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Letters to the editor

OVERVIEW

Please submit letters for the editor's consideration within three weeks of receipt of *Clinical Medicine*. Letters should ideally be limited to 350 words, and sent by email to: clinicalmedicine@rcplondon.ac.uk

Brucella and *Coxiella*; if you don't look, you don't find

We thank Dr Giles Youngs and Dr Peter Stride for highlighting a factual error in an article on *Brucella* and *Coxiella* (*Clin Med* 2015;15:91–2). The authors confirm that the statement '*Coxiella burnetii* is the cause of Q fever, a term first used in 1983 during the investigation of a cluster of febrile Australian meat workers' should in fact read, '*Coxiella burnetii* is the cause of Q fever, a term first used in 1937 during the investigation of a cluster of febrile Australian meat workers'.

Myasthenia gravis as a 'stroke mimic'

Editor – Shaik and colleagues (*Clin Med* December 2014 pp 640–2) elegantly highlight the importance of an accurate history in the diagnosis of myasthenia gravis (MG) and offer important differentials of the condition. However, by not explicitly discussing the possible role of iatrogeny as a contributing factor for the 'patient's rapid deterioration,' an important learning point may have been missed.

In the case, the patient's condition appears to have deteriorated further after he was administered gentamicin (for possible aspiration pneumonia) and verapamil (for atrial fibrillation). Both of these drugs can affect neuromuscular transmission and result in clinically significant weakness in patients with MG.[1,2] Indeed the British National Formulary registers all aminoglycosides along with two other antibiotics, telithromycin and colistin, as a contraindication in MG. Other agents that could conceivably be administered to critically unwell patients but should be avoided in MG if possible include: high dose intravenous magnesium (pre-eclampsia or severe asthma), intravenous lignocaine for ventricular arrhythmias (safe as a local anaesthetic) and neuromuscular blocking agents.[4] If these drugs are given then the patient should be monitored in a high-dependency area, where they are able to receive ventilatory support if acutely needed.

It is not necessary to recall all the medications that ought to be used with caution in patients with MG as these are readily available online.[3,4] However, we hope this letter will serve to remind those that might be involved in the care of patients with MG to perform a thorough risk benefit analysis before starting new drugs and have a process for actively monitoring them for early signs of deterioration. ■

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References

1 Torda T. The nature of gentamycin-induced neuromuscular block. *Br J Anesth* 1980;52:325–9.
2 Ribera AD, Nastuk WL. The actions of verapamil at the neuromuscular junction. *Comp Biochem Physiol* 1989;93:137–41.
3 Myasthenia Gravis Association. *Myasthenia gravis medication list.* Kansas City, MO: Myasthenia Gravis Association, 1 December 2012. Available online at http://mgakc.org/wp-content/uploads/2011/07/MGA-Medication-List-12-1-12.pdf [Accessed 15 January 2015].
4 Pascuzzi R. *Medications and myasthenia gravis* (a reference for health care professionals). New York, NY: Myasthenia Gravis Foundation of America, 2007. Available online at www.myasthenia.org/LinkClick.aspx?fileticket=JuFvZPPq2vg%3D [Accessed 15 January 2015].

Response

Editor – The comments by Patel *et al* are very welcome as they make an important point that certain drugs can exacerbate myasthenia gravis.

In our case, the initial clinical deterioration occurred prior to the administration of gentamicin and verapamil. When the patient deteriorated he was transferred to the intensive care unit, which facilitated close monitoring, and indeed, ventilatory support.

It should also be borne in mind that at the time of administration of these drugs, the diagnosis of myasthenia gravis had not been confirmed. Nonetheless, caution certainly needs to be exercised with the administration of drugs which have the potential to exacerbate myasthenic weakness, even when the diagnosis is suspected on clinical grounds alone.

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