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Myasthenia gravis with dysphagia : A case report

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Introduction

Myasthenia gravis (MG) is an autoimmune disease of the neuromuscular junction by antibody-mediated attack of the acetylcholine receptors in postsynaptic membrane. Initial presentation is progressive muscle fatigue, mostly ocular system, and resulting in ptosis and diplopia. Bulbar symptoms, such as dysarthria and dysphagia, are often seen in the elderly.

Case

A 71-years-old man was admitted for aspiration pneumonia. He was referred to our part for evaluation of swallowing function. His past medical history was thymomectomy 4 month ago due to mass effect. He complained of progressive dysphagia accompanied of frequent choking sign. On physical examination, there is no motor weakness, sensory deficit. Also, he denied dysarthria, diplopia and ptosis. Initial VFSS findings showed delayed swallowing reflex, incomplete laryngeal elevation and closure, and reduced pharyngeal wall contraction in the pharyngeal phase but oral phase was intact. Direct aspiration was observed on thin liquid. Residual food was pooled in bilateral pyriform and vallecular sinus. Functional dysphagia scale (FDS) was 38 score. He had to be fed through nasogastric tube. He referred to neurologic department for evaluation because neuromuscular junction disorder like MG or Eaton Lambert syndrome which could be suspected by history and dysphagia. In the laboratory finding, the Ach-R Ab levels were higher than normal limit (17.488nmol/L). The EDX showed normal NCS findings but RNS test showed abnormal decrement at high frequency stimulation and post-tetanic exhaustion in right FCU muscle. His final diagnosis was seropositive Myasthenia gravis. He started to treat with pyridostigmine and high-dose steroids. 2 weeks later from medication, VFSS finding showed mild improvement which was subtle decreased residual volume in vallecular sinus but pharyngeal wall contraction was inadequate. FDS was 34 score. He had to maintain tube feeding due to risk of aspiration. 1 month later, he had significant improvement in VFSS findings. Residual food was still pooled but decreased amount. On thin liquid test, the penetration at vocal fold was observed PAS grade 3 with compensation maneuver. The FDS was 30 score. He was recommended to oral feeding which is like yogurt consistence with chin-tuck and double swallowing maneuver. 2 months later, dysphagia was dramatically improved. In the VFSS findings, aspiration/penetration was not observed on semisolid and

solid but only 5cc liquid of aspiration was seen. Pharyngeal wall contraction is nearly normal. FDS was 26 score. He could make progress regular diet gradually. Additionally, high dose steroid therapy was planned to tapering with improvement of dysphagia.

Conclusion

This case reports highlights the proper management of dysphagia which was accompanied with neuromuscular junction disorders. Early diagnosis can reduce morbidity caused by severe malnutrition, aspiration pneumonia and other complications associated with MG.