


REVIEW OF THE DIAGNOSIS AND TREATMENT OF PERIODIC PARALYSIS

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Accepted 7 November 2017

ABSTRACT: Periodic paralyses (PPs) are rare neuromuscular disorders caused by mutations in skeletal muscle sodium, calcium, and potassium channel genes. PPs include hypokalemic paralysis, hyperkalemic paralysis, and Andersen-Tawil syndrome. Common features of PP include autosomal dominant inheritance, onset typically in the first or second decades, episodic attacks of flaccid weakness, which are often triggered by diet or rest after exercise. Diagnosis is based on the characteristic clinic presentation then confirmed by genetic testing. In the absence of an identified genetic mutation, documented low or high potassium levels during attacks or a decrement on long exercise testing support diagnosis. The treatment approach should include both management of acute attacks and prevention of attacks. Treatments include behavioral

interventions directed at avoidance of triggers, modification of potassium levels, diuretics, and carbonic anhydrase inhibitors.

Muscle Nerve 57: 522–530, 2018

Additional supporting information may be found in the online version of this article.

Funding: N.J. is funded by the NIH, grant #1K23NS091511-01.

Conflicts of Interest: J.S. is a consultant for aTyr, Fulcrum, Acceleron, Strongbridge Biopharma, and Novartis. B.F. has received honoraria from Taro Pharmaceuticals. M.H. is a consultant to Novartis. N.J. serves as Deputy Editor for *Neurology: Genetics*. He has received research support from the Muscular Dystrophy Association, Myotonic Dystrophy Foundation, Valerion Therapeutics, Ionis Pharmaceuticals, and Biogen Idec, and is a consultant for Strongbridge Biopharma. P.S. served on Advisory Boards for Sarepta Therapeutics and Biogen and speakers bureau for Grifols and Biogen. S.C. is a consultant for Strongbridge Biopharma. R.C.G. consults for Medpace, Taro Pharmaceuticals, Marathon Pharmaceuticals, Bamboo Pharmaceuticals, Sarepta Pharmaceuticals, Strongbridge Pharmaceuticals, PTC Therapeutics, and Idera Pharmaceuticals. J.T. is on a Speaker's Bureau for Sanofi. R.T., V.S., and J.T.K. have nothing to disclose.

Abbreviations: CMAP, compound muscle action potentials; ECG, electrocardiographic; EMG, electromyography; FDA, Food and Drug Administration; IV, intravenous; NKCC, Na-K-2Cl; PMC, paramyotonia congenita; PVC, premature ventricular contraction; VT, ventricular tachycardia

Key words: acetazolamide; Andersen-Tawil syndrome; channelopathies; dichlorphenamide; periodic paralyses; review; treatment

This article was published online on 29 November 2017. An error was subsequently identified. This notice is included in the online and print versions to indicate that both have been corrected on 12 March 2018.

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© 2017 The Authors *Muscle & Nerve* Published by Wiley Periodicals, Inc. Published online 10 November 2017 in Wiley Online Library (wileyonlinelibrary.com). DOI 10.1002/mus.26009

PPrimary periodic paralyses (PPs) are rare autosomal-dominant genetic neuromuscular disorders associated with mutations in the skeletal muscle sodium, calcium, and potassium channels.^{1,2} Common to all PP are attacks of muscle paralysis, which may last minutes to hours or days and cause morbidity and impaired quality of life.^{3,4} The attacks are often triggered by behavior or diet, and often are associated with alterations in serum potassium levels. In all forms of PP, ictal paresis is caused by depolarization of the muscle sarcolemma, which in turn causes sodium channel inactivation and reduced fiber excitability.^{1,2}

Primary periodic paralyses include hypokalemic paralysis (HypoPP), hyperkalemic paralysis (HyperPP), and Andersen-Tawil syndrome. There are also closely related diseases whose features overlap with HypoPP and HyperPP, including paramyotonia congenita (PMC) and normokalemic PP. In most instances, these diseases are caused by mutations of the sodium channel. The sodium channel mutations present as a spectrum of disorders, ranging from pure myotonic disorders to disorders which primarily have myotonia with episodic weakness (e.g., PMC) to disorders with primary episodic weakness with occasional myotonia (HyperPP and normokalemic PP). There is some overlap, and the determination of whether to classify a disorder as PMC or HyperPP will depend on the predominant symptoms. Estimated prevalences for the periodic paralyses are 1 per 200,000 for HyperPP,^{5,6} 1 per 100,000 for HypoPP,^{5,7} and 1 per 1,000,000 for Andersen-Tawil syndrome,⁸ although a study in the United Kingdom identified a lower prevalence for many of the channelopathies.⁹ Nevertheless, these diseases are rare in the general population and

