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MYASTHENIA GRAVIS : AN UNUSUAL PRESENTATION

Neurology

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ABSTRACT

Introduction: This autoimmune disease is characterized by muscle weakness that fluctuates, worsens with exertion, and improves with rest. In majority, extrinsic ocular muscles involvement is the initial symptom, usually progressing to other muscles and resulting in generalized myasthenia gravis (gMG). **Case Report:** A 37 years-old-man presented with a history of bilateral shoulder pain and unable to hold his neck, vertigo, nausea, and dry cough for 1 week. On presentation, he was in acute respiratory distress with respirations of 28/min, pulse of 75/min, and blood pressure of 200/100 mmHg. He was afebrile, and SPO2 was 92% on room air. He had a moderate dysarthria while speaking along with nasal twang in his voice. There was diplopia in the right eye and mild ptosis that worsened with sustained upward gaze. Power in all 4 limbs was normal. No contractions or fasciculations were present. Apart from leukocytosis of 20290/cumm, other blood tests were normal. MRI of the brain and CT-chest were also normal. However, mild diffuse disc bulge at C5-6,6-7 levels indenting into the thecal sac with disc osteophyte complex causing mild narrowing of bilateral neural foramina was seen on MRI of the cervical spine. The thyroid gland was normal on ultrasound. He required NIV support for respiratory distress. Anti - Acetylcholine receptor antibody was positive. Repetitive Nerve Stimulation test showed decrement of compound muscle action potential in right deltoid. NCV and SSEP of upper limbs were normal. He responded well to the given treatment, and was discharged on BiPAP support. **Discussion & Conclusion:** This case is a rare presentation of MG, as our patient did not present with the classical fluctuating weakness and fasciculations. Lambert-Eaton and Gullian Barre syndromes were ruled out. A high index of suspicion is required to diagnose MG in patients with unexplainable shoulder pain and neck weakness.

KEYWORDS

INTRODUCTION:

This autoimmune disease is characterized by muscle weakness that fluctuates, worsens with exertion, and improves with rest. In majority, extrinsic ocular muscles involvement is the initial symptom, usually progressing to other muscles and resulting in generalized myasthenia gravis (gMG).

CASE REPORT

A 37 years-old-man presented with a history of bilateral shoulder pain and unable to hold his neck, vertigo, nausea, and dry cough for 1 week. On presentation, he was in acute respiratory distress with RR - 28/min, HR -75/min, BP - 200/100 mmHg. He was afebrile, and SPO2 was 92% on room air.

He had a moderate dysarthria while speaking along with nasal twang in his voice. There was diplopia in the right eye and mild ptosis that worsened with sustained upward gaze. Power in all 4 limbs was normal. No contractions or fasciculations were present. He required NIV support for respiratory distress.

Blood reports: TLC = 20290/cumm. MRI Brain and CT-Chest – Normal, USG Thyroid gland – Normal

SPECIAL TEST

MRI C-Spine - Mild diffuse disc bulge at C5-6,6-7 levels indenting into the thecal sac with disc osteophyte complex causing mild narrowing of bilateral neural foramina.

Ice pack test - Positive, Neostigmine test – Positive, Anti-Acetylcholine receptor antibody – Positive, Repetitive Nerve Stimulation test - Decrement of compound muscle action potential in Rt. Deltoid, NCV and SSEP of upper limbs - normal.

TREATMENT:

Pyridostigmine, Azathioprine given. Due to incomplete clinical response, five days of Intravenous Immunoglobulin given. He was discharged on domiciliary BiPAP support.

DISCUSSION & CONCLUSION:

This case is a rare presentation of MG, as our patient did not present with the classical fluctuating weakness and fasciculations. Lambert-Eaton, Gullian Barre syndromes and Brachial- cervical variant, would expect more acute course. Chronic Inflammatory Demyelinating Polyneuropathy would expect concurrent distal involvement were ruled out. A high index of suspicion is required to diagnose MG in patients with unexplainable shoulder pain and neck weakness.

This case is a rare presentation of MG, as our patient did not present with the classical fluctuating weakness and fasciculations.

REFERENCES

1. Conti-Fine BM, Milani M, Kaminski HJ. Myasthenia gravis: past, present, and future. J Clin Invest 2006; 116: 2843–54.
2. Drachman DB. Medical progress: myasthenia gravis. *New Engl J Med* 1994; 330: 1797–1810.
3. Mittag TW, Caroscio J. False-positive immunoassay for acetylcholine-receptor antibody in amyotrophic lateral sclerosis. *New Engl J Med* 1980; 302: 868.
4. Koon HC, Lachance DH, Harper CM, Lennon VM. Frequency of Sero negativity in adult acquired generalized myasthenia gravis. *Muscle Nerve 2007;* 36: 651.