Medical Matters.

CHOREA.

The following abstract of a lecture on chorea, by Dr. A. E. Garrod, appeared in the *St. Bartholomew's Hospital Journal*:

To use a German term, chorea may best be described as a "symptom-complex." Various symptoms go to make up the clinical picture, of which the inco-ordinate movement is only one—the most obvious, but in many vital respects the least important. All the symptoms must be regarded as being due to a single morbid event. This morbid event is a manifestation of rheumatism. The old controversies as to the relation of chorea to rheumatism have now practically died away, and there is little doubt that acute rheumatism is a general systemic infection, and that even the chorea of pregnancy is rheumatic in origin.

It will be convenient to arrange the symptoms of chorea into the following four groups:

(1) The inco-ordinate movements.
(2) Loss of motor power.
(3) Emotional and intellectual symptoms.
(4) Cardiac and articular lesions.

The motor phenomena will only briefly be considered here. In nearly all cases the nature of the movements makes the diagnosis easy, although they may vary in degree from slight twitchings to the most violent muscular disturbance. Yet diagnostic errors may be made. The commonest is the mistaking of habit spasms for true chorea. Although such habit movements may be generalised, they are more often confined to a limited area, and the same movement tends to be repeated over and over again. Huntingdon's chorea and post-hemiplegic chorea may also be mentioned as conditions which simulate true chorea.

The movements not only affect the face, trunk, and limbs, but also extend to involuntary muscle, as in chorea cordis (which is quite distinct from the gross cardiac lesions of chorea), and in the inequality of the pupils and the oscillating movements of the iris. Often when accommodation takes place the iris seems to struggle to contract, and the contraction is interrupted by irregular expansions of the pupil.

The knee-jerks may be much exaggerated, or natural, or absent, or they may be "hung-up." The latter is the most characteristic form; in this the response is brisk, but relaxation is much delayed.

The *paralytic phenomena* are common, and are not to be confused with the ordinary muscular weakness of inco-ordination. Where there is much loss of power at first, and but little choreic movement, it not infrequently happens that a case of chorea is in the first instance diagnosed as one of hemiplegia or paraplegia. In severe attacks the weakness during convalescence is very marked and persistent.

The *mental and emotional phenomena* also vary greatly in degree. Most choreic patients are unduly emotional; little things upset them, and they cry or laugh on the slightest provocation. It is probable that the apparent determining causes of chorea—school strain, excitement, and fright—are in reality symptoms of the disease, the unstable nervous system making the patient sensitive to slight shocks and strains.

In most cases there is considerable mental impairment. The face often assumes a peculiar vacant expression. There may be gradually increasing apathy, leading to stupor, which may last for weeks without choreic movements of any note. In the so-called "dumb chorea" the condition is quite distinct from the common jerky and indistinct speech due to inco-ordination. Here the speechlessness is due to an inability to bring into action the nerve mechanism of speech, and is akin to aphasia. These are among the most grave cases of chorea. The body wastes, and if the patient recovers convalescence is slow and accompanied by much muscular weakness.

Cardiac and articular phenomena.—Of these the former are by far the more important. Irregularity of rhythm has already been mentioned, and hæmic murmurs are not uncommon, a fact which should be borne in mind.

The joint symptoms are usually slight. They may precede or follow the onset of chorea. I can recall no case of associated arthritis which gives rise to serious pain in consequence of the inco-ordinated movements.

Absolute rest in bed is essential in cardiac cases so far as the movements will allow. In grave cases nursing is of the first importance. As a routine treatment salicylate of soda is the most rational drug to employ. If considerable doses are given it is well to combine it with an equal quantity of sodium bicarbonate to avoid toxic effects. In severe mental and emotional cases a short course of chloral often proves useful. For sleeplessness bromides may also be used, together with chloral.

In some cases in which drugs have been used extensively, rapid and permanent benefit seems to arise from the stoppage of all medicines. Generally speaking, drugs, other than salicylates, should only be employed for symptoms and in times of danger.

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