Table 1. Clinical presentation of PPPs

Feature	HypoPP	HyperPP	Andersen-Tawil syndrome
Ictal K ⁺ level	Low	High/normal	Variable
Age at onset	Age 5–35 y	Before age 20 y	Age 2–18 y
Mean duration of episodes	>2 h	<2 h	1 to 36 h
Muscle stiffness	Absent	Moderate	Absent
Episodic weakness	Yes	Yes	Yes
Maximum weakness	Severe	Mild to severe	Moderate
Characteristic facies	Absent	Absent	Present
Arrhythmias	Absent	Absent	Long QT arrhythmia

as a consequence prospective clinical studies of treatment interventions are limited.

Treatment options include avoidance of triggers, potassium supplementation to increase potassium levels, and carbonic anhydrase inhibitors. Because of the low prevalence of primary PP and limited treatment options, few prospective studies are available to guide management recommendations, which are primarily based on anecdotal evidence and patient case reports.

This review addresses the diagnosis and treatment of primary PP. The recommendations are based on published literature and on experience of clinicians in managing patients with PP.

TYPES OF PRIMARY PERIODIC PARALYSIS

Most individuals with primary PP have inherited autosomal dominant disorders; sporadic cases also occur, although the frequency is unknown.¹⁰ While all of the familial disorders can be attributed to genetic mutations in muscle ion channels, they differ in their genetics, signs and symptoms, and treatment.

HypoPP is associated with mutations in calcium channel (*CACNA1S*; 60% of kindreds) and sodium channel (*SCN4A*; 20% of kindreds) genes.^{11–15} The clinical presentation is identical for patients with HypoPP caused by calcium or sodium channel mutations because homologous gene defects of either channel cause an anomalous leakage current, which is active at the resting potential and produces susceptibility to paradoxical depolarization of the fiber and inexcitability in the setting of low extracellular K⁺ (2.5 to 3.5 Meq/L).^{1,12}

HyperPP is associated with mutations in the sodium channel (*SCN4A*) gene on chromosome 17q23.^{11–15} These mutations are associated with gain of function changes, usually from impaired channel inactivation or occasionally from enhanced activation.

Andersen-Tawil syndrome in some cases is caused by mutations of the *KCNJ2* gene, which encodes the inward rectifier potassium channel, Kir2.1, stabilizing resting potential of skeletal muscle and cardiac myocytes.⁸ Unlike HypoPP and HyperPP, which are limited to mutations in channels expressed almost exclusively in skeletal muscle, the potassium channel mutations

leading to Andersen-Tawil syndrome affect multiple tissues, and are associated with a highly variable phenotype of periodic paralysis, cardiac arrhythmia, and distinctive facial and skeletal anomalies.^{2,16}

GENERAL CLINICAL PRESENTATION

Patients with PP experience an onset of signs and symptoms typically beginning in the first or second decade of life (Table 1). Patients generally present with intermittent attacks of focal or generalized muscle weakness, often precipitated by triggers.^{10,17,18} Patients can develop between-attack weakness of varying severity, and the majority of affected individuals manifest persistent weakness later in life.^{19–21}

In addition to its effects on strength, PP is associated with impairments of quality of life due to muscle weakness, myotonia, fatigue, loss of energy, and a reduced ability to participate in social and family life, including school and sporting activities.^{3,4}

The effect of PP on quality of life was assessed from patient surveys and a clinical study.^{3,4,22} An online survey of 66 patients with HypoPP (46), HyperPP (6), PMC (4), Andersen-Tawil syndrome (6), or unknown cause (4) found permanent weakness in 68%, muscle pain in 82%, and muscle fatigue in 89%.³ Beginning at age 18–35 years, 83% self-reported that they were moderately to very active compared with 14% at the time of the survey (mean age, 60 years), 67% incurred injuries due to falls, and 49% required mobility aids. Sansone et al⁴ assessed quality of life in 66 patients with skeletal muscle channelopathies including 26 patients with periodic paralysis and 4 with Andersen-Tawil syndrome. Quality of life was impaired in all patients, but especially impacted were muscle weakness in HypoPP patients, myotonia in HyperPP patients, fatigue in Andersen-Tawil syndrome, and energy in all patients.

