarged with broad gyri. The fresh brain felt firm on palpation. Blood vessels were essentially normal throughout. On section of the fresh brain the cerebral white matter was firm and rubbery, except in the frontal lobes where the tissue was somewhat softer. The basal nuclei and cerebral cortex on cut section appeared within normal limits. By comparison the brainstem appeared small and was somewhat brownish in color. (Case contributed by Dr. W. A. Chadbourn).