Surgical treatment of myasthenia gravis in two major Middle East teaching hospitals: factors influencing outcome

S Ahmad Hassantash, David G Ashbaugh, Edward D Verrier, Ronald V Maier

Abstract

Background – The results of thymectomy on patients with generalised myasthenia gravis have been widely reported. However, there is no information on whether the experience of western countries can be generalised to the population of the Middle East. The purpose of this study was to evaluate the safety and efficacy of thymectomy in patients with myasthenia gravis in a Middle East patient population and to identify clinical and histopathological factors associated with improved long term outcome of surgery.

Methods – In a prospective study, sixty three patients (aged 1-51 years) were treated in two university teaching hospitals between 1984 and 1991 and followed up for a mean of four years. Close communication was established with neurologists to obtain early referral. Radical anterior mediastinal dissection through a median sternotomy was performed in all patients. The response was evaluated by modified Osseman’s classification.

Results – Eighteen patients achieved complete remission and a further 39 improved, producing an overall response rate of 90-5%. Patients with milder disease (stage II) had a higher response rate (97%) than those with more advanced disease (78%). Patients operated on with less than three years of symptoms had a better outcome (94%) than those with longer duration of preoperative symptoms, especially in non-thymomatous patients. Age and sex had no effect on the outcome. There was no effect on response rate if patients had hyperplastic or non-specific thymic histological findings, but patients with thymoma fared worse.

Conclusions – These results are comparable with reports from the western world and represent the first prospective study from the Middle East. Thymectomy is indicated for all patients suffering from generalised myasthenia gravis soon after the diagnosis is made, regardless of age, stage, thymic pathology, and preoperative clinical status.

(Thorax 1996;51:193-196)

Keywords: myasthenia gravis, thymectomy, prognosis, outcome.

Myasthenia gravis is an autonomic disorder directed against postsynaptic acetylcholine receptors which causes weakness and easy fatigueability of voluntary muscles. The excellent outcome following thymectomy reported in many series has established this procedure as the mainstay of treatment in patients with myasthenia gravis.

Thymectomy typically removes the major source of antibody production and offers the best chance of remission. Improvement has been reported in 80–90% of patients after surgery.

However, there is still no general agreement about which patients would benefit most from the removal of the thymus. Our aim was to evaluate the influence of some of the factors known to be controversial for outcome after thymectomy in patients with myasthenia gravis in a Middle East patient population. We were also interested to know the safety and efficacy of this procedure and the clinical course of 63 consecutive patients with myasthenia gravis treated with thymectomy is reviewed.

One important issue is the timing of surgical intervention in these patients. Most neurologists advocate thymectomy for selected patients with generalised myasthenia gravis without thymoma. To support the practice of early referral for surgical treatment of patients with myasthenia gravis we communicated closely with the department of neurology responsible for the care of these patients in the region.

Methods

The study was designed prospectively to assess the remission and response rate as well as the safety of thymectomy in patients treated in two university affiliated teaching hospitals. Sixty three patients with generalised myasthenia gravis were operated on between 1984 and 1991. The procedures were performed by the same surgical team in two tertiary medical centres, Shohada and Khatam centres in Iran.

Some of the controversial factors which may have an effect on the outcome in patients with myasthenia gravis undergoing thymectomy were evaluated including age, sex, duration of symptoms, thymic pathology, disease severity, and the amount of preoperative medication.

The diagnosis was established on the basis of history and physical findings, and a positive tension (edrophonium) test. In some patients adjuvant diagnostic tests were also used (Jolly test, electromyography (EMG), and acetylcholine receptor (AChR) antibody). All patients were evaluated for other possible associated conditions – for example, thyroid auto-
immune disorders, thymoma, collagen vascular diseases, red cell aplasia, and multiple sclerosis. One patient also had Grave’s disease and two had migraine.

The patients were divided into three groups based on the duration of the preoperative symptoms: <1 year, 1–3 years, and >3 years. The Osserman classification was used to group the patients according to the severity of their disease (table 1).

