CC:, Intermittent binocular horizontal, vertical, and torsional diplopia.,HX: ,70y/o RHM referred by Neuro-ophthalmology for evaluation of neuromuscular disease. In 7/91, he began experiencing intermittent binocular horizontal, vertical and torsional diplopia which was worse and frequent at the end of the day, and was eliminated when closing one either eye. An MRI Brain scan at that time was unremarkable. He was seen at UIHC Strabismus Clinic in 5/93 for these symptoms. On exam, he was found to have intermittent right hypertropia in primary gaze, and consistent diplopia in downward and rightward gaze. This was felt to possibly represent Grave's disease. Thyroid function studies were unremarkable, but orbital echography suggested Graves orbitopathy. The patient was then seen in the Neuro-ophthalmology clinic on 12/23/92. His exam remained unchanged. He underwent Tensilon testing which was unremarkable. On 1/13/93, he was seen again in Neuro-ophthalmology. His exam remained relatively unchanged and repeat Tensilon testing was unremarkable. He then underwent a partial superior rectus resection, OD, with only mild improvement of his diplopia. During his 8/27/96 Neuro-ophthalmology clinic visit he was noted to have hypertropia OD with left pseudogaze palsy and a right ptosis. The ptosis improved upon administration of Tensilon and he was placed on Mestinon 30mg tid. His diplopia subsequently improved, but did not resolve. The dosage was increased to 60mg tid and his diplopia worsened and the dose decreased back to 30mg tid. At present he denied any fatigue on repetitive movement. He denied dysphagia, SOB, dysarthria,

facial weakness, fevers, chills, night sweats, weight loss or muscle atrophy.,MEDS: , Viokase, Probenecid, Mestinon 30mg tid.,PMH:, 1) Gastric ulcer 30 years ago, 2) Cholecystectomy, 3) Pancreatic insufficiency, 4) Gout, 5) Diplopia.,FHX:, Mother died age 89 of ""old age."" Father died age 89 of stroke. Brother, age 74 with CAD, Sister died age 30 of cancer.,SHX:, Retired insurance salesman and denies history of tobacco or illicit drug us. He has no h/o ETOH abuse and does not drink at present.,EXAM: ,BP 155/104. HR 92. RR 12. Temp 34.6C. WT 76.2kg.,MS: Unremarkable. Normal speech with no dysarthria.,CN: Right hypertropia (worse on rightward gaze and less on leftward gaze). Minimal to no ptosis, OD. No ptosis, OS. VFFTC. No complaint of diplopia. The rest of the CN exam was unremarkable.,MOTOR: 5/5 strength throughout with normal muscle bulk and tone.,SENSORY: No deficits appreciated on PP/VIB/LT/PROP/TEMP testing.,Coordination/Station/Gait: Unremarkable.,Reflexes: 2/2 throughout. Plantar responses were flexor on the right and withdrawal on the left.,HEENT and GEN EXAM: Unremarkable.,COURSE:, EMG/NCV, 9/26/96: Repetitive stimulation studies of the median, facial, and spinal accessory nerves showed no evidence of decrement at baseline, and at intervals up to 3 minutes following exercise. The patient had been off Mestinon for 8 hours prior to testing. Chest CT with contrast, 9/26/96, revealed a 4x2.5x4cm centrally calcified soft tissue anterior mediastinal mass adjacent to the aortic arch. This was highly suggestive of a thymoma. There were diffuse

emphysematous disease with scarring in the lung bases. A few nodules suggestive of granulomas and few calcified perihilar lymph nodes. He underwent thoracotomy and resection of the mass. Pathologic analysis was consistent with a thymoma, lymphocyte predominant type, with capsular and pleural invasion, and extension to the phrenic nerve resection margin. Acetylcholine Receptor-binding antibody titer 12.8nmol/L (normal<0.7), Acetylcholine receptor blocking antibody <10% (normal), Acetylcholine receptor modulating antibody 42% (normal<19), Striated muscle antibody 1:320 (normal<1:10). Striated muscle antibody titers tend to be elevated in myasthenia gravis associated with thymoma. He was subsequently treated with XRT and continued to complain of fatigue at his 4/18/97 Oncology visit.