Isaacs syndrome: the frontier of neurology, psychiatry, immunology and cancer

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A syndrome of continuous muscle-fibre activity
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produced by sodium diphenyl hydantoate (phenytoin) treatment.

Over the past 60 years, while we have learnt much more about the pathophysiology of Isaacs syndrome, there are still many elements that remain unresolved. A critical factor in understanding the Isaacs jigsaw puzzle came with the identification of the autoimmune basis for the disorder by the group led by John Newsom-Davis and Angela Vincent.2 The demonstration of pathogenic immunoglobulin G (IgG) autoantibodies in a patient with severe Isaacs syndrome refractory to treatment, and the successful use of plasma exchange to ameliorate symptoms,2 highlighted the role of the immune system in the syndrome and provided another avenue of treatment approaches.

Presently, autoantibodies are identified in a significant proportion (45–50%) of Isaacs syndrome patients.3 4 These were initially considered to be antibodies against voltage-gated potassium channels (VGKC), but in the past 10 years the molecular identity of these autoantibodies has been further clarified, with targets revealed to be VGKC-complex proteins including contactin-associated protein 2 (CASPR2) and leucine-rich glioma inactivated 1 (LGI1).5 6 The molecular identification of these antibodies has revealed a spectrum of overlapping disorders from Isaacs syndrome, through to Morvan’s syndrome and limbic encephalitis.7 8 However, the lack of specific antibody targets in the remaining patients suggests that there are likely to be additional autoantibody targets yet to be discovered.

In addition to the classical muscle symptoms of Isaacs syndrome, there is a spectrum of autonomic and central nervous system (CNS) involvement that link Isaacs syndrome to other autoimmune disorders. Sensory symptoms including paraesthesia and pain and autonomic disturbance including excessive sweating, tachycardia or diarrhoea are reported by almost half of patients.9 CNS symptoms are also prominently reported including insomnia, personality and mood changes, anxiety and depression.3 4 There is no specific association of autoantibody type with clinical symptoms—while LGI1 antibodies are primarily associated with limbic encephalitis and CNS involvement, 31% of patients display peripheral involvement including hyperexcitability or neuropathic pain in >20%.10 Similarly, CASPR2 antibodies are associated with both CNS and peripheral-predominant clinical presentations,9 and associated with neuromyotonia in <40% of cases.10 Further clinical and molecular phenotyping of large-scale cohorts will be necessary to determine specific associations with neuromyotonia across syndromes.

Underlying the immune basis of Isaacs syndrome there is a prominent association with cancer, with 21–25% of Isaacs syndrome patients diagnosed with recent tumours,3 4 highlighting the need to screen carefully for malignancy. In particular, CASPR2 antibodies are associated with thymoma in 20% of cases.10 The association with cancer suggests that Isaacs syndrome can develop through paraneoplastic mechanisms, with tumour-associated antigens triggering an autoimmune response via cross-reacting antibodies with nerve related epitopes.7

In terms of understanding the clinical hallmark of Isaacs syndrome, namely continuous muscle activity, the site of origin for this spontaneous activity remains to be determined. The typical patterns of ectopic activity (figure 1) do not seem to be caused by a generalised disturbance of motor axon membrane excitability.8 11 12 Most likely, the activity is generated focally, perhaps at the motor nerve terminal which is relatively unprotected by the blood–nerve barrier, making it vulnerable to autoantibody attack. A proximal or central generator of ectopic activity seems less likely, particularly in the context of normal corticomotorneuronal integrity as established in acquired

Figure 1 A raster display of the ectopic activity typical of Isaac’s syndrome, with uniplet, doublet and multiplet discharges recorded at rest. Adapted from Kiernan et al, 2001.11

REFERENCES