Clinical Presentation of HypoPP. HypoPP is characterized by focal or generalized paralytic episodes of skeletal muscle, which can last hours to days and are associated with concomitant hypokalemia (<2.5 mEq/L). A variable myopathy develops in many affected individuals and may result in a progressive muscle weakness predominantly in proximal muscle

groups of the lower limbs. The myopathy may occur independent of paralytic symptoms.⁶ Patients with HypoPP are at increased risk for pre- or postanesthetic weakness. Late-onset proximal myopathy may develop in some patients.²

The first attack usually occurs between ages 5 and 35 years, but the frequency of attacks is highest between ages 15 and 35 years and subsequently decreases with age.^{1,10} Acute attacks occur repeatedly at daily, weekly or monthly intervals and typically last several hours and sometimes days. Attacks can occur both spontaneously, but also in response to triggers such as carbohydrate-rich meals, alcohol, and rest after strenuous exercise.^{1,10}

Clinical Presentation of HyperPP. Characteristic features of HyperPP are attacks of limb weakness and an increase of serum potassium during an attack, but some patients have normal serum potassium levels during attacks.²³ Administration of potassium may trigger an attack or worsen an ongoing episode.

Attacks of muscle weakness begin in the first decade of life in approximately 50% of patients, with only 25% reporting their first attack at age ≥ 10 years. Attacks may be triggered by potassium-rich food, rest after exercise, fasting, exposure to cold, emotional stress or pregnancy and often begin in the morning lasting up to 2 h.^{1,10} Between attacks, approximately half of patients with HyperPP experience muscle stiffness arising from myotonia or paramyotonia that does not impede voluntary movements. More than 80% of patients older than 40 years with HyperPP experience permanent muscle weakness, and one third develop chronic progressive myopathy. Attacks in HyperPP tend to be more frequent and shorter in duration than attacks in HypoPP.¹⁸ Patients with PMC complain of muscle stiffness, often exacerbated by cold temperatures that may progress to weakness.¹⁸

Clinical Presentation of Andersen-Tawil Syndrome. Andersen-Tawil syndrome is characterized by a triad of episodic flaccid muscle weakness (periodic paralysis), cardiac abnormalities (ventricular arrhythmias, prolonged QT interval, and prominent U waves), and distinctive skeletal features (low-set ears, ocular hypertelorism, small mandible, fifth-digit clinodactyly, syndactyly, short stature, scoliosis, and a broad forehead).^{16,24} This characteristic triad is present in 58–78% of patients with *KCNJ2* mutations.^{25,26} Those affected typically present in the first or second decade with either cardiac symptoms (palpitations and/or syncope) or weakness that occurs spontaneously following prolonged rest or following rest after exertion. Permanent weakness is common. Attacks of muscle weakness can be associated with high, low or normal serum potassium levels.¹⁶

Andersen-Tawil syndrome is a potentially fatal condition.^{27–29} In patients with the *KCNJ2* gene mutation, ventricular arrhythmias are common (Table 1).^{27–29} Cardiac manifestations of Andersen-Tawil syndrome include premature ventricular contractions (PVCs), complex ventricular ectopy (bigeminy, consecutive PVCs, or multifocal PVCs), polymorphic ventricular tachycardia (VT), and bidirectional VT.²⁹ Despite the common occurrence of ventricular arrhythmias, syncope or cardiac arrest is rare.^{27,30} Early identification and diagnosis of these patients is important for treatment optimization.

DIAGNOSIS

The diagnosis of PP can be confirmed by genetic testing, which we recommend as the first diagnostic step when there is an intermediate-to-high clinical suspicion.³¹ All PPs are inherited in an autosomal dominant manner. Genetic testing identifies a heterozygous pathogenic mutation in 60% to 70% of patients meeting clinical criteria.^{15,17} For HypoPP, the gene is *CACNA1S* ($Ca_v1.1$) or *SCN4A* and the chromosome is 1q31-32 or 17q23-25; for HyperPP, the gene is *SCN4A* ($Na_v1.4$) and the chromosome is 17q23-25; and for Andersen-Tawil syndrome, the gene is *KCNJ2* (Kir2.1) and the chromosome is 17q23. Several mutations have been associated with thyrotoxic HypoPP, most commonly *KCNJ18*, which may be seen in up to 3% of patients with HypoPP,³² and *KCNE3*, which was originally associated with HypoPP, but whose association is currently controversial.¹⁴ More recently mutations in the gene *KCNJ5* have been implicated in one family with Andersen-Tawil syndrome, and then subsequently found in 1/21 gene negative Andersen-Tawil syndrome, but this will require verification in separate cohorts.³³

