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Clinical Image
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Myasthenia Gravis: A Case Report of a Classical Presentation

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Clinical Image

This clinical report details a 54-year-old male with myasthenia gravis. He had a childhood measles encephalitis without sequelae and did not take any treatments routinely.

The patient described a 2-to-3-week history of weakness in the cervical and upper limb muscles, predominantly in the evening, without accompanying myalgias or fever. Additionally, for the past 2 years, he had occasionally experienced periods of weakness at these levels along with other symptoms such as left eyelid ptosis and dysphagia. He denied any other symptoms.

On physical examination, he presented phonatory fatigability and left eyelid ptosis obscuring one-third of the eye, exacerbated by the Cogan maneuver, which also appeared contralaterally afterward. He had vertical diplopia upon gaze elevation following the maneuvers. Several muscle strength imbalances were noted upon inspection, with the most remarkable being: Neck flexion in supine position (2+/5), bilateral deltoids and biceps (3/5 and 2/5 after fatigue maneuvers). Additionally, all osteotendinous reflexes were normal except for weakly positive Achilles reflexes. The remainder of the physical examination was strictly normal.

Laboratory findings revealed elevated CK (536 U/l) and aldolase (11 U/l) levels, with negative serologies, tumor markers and the following autoantibodies: Antinuclear, anti-cytoplasmic, antimitochondrial, antithyroid and anti-smooth muscle. However, anti-titin antibodies and anti-acetylcholine receptor (AChR) antibodies were positive.

Neurophysiological study detected postsynaptic neuromuscular junction pathology in the facial and proximal muscles of both upper limbs, and radiologically, a partially calcified heterogeneous mass was observed in the anterior mediastinum.

Given the suspicion of possible myasthenia gravis, the patient received intravenous corticosteroid therapy and pyridostigmine bromide upon admission. Close follow-up assessments were conducted, and when peak flow fell below 200 l/min, immunoglobulin treatment was initiated with good clinical improvement.

After the resolution of the myasthenic crisis, he underwent a scheduled surgery for thymoma resection.

Myasthenia gravis is an autoimmune neurological disorder caused by the presence of specific antibodies directed against various postsynaptic components of the neuromuscular junction. This

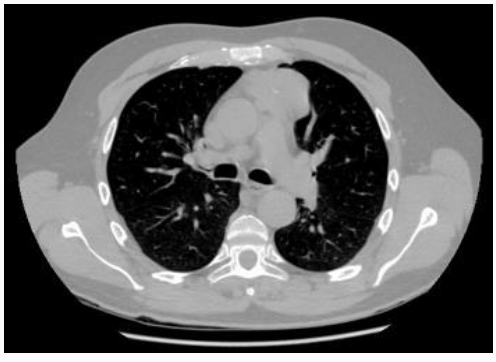

Figure 1: Thymoma.

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can lead to fluctuating motor weakness affecting different muscle groups. AChR antibodies are positive in up to 90% of patients with generalized MG, and high titers are more specific. Diagnosis can also be supported by neurophysiological studies and the detection of a mediastinal mass (up to 15% of patient with thymoma may develop MG) [1] (Figure 1).

References

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