

## MYOTONIC DYSTROPHY TYPE 1 (DM1)



### ACUTE RESPIRATORY INSUFFICIENCY

- Respiratory complications are **frequent**. Respiratory muscles weakness can compromise pump function of the respiratory system, upper airway muscles tone and efficiency of secretion clearance. The respiratory consequences are **secretion retention, upper airway obstruction, nocturnal and finally daytime hypoventilation. Central sleep apnoea** are also reported.
- **Respiratory infections** (i.e., tracheobronchitis or pneumonia) are the most frequent cause of acute respiratory failure and require early management. Low threshold for empiric antibiotic therapy is recommended for chest infections.
- If no infectious cause of acute respiratory failure is evident, consider non-infectious causes (e.g., **pneumothorax or atelectasis**). Cardiogenic pulmonary oedema should be also ruled out.
- Collect respiratory symptoms and **monitor SpO<sub>2</sub> levels via pulse oximetry**; even mild hypoxaemia (e.g., SpO<sub>2</sub> <95% in room air) is a concern and requires a chest x-ray and a blood gas analysis test. Chest x-ray may be difficult to interpret, especially in the presence of scoliosis. In this case chest CT scan may be useful in order to rule out pneumothorax, pneumonia or atelectasis. If even chest CT scan does not show any cause for acute RF, it is useful to deepen the examination by administering contrast medium to exclude a pulmonary thromboembolism.
- **NIV** is often required. In addition, assisted coughing (i.e., breath-stacking techniques with an Ambu bag combined with compression of the chest wall or abdomen) or cough assist device (**MI-E**) help to clear airways secretions. Use the patient's home equipment when available.
- **O<sub>2</sub>** must never be used without associating it with NIV. If supplemental oxygen is required titrate oxygen therapy to achieve SpO<sub>2</sub> 94-98% and monitor CO<sub>2</sub>.
- In case of an acute, reversible event **intubation** and invasive ventilation is indicated when NIV failure occurs (unless there is a known advance directive stating otherwise). When indicated tracheal intubation must not be delayed. Consider that in these patients tracheal intubation may be difficult due to jaw ankylosis, atrophy of the masseter muscle and/or other masticatory muscles, macroglossia or limited mobility of the cervical spine.
- After recovery from the acute illness, these patients should be **promptly extubated to NIV combined with MI-E**. Tracheotomy can be evaluated in particular in patients with severe bulbar dysfunction. However, in the acute phase it should be considered only in the case of multiple failures of weaning protocol including preventive application of NIV combined with MI-E after extubation.



### CHOKING DUE TO SWALLOWING DIFFICULTIES

- Swallowing difficulties are very frequent. Signs and symptoms of swallowing difficulties such as a meal time longer than 30 minutes, **recurrent chest infections**, unintentional weight loss, and **choking** when eating or drinking should be considered.
- Severe bulbar dysfunction increases the patient risk for **aspiration** and hampers the elimination of airway secretions. In addition, it may impede successful use of NIV.
- In case of choking use **MI-E** or manual assisted coughing; if it is ineffective consider **emergent tracheal intubation**.



## ACUTE CARDIAC COMPLICATIONS

- **Conduction defects and arrhythmia** are very frequent. Dilated cardiomyopathy is occasional. However, clinical manifestations of heart failure are often unrecognized until very late, owing to musculoskeletal limitations.
- Consider worsening cardiomyopathy and rule out congestive heart failure, atrio-ventricular blocks and arrhythmias.
- Ask for the patient's baseline test results, including echocardiogram and electrocardiogram.
- Obtain a brief history with a focus on baseline cardiac status, including use of medications.
- Ask about cardiac symptoms and **monitor heart rate rhythm, blood pressure and SpO<sub>2</sub>**.
- Measure blood levels of **B-type natriuretic peptide** and obtain an **electrocardiogram**; a chest radiograph and/or chest ultrasound may be useful if pulmonary oedema is suspected.
- Obtain an **echocardiogram** and early consultation with a cardiologist.
- In these patients blood level of cardiac Troponin T (cTnT) may be chronically high, while blood level of cardiac Troponin I (cTnI) are more rarely high. Consequently, in the case of suspected myocarditis or myocardial ischemia, it is recommended to measure cTnI.



