



## Myasthenia Gravis – A Case Report

Author

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### Abstract

*Myasthenia Gravis is an autoimmune disorder presenting with mostly ocular and respiratory symptoms. Here I am presenting a case of a 45-year-old middle aged woman who presented with partial ptosis and respiratory distress but improved and went onto remission with immune suppressive therapy.*

**Keywords:** *Myasthenia Gravis, Partial ptosis, respiratory distress.*

### Introduction

Myasthenia Gravis affects neuro muscular transmission characterized by localized or generalized weakness. Prevalence is 100 to 125 cases per million population. Antibodies are formed against the acetylcholine receptors in the post synaptic motor end plate.

### Case Presentation

45-year-old middle aged woman presented suddenly on one morning with partial ptosis of the left eye and difficulty in breathing. She was taken to a physician who on seeing her difficulty in breathing, got a Pulmonary Function Test done. She was put on deriphylline as there was wheeze on auscultation and was sent home. But on the third day, she presented with difficulty in getting up from the squatting position and complete ptosis of the left eye. There was no improvement in respiratory distress and was not able to lie in supine position. She was taken to the emergency room, at Nizams Institute of medical sciences Hyd. She was attended by a physician and a neurologist was called in. A detailed history was taken and

clinical examination done. Vitals were stable except for the respiratory rate of 27 per minute. Suspecting it to be Myasthenia, she was administered an intravenous injection of Edrophonium by the neurologist. As the injection was being administered Ptosis got corrected. We could literally see the upper eye lid moving up confirming it to be Myasthenia. She was immediately admitted to the neuro intensive care unit and was put on Pyridostigmine. Her shortness of breath improved and by evening her respiratory rate became normal. The next day, Computerized Tomographic scan of the chest including neck was done to visualize for any thymic swellings.

ABG analysis showed Ph of 7.39, pco<sub>2</sub> of 45.8 mmHg, Po<sub>2</sub> of 71.2 mmHg, HcO<sub>3</sub> of 26.8 mEq/L. Chest X-Ray was normal, CT scan chest was normal. As there was clinical improvement with Pyridostigmine, plasmapheresis and immunoglobulin therapy was deferred. From day 2 she was put on immunosuppressants (high dose of steroids and Azathioprine) She improved well and was discharged on day 9. No symptom returned back and she continued on the same therapy for a

period of two years, but she developed many side effects of steroids like hypertension and bilateral cataract for which she had to undergo surgery (IOL replacement).

### **Discussion**

Though she presented with Myasthenic crisis, she responded very well to steroids and Azathioprine without the need for plasmapheresis or immunoglobulin therapy. When she presented with these symptoms she was in her Perimenopausal age. Did the lowered levels of oestrogens and progesterone precipitate this? She is into complete remission now and asymptomatic for twenty years now.

### **Conclusion**

Autoimmune diseases can manifest for the first time during menopause.

### **Declaration**

**Ethics and Concerns:** Informed consent was obtained from the patient (my mother) for the publication

**Competing interest:** Nil

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