In the absence of an identified genetic mutation in approximately 30% of patients, periodic paralysis subtypes can be distinguished on the basis of clinical presentation, serum potassium levels during attacks, and pattern of abnormalities on long exercise testing.^{10,15,23,31,34} If primary PP is suspected but cannot be confirmed by genetic testing, further examination should be undertaken to confirm that the symptoms are not secondary to other conditions such as thyrotoxicosis³⁵ or secondary causes of blood potassium deficiency or excess (Tables 2 and 3).

Electrodiagnostic testing has been a mainstay to demonstrate evidence of muscle fiber changes in excitability in the muscle channelopathies. On needle electromyography (EMG), positive sharp waves and myotonia, characterized by spontaneous waxing and waning motor unit potential amplitude and frequency, can be seen in PMC and HyperPP. In PP, long exercise testing has largely replaced provocative maneuvers, which induce full body

Table 2. Supportive diagnostic criteria for HypoPP

1. Two or more attacks of muscle weakness with documented serum K <3.5 mEq/L
2. One attack of muscle weakness in the proband, and 1 attack of weakness in 1 relative with documented serum K <3.5 mEq/L in at least 1 attack
3. Three of 6 clinical or laboratory features:
 - a. Onset in the first or second decade
 - b. Attack duration (muscle weakness involving 1 or more limbs) > 2 hours
 - c. Positive triggers (high carbohydrate rich meal, rest after exercise, stress)
 - d. Improvement with potassium intake
 - e. Positive family history or genetically confirmed skeletal calcium or sodium channel mutation
 - f. Positive McManis long exercise test
4. Exclusion of other causes of hypokalemia (renal, adrenal, thyroid dysfunction; renal tubular acidosis; diuretic and laxative abuse)
5. Absence of myotonia (clinically or latent detected by needle EMG), except eye lids

attacks of paralysis. In the long exercise test a focal attack of paralysis is induced by exercise of a single muscle. The patient is instructed to perform repeated isometric contractions of the abductor digiti minimi muscle over 5 min (in 15-s blocks alternating with 3–4 s of rest), and compound muscle action potentials (CMAPs) are recorded after supramaximal stimulation of the ulnar nerve every minute or every other minute for 40–60 min postexercise. A reduction in CMAP amplitude of 40% or more from the maximal during exercise or post exercise is considered abnormal and is typically seen in >70% of patients.^{31,36,37}

Several symptoms or signs, or test results, can suggest an alternative diagnosis.^{7,38} The first attack most commonly occurs in the first 2 decades of life, and rarely after 30 years of age. Prominent sensory symptoms or pain or autonomic symptoms during the attacks may indicate Guillain-Barré syndrome or spinal cord injury. Alteration of consciousness or abnormal movements may be indicative of seizure or stroke. Symptoms such as double vision, ptosis, or difficulty swallowing might point to a neuromuscular junction disorder. During the attacks, the motor exam should reveal a flaccid paralysis, so preservation of reflexes in a paralyzed limb should raise the possibility of a different cause. When interpreting genetic testing it is important to put the results in the clinical context. A known pathological mutation in the typical clinical context is confirmatory. Variants of unknown

significance may require testing of additional family members, or further functional testing of the mutation in vitro to fully resolve its significance.

Andersen-Tawil Syndrome. Andersen-Tawil syndrome occurs with a high degree of phenotypic variability rendering diagnosis very difficult. Mutations in the *KCNJ2* gene are identified in approximately 60% of all individuals with the disorder; a genetic mutation is not identified in the remaining 40% of cases where the cause is unknown. In those with *KCNJ2* mutations, hyperkalemic episodes occur in approximately 15% of patients, normokalemic episodes in approximately 20% of patients, and the remainder have hypokalemic episodes of paralysis that are similar to those seen in HypoPP.⁸

The presence of characteristic physical features and/or electrocardiographic (ECG) abnormalities is consistent with a diagnosis of Andersen-Tawil syndrome.^{18,24} Typical resting ECG abnormalities include a long QTc or long QU interval in the absence of hypokalemia. When the diagnosis of Andersen-Tawil syndrome is suspected, electrophysiological studies including the long exercise protocol may help support the diagnosis.^{31,39}