## ANAESTHETIC PRECAUTIONS AND PERIOPERATIVE MANAGEMENT

- Ideally, surgery should occur in a specialist centre with staff experienced in managing these individuals. Otherwise, the urgent surgical interventions may be performed in non-specialized centres following recommendations regarding anaesthesia and perioperative management.
- Obtain a preoperative evaluation including **lung function tests and cough assessment**; if respiratory muscle weakness is present (i.e., forced vital capacity less than 50% of predicted value or peak cough less than 270 l/min), familiarization with ventilatory support (i.e., MI-E and NIV) should be warranted prior to procedure whenever possible.
- Patients should also undergo careful **assessment of heart function** as well as optimization of cardiac therapies in the preoperative period. An electrocardiogram and echocardiogram should be performed before anaesthesia.
- **Use of succinylcholine and inhaled anaesthetics must be avoided** to prevent rhabdomyolysis.
- They may experience increased **sensitivity to sedatives, anaesthetics agents and muscle relaxants**; thus, the depth of anaesthesia and the neuromuscular function should be monitored in order to titrate the appropriate dose of those drugs. In addition, the effect of muscle relaxants should be completely reversed at the end of surgery (i.e., rocuronium should be used and must be reversed by sugammadex).
- **Tracheal intubation may be difficult** in patients with NMDs and frequent use of fiberoptic-assisted endotracheal intubation is reported.
- The use of **regional or local anaesthesia** offers a significant advantage in term of avoidance of general anaesthesia and reduction of postoperative respiratory complications.
- **Morphine** infusions should be avoided, mainly in patients with reduced respiratory function or obstructive sleep apnoea.
- Admission to an **Intensive Care Unit** should be considered in any patient who is at risk for respiratory or cardiac complications. Patients with decreased respiratory muscle strength require close monitoring and aggressive postoperative respiratory management including **early extubation to NIV with aggressive use of MI-E**. O<sub>2</sub> must never be used without associating it with NIV.



## ANAESTHETIC PRECAUTIONS AND PERIOPERATIVE MANAGEMENT

- In these patients respiratory insufficiency may be caused both by weakness or myotonic reactions, which may involve laryngeal and respiratory. Many factors like hypothermia, postoperative shivering, dyskalemia, mechanical and electrical stimulation or drugs (i.e., propranolol, succinylcholine and anticholinesterase agents) can precipitate myotonic contractures. Myotonia occurs for an intrinsic change in the muscle and not in the peripheral nerve or neuromuscular junction. Thus, it cannot be abolished by peripheral nerve blockades or neuromuscular blockers. Myotonia may be treated with **midazolam**, otherwise the treatment is mainly preventive, avoiding all triggering factors.



## FALLS AND FRACTURES

- Owing to weakness, contractures and poor balance, patients with NMDs are at high risk of frequent falls. On the other hand, osteoporosis increases the risk of fractures.
- In ambulatory adult patients, **internal fixation** of femoral fracture is preferable to **conservative treatment** because it allows early walking recovery, preserving muscle function.
- In non-ambulatory adult patients, **conservative treatment** can be considered in case of non-displaced sub capital femoral neck fracture. On the contrary, in diaphyseal or trochanteric femoral fracture **internal fixation is required**.
- In paediatric patients the treatment of femoral fractures is strictly related with the age of the child, the site of the fracture and the disability related to muscle weakness. **Conservative treatment** can be considered in patients under 5-6 years of age, with non-displaced fractures and when a short period of immobilization is expected. In the other cases surgical fixation using **minimally invasive techniques is preferred** (e.g., percutaneous fixation by Kirshner wires and plaster casts, Flexible Intramedullary Nailing or light external fixators).



## ACUTE CONSTIPATION DUE TO BOWEL DYSFUNCTION

- Some patients can experience constipation due to abnormal gastrointestinal motility.
- **Gastric and/or abdominal distention** may cause acute respiratory failure in patients at high risk of respiratory complications. In these cases, gastrointestinal decompression by using of a nasogastric tube and/or rectal tubes is often an effective therapy.



## AOTHER ISSUES

- In these patients blood levels of **transaminases and creatine kinase** may be increased. If other hepatic function tests (e.g., bilirubin and gamma GT) are normal, this pattern doesn't necessarily reflect hepatopathy and may be due to muscle involvement.
- DM1 may be associated with insulin resistance and cataract.
- Intellectual impairment and cognitive dysfunction are often present.
- **Excessive daytime sleepiness** (EDS) is common and is most often owing to CNS involvement. Sleep apnoea and chronic respiratory failure also need to be considered and sleep study should be considered to assess possible obstructive sleep apnoea and CNS mediated sleep apnoea.

### BIBLIOGRAPHIC REFERENCE

Racca F et al. Emergencies cards for neuromuscular disorders 1st Consensus Meeting from UILDM - Italian Muscular Dystrophy Association Workshop report. Acta Myol. 2022 Dec 31;41(4):135-177.