Stridor as a Neonatal Presentation of Skeletal Muscle Sodium Channelopathy

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Objective: To describe stridor as the presenting feature in a neonate with the skeletal muscle sodium channelopathy paramyotonia congenita.

Design: Case report.

Setting: Outpatient neuromuscular clinics at Great Ormond Street Hospital for Children and the Medical Research Council Centre for Neuromuscular Disease at the National Hospital for Neurology and Neurosurgery, London, England.

Patient: A child carrying the Thr1313Met SCN4A mutation associated with paramyotonia congenita.

Intervention: Supportive care in the neonatal period and administration of mexiletine hydrochloride at age 4 years.

Main Outcome Measure: The association of stridor and paramyotonia congenita was made retrospectively following the diagnosis in the infant’s mother; the child is now regularly reviewed at the pediatric outpatient clinic.

Results: Persistent stridor was present for the first 6 months of life, and episodic stridor can still be exacerbated by intercurrent respiratory tract infection, cold, laughter, or crying. Common symptoms of paramyotonia congenita have been apparent from age 1 year and are beginning to respond to a recent trial of mexiletine.

Conclusions: To our knowledge, neonatal stridor has not previously been reported in skeletal muscle sodium channelopathies. The recognition that infants inheriting mutations known to cause paramyotonia congenita are inherently at risk for developing neonatal complications following an uneventful labor is important for all training neurologists so they can advise expectant mothers and pediatric and obstetric colleagues appropriately.

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PARAMYOTONIA CONGENITA (PMC) is a skeletal muscle sodium channelopathy due to mutations in the SCN4A gene (GenBank AA083647) that lead to dysfunction of the voltage-gated sodium channel Nav1.4 and altered sarcolemmal excitability. Clinical symptoms of episodic muscle stiffness (myotonia due to a hyperexcitable membrane) and muscle weakness (an inexcitable membrane) reflect this. Affected mothers are counseled and monitored for the possibility of perinatal complications such as generalized muscle paralysis or a myotonic crisis that may place the neonate and mother at risk for a prolonged and difficult labor. Neonatal presentations varying from hypotonia to a fatal outcome have only recently been described and attributed to the presence of an SCN4A mutation in the child irrespective of the mother’s genetic predisposition or progress of labor. Herein, we expand these presentations further by describing neonatal stridor in an infant carrying the Thr1313Met SCN4A mutation associated with PMC.

A 4-year-old boy was referred to pediatric services following the diagnosis of PMC in his mother. He was the mother’s second child and was born by vacuum-assisted delivery at 39 weeks following an uncomplicated pregnancy. The Apgar scores were normal and postnatal examination results were unremarkable. Within 24 hours of delivery, he was transferred to the neonatal intensive care unit owing to inspiratory stri-
Paramyotonia congenita is a dominantly inherited neuromuscular disorder caused by mutations in the SCN4A gene that encodes the α subunit of the skeletal muscle voltage-gated sodium channel. These mutations result in altered skeletal muscle membrane excitability. Nav1.4 is expressed in all skeletal muscles, including those of the larynx. Typically, PMC presents in the first decade of life with cold- and exercise-induced episodic muscle stiffness (myotonia) and muscle weakness, predominantly affecting the muscles of the face and upper limbs.

Hyperkalemic periodic paralysis is a dominantly inherited disorder that is allelic to PMC and is characterized by episodes of muscle weakness and myotonia, although weakness is the predominant symptom. In both hyperkalemic periodic paralysis and PMC, mutations result in gain-of-function sodium channel defects. It has been proposed that the two disorders reflect ends of a spectrum of the same disease.²

Stridor has been described in both neonates and adults with myotonic dystrophy.³ In addition, there are several reports of stridor in American Quarter Horses affected by the equine form of hyperkalemic periodic paralysis. In one series, 63 of 68 affected horses had stridor in association with exertion, muscle weakness, or excitement.⁷ There is also a case report of an adult with PMC in whom provocative testing with muscle cooling induced severe laryngeal myotonia with stridor.⁸

We suggest that it is likely the stridor reflects myotonia of the laryngeal muscles. In addition, the child described here experienced feeding and respiratory difficulties; these were also noted in our previously reported cases of hypotonia,¹ suggesting that these are common neonatal features of PMC. Dysphagia and respiratory compromise are rarely reported in adult cases.

The present cases of neonatal stridor add to our recent report of neonatal hypotonia with the PMC sodium channel mutation Ile693Thr.¹ Taken together, these observations indicate that offspring of parents with sodium channel mutations are at risk for neonatal complications. While idiopathic causes of stridor are not excluded in these infants, we suggest that treating neurologists should be aware of the possibility of laryngeal myotonia and the other described complications so they can counsel mothers and avoid unnecessary investigations of affected neonates.

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REFERENCES


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