INTRODUCTION
Myasthenia gravis (MG) is a relatively rare autoimmune disorder in which antibodies form against acetylcholine nicotinic postsynaptic receptors at the neuromuscular junction of skeletal muscles. The usual initial complaint is a specific muscle weakness that progresses to the more severe generalized form in most patients, producing severe muscular deterioration.[1,2] Thymic abnormalities are common: of patients with MG, 75% have thymic disease, 85% have thymic hyperplasia, and 10-15% have thymoma.[3]

AIM
The aim of our poster is to present several cases of Myasthenia gravis (MG) patients with head and neck manifestations including ptosis, laryngeal paresis, dysphagia, velopharyngeal insufficiency and hypernasality.

MATERIALS AND METHODS
These MG patients were referred to our clinic in 2015 for evaluation on the account of their complaints. Among the used methods were full neurological and ENT examinations, CT scan of neck and mediastinum (one had untreated thymoma), fibrolaryngoscopy, serological testing for AChR antibodies.

Case 1
A 59 yo male patient presenting with a newly diagnosed MG (tested positive for AChR antibodies) with left eye ptosis, dysphonia and slight dysphagia. He had had these symptoms for a few days.

Case 2
A 64 yo female patient with multiple co-morbidities among which diabetes, chronic heart failure and hypertension. Diagnosed with MG ten years ago; main head and neck complaints: foreign body sensation in the throat, mild dysphagia and voice weakness.

Case 3
A 36 yo male patient presenting with dysphonia, dysphagia and hypernasality. He was diagnosed with MG and underwent a thymectomy in 2004. He had not been on any medication for a few years. He was treated with corticosteroids for 3 weeks and then started taking pyridostigmine regularly with some improvement.

DISCUSSION AND CONCLUSION
Although rare, MG should always be considered in the differential diagnosis of the neurological disorders of the head and neck region and it has to be distinguished from cranial nerve neuropathies and other infectious and non-infectious diseases that cause dysphonia, dysphagia, etc. As far as the head and neck region is concerned, most common is extracranial muscle weakness or ptosis - present initially in 50% of patients and occurs during the course of illness in 90%; weakness of the facial muscles is almost always present. Laryngeal involvement manifests with flaccid paresis and dysphonia. Patients can also have dysphagia, hypernasality, and velopharyngeal insufficiency. Diagnosis is based on the highly specific anti-acetylcholine receptor (AChR) antibody test [4] and additional CT chest scan to rule out thymoma. The disease is comparatively well-managed by the use of anticholinesterase (AchE) inhibitors, Immunomodulating agents, intravenous immune globulin (IVIg), plasmapheresis and thymectomy. [5]

References