All the patients were followed up at intervals of three months for the first year and yearly thereafter for a range of 2–8 years. The response to surgery was recorded at the last check up and the patients were classified by a modified Osserman’s response to thymectomy (table 2). Asymptomatic patients receiving no medical treatment for more than three months (grade A) were considered to be in remission. Patients in remission (grade A), symptom-free patients on decreased doses of medication (grade B), and patients with significant clinical improvement with the same dosage of medications as before surgery (grade C) were all considered to have responded to thymectomy. The remission and response rates between the different groups were compared using the χ² test.

The operation was performed through a complete median sternotomy. Mediastinal dissection began from the lowest part of the anterior mediastinum but not beyond the phrenic nerves. If prominent lymph nodes were present around these nerves they were isolated and the lymph nodes and their adjacent fatty tissue included en bloc with the specimen. The dissection continued cephalad until the lower portion of the thyroid was reached.

The patients were weaned from the ventilator when continuous pulse oximetry, serial evaluation of arterial blood gas tensions, lung volume and mechanics, and ability to protect airway or control secretions permitted. The patients were extubated according to the same parameters and his/her response to the weaning process.

Tapering of medications did not have a standard protocol as different strategies were used by the various neurologists involved. In some patients treatment started 1–3 days after surgery and decreased as symptoms decreased, while in others, especially those with more mild disease, the dosage was started as low as possible and increased to an optimum over the hospital stay or next clinical visit and modified again at future visits.

### Results

Thirty-four of the patients (54%) were women and the age range was 1.5–51 years (mean 25.7). Eight patients were under 15 years of age, of whom four were aged 1.5–4 years. The mean age of the patients older than 15 years was 28.2 (figure). The interval between the onset of symptoms to surgery was 4–180 months (median 21). None required perioperative blood transfusion and the average amount of blood loss was less than 300 ml.

Seven patients with class IIA disease were taking no medication before surgery. Twenty-nine patients were treated with neostigmine or pyridostigmine, eight were on steroids, and another 19 were treated by both medications preoperatively.

There was no operative mortality. Forty-six patients were extubated in the recovery room, 14 of whom were not admitted to the ICU and were returned to the surgical ward. In seven patients intubation was continued for 1–7 days postoperatively (mean 3.7 days) including the

---

### Table 1

<table>
<thead>
<tr>
<th>Class</th>
<th>Symptoms</th>
<th>No. of patients (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>Ocular involvement only</td>
<td>0 (0)</td>
</tr>
<tr>
<td>IIA</td>
<td>Generalised muscular involvement without respiratory impairment</td>
<td>8 (12-8)</td>
</tr>
<tr>
<td>IIIB</td>
<td>More bulbar manifestations than group IIA</td>
<td>32 (50-8)</td>
</tr>
<tr>
<td>III</td>
<td>Rapid onset and progression of bulbar and generalised disease with</td>
<td>21 (33-3)</td>
</tr>
<tr>
<td>IV</td>
<td>Progressive symptoms developing at least two years after the patient</td>
<td>2 (3-1)</td>
</tr>
</tbody>
</table>

### Table 2

<table>
<thead>
<tr>
<th>Response grade</th>
<th>Definition</th>
<th>No. of patients (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Complete remission for more than 90 days</td>
<td>18 (29)</td>
</tr>
<tr>
<td>B</td>
<td>Symptom-free on decreased dose of medication</td>
<td>28 (44)</td>
</tr>
<tr>
<td>C</td>
<td>Marked clinical improvement with no change in medications</td>
<td>11 (18)</td>
</tr>
<tr>
<td>D</td>
<td>No clinical improvement with same dose of medication</td>
<td>4 (6)</td>
</tr>
<tr>
<td>E</td>
<td>Clinically worse</td>
<td>2 (3)</td>
</tr>
</tbody>
</table>
Surgical treatment of myasthenia gravis in two Middle East teaching hospitals

