Letters to the editor

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.3 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

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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