The primary diagnostic criterion is documentation of the *KCNJ2* mutation. In the absence of an identified genetic mutation, Andersen-Tawil syndrome should be suspected in individuals with either A or B in Table 4.²⁴

Table 3. Supportive diagnostic criteria for HyperPP

1. Two or more attacks of muscle weakness with documented serum K >4.5 mEq/L
2. One attack of muscle weakness in the proband, and 1 attack of weakness in 1 relative with documented serum K >4.5 mEq/L in at least 1 attack
3. Three of 6 clinical or laboratory features:
 - a. Onset before third decade
 - b. Attack duration (muscle weakness involving 1 or more limbs) < 2 hours
 - c. Positive triggers (exercise, stress)
 - d. Myotonia
 - e. Positive family history or genetically confirmed skeletal sodium channel mutation
 - f. Positive McManis long exercise test
4. Exclusion of other causes of hyperkalemia (renal, adrenal, thyroid dysfunction; potassium-sparing diuretics use)

Table 4. Supportive diagnostic criteria for Andersen-Tawil syndrome.²⁴

- A. Presence of 2 of the following 3 criteria:
- Periodic paralysis
 - Symptomatic cardiac arrhythmias or ECG evidence of enlarged U-waves, ventricular ectopy or a prolonged QTc or QUc interval
 - Characteristic facies, dental anomalies, small hands and feet, and at least 2 of the following:
 - Low-set ears
 - Widely spaced eyes
 - Small mandible
 - Fifth-digit clinodactyly
 - Syndactyly of toes 2 and 3
- B. One of the above 3 in addition to at least 1 other family member who meets 2 of the 3 criteria.^{18,24,30}

GENERAL TREATMENT CONSIDERATIONS

A progressive strategy should be used beginning with patient education and lifestyle changes to minimize triggers of PP, and then potassium therapy (supplement or avoidance) followed by use of carbonic anhydrase inhibitors. As an initial step, discussion of triggering factors, especially diet, may be of benefit to decrease the number of attacks. Professional advice from a dietician may be beneficial. An understanding of the episodic nature of the disease is important for children, and health officials should be informed at schools where children with periodic paralysis are enrolled. If the potassium level during attacks is unknown, behavioral strategies for acute attacks should be used (e.g., mild exercise at attack onset).

Pharmacological interventions consist of therapy to abort acute attacks and chronic preventive therapy to reduce attack frequency.¹⁸ Treatment options for periodic paralyses are limited, and aside from the recent Food and Drug Administration (FDA) approval of dichlorphenamide, are based largely on anecdotal experience (Table 5).^{22,40,41}

Carbonic anhydrase inhibitors (in particular acetazolamide and dichlorphenamide) have been used for almost 50 years as empiric treatment for both HypoPP and HyperPP.^{1,40,42} The mechanism of action in periodic paralyses is incompletely understood. Carbonic anhydrase inhibitors promote kaliuresis and a nonanion gap acidosis by increasing urinary bicarbonate excretion. The systemic acidosis may reduce the susceptibility to periodic paralysis.^{1,34,43} An alternative proposal is enhanced opening of calcium-activated K channels.⁴⁴ In addition, carbonic anhydrase inhibitors also may be effective for treating permanent weakness in HypoPP by reducing intracellular sodium accumulation.⁴⁵ This lessens damage to the structure of muscle fiber, thus allowing the remaining muscle fibers to regenerate. However, whether these pharmacological effects are directly responsible for the benefits of carbonic anhydrase inhibitors in PP remains poorly understood.⁴² The interval between attacks varies widely, and the interval may be prolonged by treatment with potassium or carbonic anhydrase inhibitors.

Those with HypoPP caused by an *SCN4A* mutation are less responsive to carbonic anhydrase inhibitors or may even experience worsening of symptoms. In a study of 74 patients with HypoPP who were genotyped, the overall response to acetazolamide was 46%, but the response differed by genotype.⁴⁰ Among those with the *CACNA1S* mutation, the response was 56% (31/55), but among those with the *SCN4A* mutation the response was 16% (3/19). Exacerbation of HypoPP with acetazolamide has been reported in patients with the *SCN4A* mutation.^{46,47} Specific gene defects have been associated with clinical worsening on carbonic anhydrase inhibitors. Acetazolamide caused worsening for several patients with the *SCN4A* HypoPP mutations R672G or R672S and in one patient with the *CACNA1S* mutation R1239H.^{48,49} Another report describes 3 patients with HypoPP who worsened with acetazolamide treatment but subsequently responded to treatment with dichlorphenamide.¹⁹