Table 3  Effect of different variables on prognosis after thymectomy in 63 patients

<table>
<thead>
<tr>
<th>Variable</th>
<th>No. of patients</th>
<th>No. of patients in remission</th>
<th>No. of patients responded</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (years)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;1</td>
<td>26 (41)</td>
<td>7 (27)</td>
<td>25 (96)</td>
</tr>
<tr>
<td>1-2</td>
<td>25 (40)</td>
<td>8 (32)</td>
<td>23 (92)</td>
</tr>
<tr>
<td>3-5</td>
<td>12 (19)</td>
<td>3 (25)</td>
<td>9 (75)*</td>
</tr>
<tr>
<td>Preoperative stage</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IIIA</td>
<td>8 (13)</td>
<td>3 (38)</td>
<td>8 (100)</td>
</tr>
<tr>
<td>IIIB</td>
<td>32 (51)</td>
<td>12 (38)</td>
<td>31 (97)</td>
</tr>
<tr>
<td>III</td>
<td>21 (33)</td>
<td>3 (13)</td>
<td>17 (80)</td>
</tr>
<tr>
<td>IIV</td>
<td>4 (3)</td>
<td>0 (0)</td>
<td>1 (25%)</td>
</tr>
<tr>
<td>Non-thymomatous pathology</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hyperplasia</td>
<td>30 (48)</td>
<td>10 (33)</td>
<td>28 (93)</td>
</tr>
<tr>
<td>Non-specific</td>
<td>28 (44)</td>
<td>8 (28)</td>
<td>26 (93)</td>
</tr>
<tr>
<td>Thymoma</td>
<td>5 (8)</td>
<td>0 (0)</td>
<td>3 (60)*</td>
</tr>
</tbody>
</table>

Numbers in parentheses are percentages.

*p < 0.05 patients with <3 years v >3 years preoperative duration of symptoms

**p < 0.05 stage II v stage III and IV

† p < 0.05 for thymoma v non-thymoma.

Discussion

Since the first excision of a thymic cyst in a 19 year old girl with myasthenia gravis in 193913 thymectomy has gradually become accepted as the definitive treatment for generalised myasthenia gravis.14-15 As the thymus gland is the source of antibodies against acetylcholine receptors, thymectomy is the only treatment that removes the cause of the disease. Patients with myasthenia gravis not treated surgically have a 40% mortality in 10 years with a median survival of seven years.1 Based on a computer-matched study in 1975, Buckingham et al showed significantly superior results in patients undergoing thymectomy compared with those undergoing medical treatment alone.1 Our patients had a complete remission of 28-5% and an overall response to surgery of 90-5%, which is comparable with most published results7,8 which range from 80% to 94%. The patients in our study were generally operated on at a more advanced stage of disease than were patients in studies which have reported a higher response rate.14,15

Three of our patients had thymic tissue (4-7%) separate from the main thymus gland. From the anatomy of these extrathymic remnants we believe that they would have been overlooked if a less aggressive surgical approach had been used. Jaretzki et al reported that thymic tissue was found in the mediastinum outside the main thymus gland in all but one dissection in their 50 patients.56 Some other studies have also shown that more limited resections may result in retained thymic tissue.57

The effect of early surgical intervention after the onset of symptoms on the response rate is controversial. In a survey by Lanska11 only four of 56 experienced neurologists advocated thymectomy in less than one third of their patients; 28 advocated it for between one third and two thirds, and 17 advocated it for more than two thirds of their patients. Most of the neurologists in that report advocated thymectomy for selected patients with generalised myasthenia gravis without thymoma. Some reports have shown no relation between the preoperative duration of symptoms and the outcome.10,19 Our results and those of others4,7,15,20,21 show that patients operated on early in the course of their disease have a better outcome. More than 80% of our patients were referred less than three years after the onset of symptoms. Patients operated on later during the study had a significantly shorter duration of symptoms than those seen earlier in the study.

