

In this article published in 1957, Dr. Fred Klenner describes successfully treating a nineteen-month-old child suffering from what he described as a “brain pathology caused by an insidious virus.” “After fourteen years of research,” he says, “we are convinced that ascorbic acid is the drug of choice in virus pathology.” “We are convinced,” he goes on to say, “that it should be a *maxim* of medicine for large doses of ascorbic acid to be given in all pathological states. It should be given by all physicians while they wait their diagnosis.” Mystified at the lack of acceptance of his research findings, he adds, “The information which we have published on the use of ascorbic acid since 1948 makes me wonder what the response might have been had the source of reporting been a large teaching unit of a major research center.”—*R.D.M.*

An ‘Insidious’ Virus

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“**E**verything that is written in books is worth much less than the experience of one physician who *reflects* and *reasons*.” So wrote *Rbazes* who lived 850–923 A.D.

February 5th, 1950, while on emergency call at the local hospital, we saw a white baby, 19 months old, who according to its mother, was bothered with a little cold for two weeks. Twenty-four hours prior to hospital admission, this child began “running a high fever that could not be broken with aspirin.” Clonic convulsive seizures of the right arm and leg began 12 hours before coming to the hospital. The presenting picture was that of an undernourished infant, lying rigidly in its mother’s arms. The skin was cold to the touch, color actually ‘cadaver-like,’ eyes closed. There was a grade II mucopurelant nasal discharge and the throat, difficult to visualize, was red. The rectal temperature, which tended to confuse the picture, was 98.4 °F (uncorrected). Areas of skin over the back presented an appearance similar to that seen in rigor mortis. Two grams ascorbic acid was given intramuscularly while the child was in the emergency room and one gram was given approximately 45 minutes later on the ‘floor.’ Following the second injection, ascorbic acid was given every four hours, one gram each time. It was more than academic interest to note that the child *did not* respond to pain with the initial injection of ascorbic acid. To give rapid external heat, mustard plasters were applied to the anterior and posterior chest, the plasters being preceded by an application of olive oil. The proportions used in preparing the plasters was one part mustard to three parts flour and cold tap water was employed in making the paste. A croup tent was set up using bathe blankets which were fastened to the ‘crib’ bed with large safety pins. The steam vapor carried compound tincture benzoin. 50 c.c. 5D in saline was given under

the skin in the scapular areas. Two hours following the first injection of ascorbic acid our little patient drank 240 c.c. of orange juice from a bottle which was held by a nurse. This was the first nourishment, even water, taken by the child in 24 hours. The baby, at this point, was beginning to respond to pain. The same amount of orange juice was repeated 1½ hours following the completion of the first bottle. The temperature, at this point, was 103.8 °F rectally (uncorrected). Roughly four hours following admission to the hospital it was possible to determine that this little patient had a complete paralysis of the right arm and leg. It was pathetic to observe the quickened, purposeless movements of the left extremities. Eight hours later, however, the right leg was moved and one hour beyond this time, by the clock, the baby grasped a bottle of orange juice with both hands. From this point on the recovery was un-eventful. Penicillin (single injection type) 200,000 U was given on the 2nd and 3rd hospital days to *discourage secondary invaders*. The patient was discharged on the 5th hospital day.

Since 1950, at least six additional cases, presenting a similar picture, have been admitted to Annie Penn Memorial Hospital, Reidsville, North Carolina. The difference 'in results' suggested the preparation of this paper. All six children were under four years of age. Four of these cases were seen by the same physician and in each instance his remark at case conference was that he was "not impressed with the illness of the child." The significant finding as reported by this doctor was that no fever was recorded. All four children were dead within 30 minutes to two hours following the initial examination. No treatment was started because in the words of the attending physician no diagnosis had been established and that he was opposed to administering medication without knowing the pathology. We will not debate the merit of this opinion. We remember, however, an old, old story which related how a Kingdom was lost for want, in the first place, of a 'nail.' An autopsy was performed on one of these patients. Pathology, as reported, was limited to the chest which showed bilateral involvement of the bronchial tree compatible with a virus infection. (From our own observation in two cases we believe that this child, as well as the others, died from an insidious virus involvement of the brain.) A fifth case was seen by two other physicians. They, too, did not arrive at a diagnosis and therefore withheld treatment. When, on the second hospital day, the patient demonstrated convulsive seizures a spinal tap was done with the fluid being reported as within normal limits. The child died on the 3rd hospital day *without* treatment. One explanation advanced at case conference was that they were awaiting the return to town of a third consultant and the second was that they, too, did not believe in treating a disease before the diagnosis had been established. Life is a continual battle between error and truth, but as Balzac wrote: "Opinions are caught like an infection, and put into practice without examination."

It was Lamartine who said: "Chance often gives us that which we should not have presumed to ask." The sixth case was mine on Monday, April 5th, 1957. This was a well developed, well nourished eighteen month old white female who was brought to my home about 7 p.m. by the child's Uncle and Aunt. The history was brief. The child had strangled on food while eating supper and it appeared to them that she would not recover. A cursory examination given in the front seat of an automobile revealed an extremely restless, whining child. The temperature, taken five minutes axillary, was 98.6 °F (cor-

