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Chorea and Phenothiazines

By P. F. KENNEDY

The case history is reported here of a woman who has developed involuntary movements while having prolonged phenothiazine therapy. The disorder has developed gradually and is apparently irreversible. It has some unusual features.

An irreversible hyperkinetic extra-pyramidal disorder has been recognized to occur in association with prolonged phenothiazine therapy. The disorder is descriptively called persistent oral dyskinesia, because the abnormal movements focus mainly on the lingual, facial and masticatory musculature. However, the neck, shoulders, pharynx, larynx and respiratory musculature may also be involved; moreover, some of those affected have associated involuntary movements in other parts of the body, particularly the hands and feet, which are predominantly choreiform and of a relatively milder degree (Hunter, Earl and Thornicroft, 1964; Heathfield, 1965).

Case Report

The patient, a woman, now aged 67 years, has suffered recurrent acute schizophrenic episodes since she was 20 years old. Treatment with major tranquillizers was first instituted in April, 1963, and since that time she has been given a succession of courses with thioridazine, haloperidol, trifluoperazine, and chlorpromazine respectively.

Very mild dyskinesia was first detected in April, 1965, after terminating medication with trifluoperazine, which she had been taking during the previous four months in a dosage of 15 mg. per day. She showed the characteristic spasmodic, facial grimacing and tongue writhing, together with minimal choreiform movements in the hands. Later that year chlorpromazine in a dosage of 300 mg. per day was started because she had again become psychotic.

She presented again in June, 1967, still taking chlorpromazine. The face, tongue, and jaw movements had moderately increased, but what was more important was the fact that choreiform movements in the limbs had also increased, and together with some tremor and rigidity were causing a significant disturbance of gait and of manual dexterity.

On account of this chlorpromazine was stopped, but within three weeks the patient became severely disabled by exacerbation of the dyskinesia. Continuously occurring irregular, jerky movements of the head, neck, trunk and limbs were so violent that she was unable to walk, stand or feed herself. Respiration was jerky and irregular, but bouts of acute distress with cyanosis were not seen. The abnormal movements of the face, tongue and jaw had also increased, but to a smaller degree. Tremor, rigidity, and other signs of parkinsonism had disappeared.

At this time, and throughout the whole period of observation, her affect was markedly flat, she never complained, and seemed indifferent to her state.

The dyskinesia persisted unchanged for four months, by which time she was bedridden and had lost 16 lb. in weight, and her life was considered to be in peril. Benzhexol, diazepam and promethazine had had no significant effect on the dyskinesia. Chlorpromazine 300 mg. daily was recommenced, and within a few weeks her condition had improved to the level at which it had been before this medication had been stopped.

There is no evidence of intellectual impairment, or of any other neurological deficit, or of systemic disease.

She is one of a large family, and no relative is known to have suffered from Huntington's chorea, senile chorea or any other chronic disease of the central nervous system.

Comment

The severity of the choreiform dyskinesia in the limbs and trunk is of a greater degree than has been described hitherto. It is clinically more important than the disturbance in the oral region because the disability has more serious consequences.

Exacerbation of dyskinesia after phenothiazine withdrawal has been reported by others (Uhrbrand and Faurbye, 1960; Faurbye, Rasch, Petersen, Brandborg and Pakkenberg, 1964) and was dramatically demonstrated here. The increased level of anxiety and general motor restlessness which may follow phenothiazine withdrawal has been considered a possible factor producing exacerbation of the accompanying dyskinesia (Pryce and Edwards, 1966), but there was a striking absence of any parallel exacerbation of anxiety in this case. However, the inverse relationship between the severity of the hyperkinetic choreiform dyskinesia and that of the hypokinetic parkinsonian dyskinesia suggests that chlorpromazine effectively controlled the former by inducing the latter.

The necessity of having to treat this severe dyskinesia with the very drug which may have caused it may have grave consequences in the future, but there seems to be no alternative at the present time.

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