Hatton et al22 and Barton et al23 reported that patients with more advanced disease benefited more from thymectomy, while others24,25 found that the stage of the disease had no effect on hyperplasia and non-specific pathological findings, although those with thymoma had a worse outcome (p < 0.05). Sex and age had no impact on remission or the improvement rate. There was no difference in outcome between the paediatric and older age groups.

Discussion

Since the first excision of a thymic cyst in a 19 year old girl with myasthenia gravis in 193913 thymectomy has gradually become accepted as the definitive treatment for generalised myasthenia gravis.14-15 As the thymus gland is the source of antibodies against acetylcholine receptors, thymectomy is the only treatment that removes the cause of the disease. Patients with myasthenia gravis not treated surgically have a 40% mortality in 10 years with a median survival of seven years.1 Based on a computer-matched study in 1975, Buckingham et al showed significantly superior results in patients undergoing thymectomy compared with those undergoing medical treatment alone.1 Our patients had a complete remission of 28-5% and an overall response to surgery of 90-5%, which is comparable with most published results7,8 which range from 80% to 94%. The patients in our study were generally operated on at a more advanced stage of disease than were patients in studies which have reported a higher response rate.14,15

Three of our patients had thymic tissue (4-7%) separate from the main thymus gland. From the anatomy of these extrathymic remnants we believe that they would have been overlooked if a less aggressive surgical approach had been used. Jaretzki et al reported that thymic tissue was found in the mediastinum outside the main thymus gland in all but one dissection in their 50 patients.56 Some other studies have also shown that more limited resections may result in retained thymic tissue.57

The effect of early surgical intervention after the onset of symptoms on the response rate is controversial. In a survey by Lanska11 only four of 56 experienced neurologists advocated thymectomy in less than one third of their patients; 28 advocated it for between one third and two thirds, and 17 advocated it for more than two thirds of their patients. Most of the neurologists in that report advocated thymectomy for selected patients with generalised myasthenia gravis without thymoma. Some reports have shown no relation between the preoperative duration of symptoms and the outcome.10,19 Our results and those of others4,7,15,20,21 show that patients operated on early in the course of their disease have a better outcome. More than 80% of our patients were referred less than three years after the onset of symptoms. Patients operated on later during the study had a significantly shorter duration of symptoms than those seen earlier in the study.

Hatton et al22 and Barton et al23 reported that patients with more advanced disease benefited more from thymectomy, while others24,25 found that the stage of the disease had no effect on hyperplasia and non-specific pathological findings, although those with thymoma had a worse outcome (p < 0.05).

Sex and age had no impact on remission or the improvement rate. There was no difference in outcome between the paediatric and older age groups.
outcome. Our results and those of others suggest a more favourable outcome in patients with a milder form of myasthenia gravis. Patients with advanced disease received more medication when admitted for surgery so a less favourable prognosis in patients on more drugs was attributed to a more advanced stage of the disease and not to the amount of preoperative medication itself.

Compared with most others, who have reported thymoma in 9–28% of their patients with myasthenia gravis, only five (8%) of our patients had a thymoma. In addition, although some authors have shown a better outcome in patients with thymic hyperplasia, in our series and others there was no difference in remission or response between patients with germinal layer hyperplasia and those with a non-specific thymic histopathological report.


Surgical treatment of myasthenia gravis in two major Middle East teaching hospitals: factors influencing outcome.

S. A. Hassantash, D. G. Ashbaugh, E. D. Verrier and R. V. Maier

Thorax 1996 51: 193-196
doi: 10.1136/thx.51.2.193

Updated information and services can be found at:
http://thorax.bmj.com/content/51/2/193

These include:

Email alerting service
Receive free email alerts when new articles cite this article. Sign up in the box at the top right corner of the online article.

Notes

To request permissions go to:
http://group.bmj.com/group/rights-licensing/permissions

To order reprints go to:
http://journals.bmj.com/cgi/reprintform

To subscribe to BMJ go to:
http://group.bmj.com/subscribe/