Acetazolamide is routinely used for treating PP. No randomized, controlled studies have been performed with acetazolamide in PP, but rather its use is based on the results of nonrandomized, single-blind trials and anecdotal reports.²³ Overall, approximately 50% of patients respond to acetazolamide.⁴⁰

Common side effects of carbonic anhydrase inhibitors include paresthesia, fatigue, and mild, reversible cognitive disturbances.^{22,50} An additional concern with carbonic anhydrase inhibitors is an increased risk of nephrolithiasis. In 1 report, 3 of 20 (15%) patients receiving long-term treatment with acetazolamide for myotonia experienced nephrolithiasis.⁵¹ Nephrolithiasis has been widely reported with acetazolamide when used for other conditions,⁵² and may be managed by removal of renal calculi without necessitating discontinuation of carbonic anhydrase inhibitor treatment.⁵¹

Dichlorphenamide was recently approved by the FDA for the treatment of PP. Dichlorphenamide has been evaluated in four randomized, placebo-controlled studies, two each in patients with HypoPP and HyperPP (Supplementary Table 1, which is available online).^{22,53} The dose of dichlorphenamide was

Table 5. General approach to treatment for primary periodic paralyses.^{1,4,6,24}

	HyperPP	HypoPP	Andersen-Tawil syndrome
Acute attack			
Non-pharmacological	Mild exercise; carbohydrates	Mild exercise at attack onset; potassium supplements	Mild exercise; carbohydrates (if attacks associated with hyperkalemia)
Potassium supplement [†]	Not applicable	Oral K + 1 mEq/kg up to 200 mEq/24h* Avoid slow release formulations	If attacks associated with low K+, oral K + 1 mEq/kg up to 200 mEq/12h* to normalize
Beta-2 agonist – salbutamol	2 puffs 0.1 mg	Not applicable	Not applicable
Prevention			
Non-pharmacological	Frequent high carbohydrate meals; Avoid: fasting; strenuous exercise; cold exposure; K + rich foods	Low sodium and carbohydrate diet; potassium supplements; avoid hyperosmolar states (dehydration, hyperglycemia)	
Acetazolamide	Adults: 125-1000 mg daily Children: 5-10 mg/kg/d	Adults: 125-1000 mg daily Children: 5-10 mg/kg/d	Adults: 125-1000 mg daily Children: 5-10 mg/kg/d
Dichlorphenamide	50-200 mg daily	50-200 mg daily	50-200 mg daily
Potassium supplement [†]	Not applicable	Oral K + 30-60 mEq/day; sustained released formulation may be preferred	Not applicable
K + sparing diuretic	Not applicable	Triamterene 50-150 mg/d Spironolactone 25-100 mg/d Eplerenone 50-100 mg/d	Not applicable [‡]
Hydrochlorothiazide	25-75 mg daily	Not applicable	Not applicable
Antiarrhythmics	Not applicable	Not applicable	Flecainide, beta-blockers or calcium channel blockers to prevent ventricular arrhythmias

*Monitor ECG and potassium levels.

[†]Total body potassium is not depleted in HypoPP, use caution with acute K⁺ administration to avoid overshoot.

[‡]Use of K-sparing diuretics should be individualized based on patient needs.

50 mg twice daily for treatment-naïve patients. Patients already on dichlorphenamide before the study continued on the same dose during the study. In patients taking acetazolamide before the study, the dose of dichlorphenamide was set at 20% of the acetazolamide dose. Dose reduction for tolerability was permitted. The mean dose of dichlorphenamide at Week 9 was 82 mg/day. While randomized controlled trials of dichlorphenamide were performed in adults, the same approach is taken for children. Dose adjustments may be required based on age.

These studies demonstrated a significant reduction in the frequency and severity of the attacks. The most common side effects with dichlorphenamide were paresthesias, cognitive disorder, dysgeusia, headache, fatigue, hypoesthesia, and muscle spasms,²² generally not requiring discontinuation of dichlorphenamide, and reversible with drug discontinuation. During a 52-week extension, in which all remaining patients received open-label dichlorphenamide, continued improvement in outcomes was observed in both placebo and dichlorphenamide groups (Supplementary Table 2).²²

In one of the studies of dichlorphenamide, quality of life was assessed at 9 weeks with the SF-36.²² No significant improvement was observed in patients with HyperPP, but significant improvement was

reported for the physical component and physical functioning, role physical, bodily pain, vitality, and social functioning in those with HypoPP.

