The fact that attacks are precipitated by potassium administration best defines the disease. The onset is in the first decade; males and females are affected equally. Attacks are brief and mild, usually lasting 30 min to 4 ho. Weakness affects proximal muscles, sparing bulbar muscles. Attacks are precipitated by rest following exercise and fasting. In a variant of this disorder, the predominant symptom is myotonia without weakness (*potassium-aggravated myotonia*). The symptoms are aggravated by cold, and myotonia makes the muscles stiff and painful. This disorder can be confused with paramyotonia congenita, myotonia congenita, and proximal myotonic myopathy (DM2).

Potassium may be slightly elevated but may also be normal during an attack. As in HypoKPP, nerve conduction studies in HyperKPP muscle may demonstrate reduced motor amplitudes and the EMG may be silent in very weak muscles. In between attacks of weakness, the conduction studies are normal. The EMG will often demonstrate myotonic discharges during and between attacks.

The muscle biopsy shows vacuoles that are smaller, less numerous, and more peripheral compared to the hypokalemic form or tubular aggregates. Provocative tests by administration of potassium can induce weakness but are usually not necessary to establish the diagnosis. HyperKPP and potassium-aggravated myotonia are inherited as autosomal dominant disorders. Mutations of the voltage-gated sodium channel *SCN4A* gene (Fig. 462e-8) cause these conditions. For patients with frequent attacks, acetazolamide (125–1000 mg/d) is helpful. We have found mexiletine to be helpful in patients with significant myotonia.

Paramyotonia Congenita In paramyotonia congenita (PC), the attacks of weakness are cold-induced or occur spontaneously and are mild. Myotonia is a prominent feature but worsens with muscle activity (paradoxical myotonia). This is in contrast to classic myotonia in which exercise alleviates the condition. Attacks of weakness are seldom severe enough to require emergency room treatment. Over time patients develop interattack weakness as they do in other forms of periodic paralysis. PC is usually associated with normokalemia or hyperkalemia.

Serum CK is usually mildly elevated. Routine sensory and motor nerve conduction studies are normal. Short exercise test may be abnormal however, and cooling of the muscle often dramatically reduces the amplitude of the compound muscle action potentials. EMG reveals diffuse myotonic potentials in PC. Upon local cooling of the muscle, the myotonic discharges disappear as the patient becomes unable to activate MUAPs.

PC is inherited as an autosomal dominant condition; voltage-gated sodium channel mutations (Fig. 462e-8) are responsible, and thus this disorder is allelic with HyperKPP and potassium-aggravated myotonia. Patients with PC seldom seek treatment during attacks. Oral administration of glucose or other carbohydrates hastens recovery. Because interattack weakness may develop after repeated episodes, prophylactic treatment is usually indicated. Thiazide diuretics (e.g., chlorothiazide, 250–1000 mg/d) and mexiletine (slowly increase dose from 450 mg/d) are reported to be helpful. Patients should be advised to increase carbohydrates in their diet.

POTASSIUM CHANNEL DISORDERS

Andersen-Tawil Syndrome This rare disease is characterized by episodic weakness, cardiac arrhythmias, and dysmorphic features (short stature, scoliosis, clinodactyly, hypertelorism, small or prominent low-set ears, micrognathia, and broad forehead). The cardiac arrhythmias are potentially serious and life threatening. They include long QT, ventricular ectopy, bidirectional ventricular arrhythmias, and tachycardia. For many years, the classification of this disorder was uncertain because episodes of weakness are associated with elevated, normal, or reduced levels of potassium during an attack. In addition, the potassium levels differ among kindreds but are consistent within a family. Inheritance is autosomal dominant, with incomplete penetrance and variable expressivity. The disease is caused by mutations of the inwardly rectifying potassium channel (*Kir 2.1*) gene that heighten muscle cell excitability. The treatment is similar to that for other forms of periodic paralysis and must include cardiac monitoring. The episodes of weakness may differ between patients because of potassium variability. Acetazolamide may decrease the attack frequency and severity.

CHLORIDE CHANNEL DISORDERS

Two forms of this disorder, autosomal dominant (*Thomsen's disease*) and autosomal recessive (*Becker disease*), are related to the same gene abnormality. Symptoms are noted in infancy and early childhood. The severity lessens in the third to fourth decade. Myotonia is worsened by cold and improved by activity. The gait may appear slow and labored at first but improves with walking. In Thomsen's disease, muscle strength is normal, but in Becker disease, which is usually more severe, there may be muscle weakness. Muscle hypertrophy is usually present. Myotonic discharges are prominently displayed by EMG recordings.

Serum CK is normal or mildly elevated. The muscle biopsy shows hypertrophied fibers. The disease is inherited as dominant or recessive and is caused by mutations of the chloride channel gene (Fig. 462e-8) that increase muscle cell excitability. Many patients will not require treatment and learn that the symptoms improve with activity. Medications that can be used to decrease myotonia include quinine, phenytoin, and mexiletine.

ENDOCRINE AND METABOLIC MYOPATHIES

Many endocrine disorders cause weakness. Muscle fatigue is more common than true weakness. The cause of weakness in these disorders is not well defined. It is not even clear that weakness results from disease of muscle as opposed to another part of the motor unit, since the serum CK level is often normal (except in hypothyroidism) and the muscle histology is characterized by atrophy rather than destruction of muscle fibers. Nearly all endocrine myopathies respond to treatment.

THYROID DISORDERS

(See also Chap. 405) Abnormalities of thyroid function can cause a wide array of muscle disorders. These conditions relate to the important role of thyroid hormones in regulating the metabolism of carbohydrates and lipids as well as the rate of protein synthesis and enzyme production. Thyroid hormones also stimulate calorigenesis in muscle, increase muscle demand for vitamins, and enhance muscle sensitivity to circulating catecholamines.

Hypothyroidism Patients with hypothyroidism have frequent muscle complaints, and proximal muscle weakness occurs in about one-third of them. Muscle cramps, pain, and stiffness are common. Some patients have enlarged muscles. Features of slow muscle contraction and relaxation occur in 25% of patients; the relaxation phase of muscle stretch reflexes is characteristically prolonged and best observed at the ankle or biceps brachii reflexes. The serum CK level is often elevated (up to 10 times normal), even when there is minimal clinical evidence of muscle disease. EMG is typically normal. The cause of muscle enlargement has not been determined, and muscle biopsy shows no distinctive morphologic abnormalities.

Hyperthyroidism Patients who are thyrotoxic commonly have proximal muscle weakness and atrophy on examination, but they rarely complain of myopathic symptoms. Activity of deep tendon reflexes may be enhanced. Bulbar, respiratory, and even esophageal muscles may occasionally be affected, causing dysphagia, dysphonia, and aspiration. When bulbar involvement occurs, it is usually accompanied by chronic proximal limb weakness, but occasionally it presents in the absence of generalized thyrotoxic myopathy. Fasciculations may be apparent and, when coupled with increased muscle stretch reflexes, may lead to an erroneous diagnosis of amyotrophic lateral sclerosis. A form hypokalemic periodic paralysis can occur in patients who are thyrotoxic. Recently, mutations in the *KCNJ18* gene that encodes for the inwardly rectifying potassium channel, Kir 2.6, have been discovered in up to a third of cases. Other neuromuscular disorders that occur in association with hyperthyroidism include myasthenia gravis (Chap. 461) and a progressive ocular myopathy associated with proptosis (*Graves' ophthalmopathy*). Serum CK levels are not elevated in thyrotoxic myopathy, the EMG is normal, and muscle histology usually shows only atrophy of muscle fibers.