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**DEVELOPMENT OF MYASTHENIA GRAVIS IN PATIENT WITH SYSTEMIC LUPUS** **ERYTHEMATOSUS : A Rare Association**

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**Introduction**

Systemic lupus erythematosus (SLE) is an autoimmune disease that can affect the central and peripheral nervous systems, particularly through cerebral vasculitis. Myasthenia gravis (MG) is a neuromuscular autoimmune disorder caused by autoantibodies targeting the neuromuscular junction (AM). The coexistence of these two conditions is rare and poses significant diagnostic and therapeutic challenges.

We present a case illustrating this clinical and diagnostic complexity.

**Objective**

This case aims to illustrate the complexity and clinical implications of the development of MG in a patient with SLE.

**Methods**

A **36-year-old female** with **active SLE** (cutaneous, articular, pleuritic, and pericardial involvement) on hydroxychloroquine and immunosuppressants.

In **2022**, she developed progressive neuromuscular symptoms: Bilateral asymmetric ptosis, worsened by the Marie Walker test, improved by the ice pack test Vertical binocular diplopia

Global limitation of extraocular movements, Reduced eyelid closure, Proximal muscle fatigue

**Results**

Neurological examination and electrophysiological studies confirmed a diagnosis of MG, generalized myasthenic syndrome (score 60/100, MGFA IIIa) supported by a neostigmine test and the detection of Anti-muscle-specific kinase (anti-MuSK) antibodies

The patient required immunosuppressive therapy adjustments, including corticosteroids and acetylcholinesterase inhibitors (pyridostigmine), leading to clinical improvement.

In 2024, a thymectomy was performed, complicated by subclavian vein thrombosis requiring anticoagulation with vitamin K antagonists (VKAs).

The clinical course was marked by **cerebral vasculitis complicated by encephalomalacia,** necessitating intensive immunosuppression.

**Conclusion**

The association of SLE and MG is uncommon and should be suspected in cases of unexplained neuromuscular involvement in lupus patients.

Early screening and rigorous multidisciplinary follow-up are essential to prevent neurological and thromboembolic complications due to overlapping symptoms and potential treatment interactions.