Other pharmacological treatments for periodic paralyses depend on serum potassium levels and the specific diagnosis but include potassium supplementation, thiazide or potassium-sparing diuretics or beta-adrenergic agents.^{42,54} For patients receiving chronic potassium supplementation for HypoPP, providers can consider adding magnesium, which can be helpful to promote renal retention of K⁺ and, therefore, reduce the potassium dose.

Management of HypoPP. *Acute management.* Mild exercise (e.g., nonresistance activities such as walking around a room or shaking the arms) at the onset of the attack may be of benefit. Low serum potassium is not due to low total body potassium but rather shifts of potassium from the blood compartment into the intracellular muscle compartment. Therefore, correction of serum potassium should not be undertaken with the goal of correcting low total body potassium. Treatment options include oral or intravenous (IV) potassium administration.^{18,19} Oral potassium is recommended for outpatient treatment. Slow-release formulations usually should be avoided for acute management. The dose of oral potassium is 0.2–0.4 mEq/kg every 30 min not to exceed 200–250 mEq/

day. Administering potassium by IV infusion usually requires hospitalization for ECG monitoring but is only necessary if the patient cannot take oral potassium. The dose of IV potassium is 40 mEq/L in 5% mannitol solution infused at a maximum of 20 mEq/h, not to exceed 200 mEq/day. A potassium chloride IV bolus of 5 mEq can be used as an alternative. Use of glucose- and saline-containing IV solutions for administering potassium should be avoided, as this may worsen muscle weakness.⁵⁵

Prevention. The patient should be advised to avoid triggers such as high-carbohydrate and/or high-salt meals, alcohol, and stress.² Although no randomized controlled studies are available to inform dosing, a daily slow-release potassium salt formulation may be considered the standard of care for chronic therapy.

Dichlorophenamide is approved for HypoPP, and has been associated with reductions in attack frequency, severity, and duration during chronic treatment.^{22,53} Based on anecdotal reports, acetazolamide 125–1000 mg/day may be effective chronic treatment of HypoPP.^{15,20,23,56–58} In a double-blind crossover study, acetazolamide 125 mg three times daily or placebo given for 2 weeks each was evaluated in 8 patients with HypoPP.⁵⁹ Muscle strength was measured in muscle groups every week and improved significantly in seven of eight patients. Mean strength was significantly greater with acetazolamide ($P = 0.05$), and total muscle strength increased by a mean of 10% with treatment.

Potassium-sparing diuretics are a potential option for chronic treatment of HypoPP.^{6,18} Recommended doses are triamterene 50–150 mg/day, spironolactone 25–100 mg/day or eplerenone 50–100 mg daily. Spironolactone may be poorly tolerated because of androgenic side effects, and eplerenone may be substituted because it causes fewer hormonal issues. For patients with HypoPP, potassium supplementation and a potassium-sparing diuretic may be used concomitantly, but potassium levels should be routinely monitored.

Recent studies in mouse models of HypoPP with both *SCN4A* mutations and *CACNA1S* mutations show that maneuvers to reduce the activity of the Na-K-2Cl (NKCC) co-transporter can reverse an acute attack of HypoPP and protect against an attack triggered by low K^+ exposure.^{60,61} The beneficial effect is the result of biasing intracellular chloride to be low, which promotes hyperpolarization of the resting potential. The NKCC co-transporter is activated by hyperosmolarity (hence the importance of avoiding high sodium diet, dehydration or hyperglycemia) and is inhibited by loop diuretics such as bumetanide. Pharmacologic inhibition of NKCC as an acute therapy for HypoPP is under study.

Management of HyperPP. *Acute Management.* Acute management may include mild exercise at attack onset and a carbohydrate snack. Beta agonists can be an effective acute potassium-lowering therapy for HyperPP.¹ In case reports, salbutamol 1–2 puffs (0.1 mg) and other beta-agonists have shown benefits.^{62–64} While severe hyperkalemia during attacks is typically not seen, the treatment for acute hyperkalemia which is severe or life-threatening should match institutions' established protocols.

