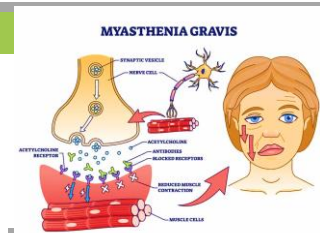


HEAD AND NECK MANIFESTATION OF MYASTHENIA GRAVIS

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MYASTHENIA GRAVIS

Myasthenia gravis (MG) is a motor neuron disease. The most common form is caused by presence of antibodies against acetylcholine receptor that impair proper function of neuromuscular junction. The rare form is congenital MG (CMG) caused hereditary autosomal recessive mutation in genes for proteins (eg. CHRNE) which participates in neuromuscular transfer. The patient is very often sent to ENT specialist because of specific problem as: **dysphagia, dysphonia, hoarseness and dysarthria** and in small babies **problems with feeding**. ENT specialist and voice and speech therapist should be a part of team taking care about patients with MG.

Case report 1

woman, 68 y.o., rheumatic myalgia, arterial hypertension

*2015 first symptoms – dysphonia (R vocal fold palsy), dysarthria, evening dysphagia for solid, MRI, CT normal - neurologist examination normal findings, no diagnosis

*2017 progressive dysphagia and dysarthria accentuated by fatigue
- EMG weakness of trapezian muscles, +antiAChR
- th. steroids, cholinesterase inhibitor -> stabilization

*6/2025 myasthenic crisis – trigger common cold, serious bulbar and motoric sym.

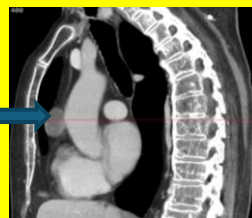


- IVIG, plasmaferesis
- respiratory distress -> UPV, tracheostomy, PEG
- CT -> thymoma, surgery + plasmaferesis, biologic treatment anti C5

*8-11/2025 complete restoration of swallowing (FEES from Rosenbek 6 to 1, VFS) and mobility

- th. steroids, cholinesterase inhibitor

*8/2026 complete remission



Case report 2

*woman, born 37+0, 2150g/42cm (small for dates)

*4 weeks failure to thrive, silent cry, laryngeal stridor, central hypotonia
- orofacial hypotonia, absent gag reflex, VFS no aspiration

*3 months progression of laryngeal stridor -> laryngoscopy in general anesthesia -> first episode of respiratory failure -> UPV 2 days, seizures -> epilepsy treatment, NJ, tracheostomy

*4-6 months – bad motor x almost normal psychosocial development -> central hypotonic syndrome of unknown origin, severe episodes of asphyxia

*7 months -> dg. CMG (CHRNE gen mutation)
- stop antiepilepsy therapy -> start cholinesterase inhibitor

*8-9 months – improvement feeding (oral intake) and motor development

*9 months – died on respiratory failure, bilateral pneumonia



Adults

First symptoms -> Dysphonia, Dysphagia, Dysarthria -> first contact ENT
- symptoms worsen when tired, evening, or during infect episode
- role ENT – refer to neurologist, dysphagia team

CONCLUSION

Children/babies

- hypotonia, feeding problems, silent cry, worsening symptoms of laryngomalacia



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