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Letter to the Editor

Bulbar-Onset Myasthenia Gravies should be Considered as a Differential Diagnosis for Dysarthria and Dysphagia

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Letter to the Editor

We read with interest the article by Zoert *et al*. about a 65-year-old woman with bulbar myasthenia gravis (MG) who was initially misdiagnosed with goiter as the cause of her bulbar symptoms. Only after the goiter was removed and bulbar symptoms did not improve was MG considered and confirmed by antibody testing. The patient responded well to pyridostigmine, prednisone, and azathioprine [1]. Some points require discussion.

The first point is that it is incomprehensible why the neurological examination of the index patient was described as normal or inconclusive. The patient suffered from dysarthria and dysphagia, which means that the clinical examination cannot have been normal. How many years of experience did the neurologist in charge have? Was he a general neurologist or a neurologist familiar with neuromuscular diseases? A patient with dysarthria and dysphagia requires a comprehensive neurological examination that includes the exclusion or confirmation of a neuromuscular transmission disease after a cause of the symptoms in the central nervous system has been ruled out. Did the intensity of dysarthria and dysphagia fluctuate throughout the day? Did the neurologist perform the gag reflex or Simpson test? Is it possible that the clinical neurological examination was insufficient? Patients with bulbar-onset MG may not only exhibit dysarthria and dysphagia, but also difficulty chewing, voice changes (e.g., dysphonia), drooling, dyspnea, and weakness of the facial or neck muscles, which worsened with activity and improved at rest. Were these symptoms overlooked? Was a pulmonary function test performed on the patient?

The second point is that dysarthria and dysphagia are rarely the only symptoms of MG in its early stages. More often than with bulbar symptoms, MG begins with ocular or muscular symptoms, which, however, are sometimes only mild [2]. Was there any indication in the medical history of double vision, exercise intolerance, easy fatigability, or exertional dyspnea?

The third point is that the diagnosis of MG was not confirmed by electrophysiological tests or the Tensilon test [1]. As soon as MG is suspected, repetitive nerve stimulation with low and high frequencies should be performed. It is also recommended to perform single fiber electromyography to determine whether there is increased jitter or an increased number of blockages.

In summary, a patient with dysarthria and dysphagia should not be classified as normal on neurological examination, and a thorough and comprehensive neurological examination is necessary until a neurological cause of the symptoms can be confirmed or ruled out.

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