Rituximab as treatment of ocular myasthenia: a case report

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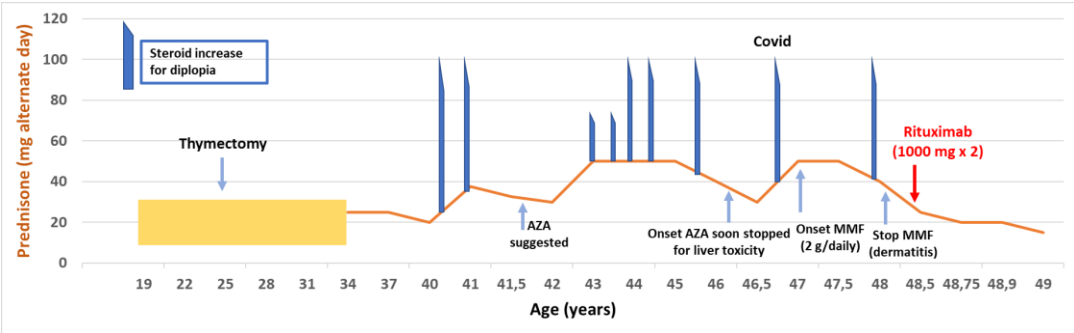
Background: Ocular myasthenia (OMG) is a subtype of MG in which only the ocular muscles are affected. Although ptosis and diplopia can be troublesome, they are usually not life-threatening. Therefore, the role of aggressive immunosuppressive therapies is debated. Rituximab is a monoclonal antibody that target CD20 depleting B cells and their precursors and has been shown to be effective to treat anti-MuSK myasthenia and refractory generalised MG.

Case report: Here we described a 49-year-old man, who experienced an onset of ocular myasthenia at 19 years of age. Diplopia was the main disabling symtom along the 30 years of the disease. Anti-AChR were positive and thymectomy was performed at 25 years of age. Thymic hyperplasia was found. Anticholinesterase inhibitors were not efficacious. Throughout his long illness, he experienced an optimal response with corticosteroids, but relapses occurred frequently. Over the last 10 years, one or two relapses per year occurred, with a transient increase in steroid dosage to 50 mg daily, followed by a slow tapering. In the last five years it was difficult to reduce steroids under 50 mg alternate day. In the meanwhile thyroiditis occurred. The patient was reluctant to begin other immunosuppressive therapies until the side effects of long-term steroid use, such as osteoporosis and skin fragility (thin skin and bruising) began. AZA was started at 46 years of age but soon stopped for elevated transaminases. MMF was not efficacious. A first cycle of rituximab was administered. Since then, after 12 months, he is in pharmacological remission; no further RTX infusions were necessary, and CD19s are still absent, steroids were reduce to 20 mg ADy.



Conclusions and discussion: There are very few case reports in the literature of ocular myasthenia treated with RTX, but the outcome is usually very good. Here, we report another case of ocular myasthenia with a good response to steroids, but with chronic side effects and inefficacy or intolerance to other immunosuppressive drugs. RTX was administered with rapid remission and reduction of the steroid dose over 50% and stable remission after 1 year without reinfusion.