rected). There was no obstruction to the air-ways. These findings were not compatible with the history. Finally, we elicited the information that the patient had had a cold for the past several days. We also learned that the child's mother had taken it for a long stroller ride the previous day—which in this area was damp and windy. Frankly, the impulse to send the child home without treatment was great. Remembering the cases described in this paper, we elected to 'buy' some time. The Uncle was asked to take the child to the emergency room of the local hospital, where, he was assured, a nurse would be instructed to give it an enema. The nurse on duty was asked, by phone, to take a rectal temperature and then give a fleets enema. If the results proved un-satisfactory she was to repeat the procedure in thirty minutes using a normal saline solution. Approximately forty-five minutes after leaving my home the intern on duty reported to me, by phone, that the child was 'out' and responded only to pain. The enema had not been given. Going at once to the hospital we found conditions exactly as described. The little patient was lying motionless on the examining table. Response was elicited only to pain. Using a suitable size rectal tube I, myself, gave the enema with good results. The stool was normal. The rectal temperature taken at the hospital was 98.4 °F (corrected). Associated with this was a pulse rate of 159 per minute and respirations 32 per minute. It was impossible to visualize the throat because the mouth was 'locked,' as one finds, after stimulation, in lockjaw. Repeated attempts to view the throat resulted in the child assuming a position of opisthotonos. Our impression was an 'insidious' virus infection. After fourteen years of research we are convinced that ascorbic acid is the drug of choice in virus pathology. Accordingly 2½ grams was given intramuscularly in the emergency room and two additional grams ascorbic acid was given approximately 30 minutes later on the 'floor.' Following this ascorbic acid was given every 2 hours for 5 doses then changed to q.4.h. After 36 hours ascorbic acid was extended to every 6 hours and eighteen hours later cut to one-half gram every 12 hours. Thirty grams ascorbic acid was given in all. A croup tent using bathe blankets was set up, the primary purpose being to keep a draft off the patient with the opening and closing of the room door. Steam vapor carried menthol. An adult hospital type woolen blanket was quartered and tucked around the child. Crystalline penicillin, 25,000 U, was given intramuscularly to destroy secondary invaders and this was repeated in one hour, then every two hours for 4 doses and subsequently at four hour intervals for 48 hours. This method of administering penicillin was adopted to compare with the single sustained dose type used in the case treated in 1950.

One hour following admission we applied a 4 x 4 gauze, saturated with water, to the child's lips. The sucking reflex was still intact, but the child immediately strangled. Turning the child quickly head down, the small amount of water taken ran from its nostrils. Now it was clear. It was this 'bulbar phenomenon' that was at play while the child ate its supper. The nursing log showed the temperature to be 99 °F rectally (corrected) one and one-half hours after admission, and one and one-half hours later was up to 100 °F. The nursing log at this point read: "Shows no sign of consciousness." Temperature 101.2 °F at four hours and up to 102 °F after five hours. By 2 a.m. (6 hours following admission) the fever curve had climbed to 102.4 °F and now the nursing log read: "Baby swallowed water without difficulty." Following this the temperature curve started back down and by 7 a.m. (11 hours following admission) the child was alert

and taking water freely from a spoon. Twenty-four hours after the first injection of ascorbic acid the temperature was back to 99.0 °F and four hours later was normal. Water, milk and orange juice were now taken from a bottle. Terramycin pediatric was started 6 hours after admission but was discontinued after the fifth dose due to diarrhea. This was corrected with lactinex granules. The child was discharged on the 5th hospital day.

CONCLUSION

It is reasonable to believe that had this child been put to bed following her evening meal episode, that she would have *died*, that night, while in her bed. Most likely, then, the cause of death would have been recorded as suffocation or perhaps strangulation by way of regurgitated food. The *real* cause of death would have been *brain pathology caused by an insidious virus*. Every practicing physician can, possibly, recall a similar situation as described in this paper. To indicate just how common this condition really is a case history of a 15 year old girl, living in a near by town, is cited. This girl had a mild, lingering cold for several weeks. Attended a dance party one evening and except for a complaint of feeling extremely tired went to bed *apparently* well. She was found *dead* in bed the following morning. An autopsy showed bi-lateral virus pneumonia. What was not reported and what was most likely the actual cause of death was a virus inflammation of the brain by 'an insidious virus.' These cases are suggestive that the toxins of this particular virus act like a 'cephalic tetanus-toxemia.' The motor nuclei which have the shortest motor nerves are reached earliest and it would seem then that this condition may culminate in diaphragmatic spasm, with dyspnoea and even *asphyxia*. Many who are dying—don't have to die. Ascorbic acid, in proper doses, first by needle and later by mouth, can and will save countless individuals once physicians awaken to the real value of this drug. Ascorbic acid, however, is not a panacea. Not all cases will recover, because once the pathological process has progressed to a certain unknown point, it cannot be reversed. The detailed case histories here presented give us an index. We are convinced that it should be a *maxim* of medicine for large doses of ascorbic acid to be given in all pathological states. It should be given by all physicians while they wait their diagnosis. These large doses should not be continued once the temperature curve approaches normal. False temperature spiking will result. We have, more recently, observed in other virus cases to be reported later, that doses of 400 mg. per Kg. body weight given with three to seven hundred c.c. 5% dextrose in water and also containing 250 to 500 mg. achromycin or panmycin will bring about 12 to 24 hour cures which are not 'touched' by any other combination of antibiotics. We have further observed that ascorbic acid taken from ampules and mixed with orange juice and taken by mouth give just as good results as the injections. Where veins are difficult to find and the patient cannot swallow then the mixture can be placed into the stomach by way of a tube. This report argues the importance for physicians to always compare the case they are treating with similar cases seen in the past. This led someone, long ago, to say: "The longer one practices the more he knows what to practice." The information which we have published on the use of ascorbic acid since 1948 makes me wonder what the

response might have been had the source of reporting been a large teaching unit of a major research center. There is no doubt but that physicians are being 'brain washed' with the current journal advertizing. Herbert Spencer summed it up rather well: "There is a principle which is a bar against all information, which is proof against all argument, and which cannot fail to keep a man in everlasting ignorance. That principle is condemnation without investigation."

Note from the Editor: The original article included no bibliography.