Prevention. In individuals with HyperPP, consider recommending consumption of multiple small carbohydrate snacks and avoid potassium-rich foods.¹⁰

Dichlorophenamide can be effective for chronic treatment and is approved for HyperPP.^{22,53} In randomized, placebo-controlled studies, dichlorophenamide reduced attack frequency and severity among patients.^{22,53} The initial dose is 50 mg twice daily, which may be increased or decreased at weekly intervals based on individual response or the occurrence of adverse events. The maximum recommended dose is 200 mg daily.^{22,53} Acetazolamide 125–1000 mg/day may be effective for chronic treatment of HyperPP.^{15,23}

Thiazide diuretics are an option for chronic treatment of HyperPP.^{1,42} The drug of choice is hydrochlorothiazide 25 mg to 75 mg daily.^{41,54} Potassium-sparing diuretics should be avoided.

There are no rigorously controlled data on the treatment of PMC, normokalemic PP, and other atypical PPs, but in general, the same treatment strategies used for HyperPP are appropriate.

Management of Andersen-Tawil Syndrome. Management of individuals with Andersen-Tawil syndrome requires the coordinated input of a neurologist familiar with the treatment of periodic paralysis and a cardiologist familiar with the treatment of cardiac arrhythmias. Treatment for acute attacks of weakness or for chronic suppression of attacks of weakness in individuals with Andersen-Tawil syndrome depends on whether the attack is associated with high or low levels of potassium, and treatment needs to be individualized for each patient (see sections above for HypoPP and HyperPP for specific recommendations).¹⁰ Evaluations recommended to establish the extent of disease and needs in a patient diagnosed with Andersen-Tawil syndrome are summarized in Table 6.⁶⁵ For asymptomatic patients with a *KCNJ2* mutation, annual screening should include a 12-lead ECG and 24-h Holter monitoring.

Treatment of Manifestations. *Cardiac considerations.* Empiric treatment with an antiarrhythmic agent should be considered for significant, frequent ventricular arrhythmias in the setting of reduced left ventricular function.^{27,66} A prospective open label

Table 6. Evaluations recommended to establish the diagnosis of Andersen-Tawil syndrome

- Baseline assessments by a neurologist familiar with periodic paralyses and a cardiologist familiar with long QT syndrome
- Syncope in patients with Andersen-Tawil syndrome requires a cardiology assessment⁶⁵
- Assess serum potassium concentrations at baseline and during attacks of weakness
- Obtain 12-lead ECG and perform 24-hour Holter monitoring
- Confirm that serum thyroid stimulating hormone concentration is within normal limits
- Obtain a medical genetics consultation

study in 10 individuals with Andersen-Tawil syndrome and a confirmed *KCNJ2* mutation tested the effect of flecainide, a type 1c antiarrhythmic, for the prevention of cardiac arrhythmias.⁶⁷ Assessments included 24-h Holter monitoring before and after treatment, and a treadmill exercise test. Flecainide significantly reduced the number of ventricular arrhythmias observed on Holter monitor and suppressed exercise-induced ventricular arrhythmias. After a mean follow-up of 23 months, no syncope or cardiac arrest was documented. Thus, flecainide may reduce cardiac arrhythmias in Andersen-Tawil syndrome, although further evaluation is needed. Others have reported beneficial effects with flecainide.^{68–70} Others report beneficial effects for suppressing ventricular arrhythmias with the use of beta-blockers, calcium channel blockers, or amiodarone.^{27,28}

Prevention of secondary complications. Some antiarrhythmic drugs (e.g., lidocaine, mexiletine, propafenone, quinidine) may paradoxically exacerbate neuromuscular symptoms and should be used cautiously in individuals with Andersen-Tawil syndrome.^{8,24} Although malignant hyperthermia has not been reported in Andersen-Tawil syndrome, appropriate precautions should be undertaken when using anesthesia for surgical procedures. Patients should be instructed about medications known to prolong QT intervals and avoid their use. Inhaled salbutamol, which may be used for the treatment of HyperPP, should be avoided because of the potential to exacerbate cardiac arrhythmias. Thiazide diuretics should be avoided, because they may induce drug-induced hypokalemia and could aggravate the QT interval.

CONCLUSIONS AND RECOMMENDATIONS FOR FUTURE STUDIES

Because of their low prevalence in the general population, most experience with treatment for these patients is obtained from anecdotal reports. The present recommendations are based on a review of published literature with the exception of the Level I evidence supporting the use of dichlorphenamide in the long-term management of HypoPP and HyperPP.

Despite the rarity of these disorders, which creates many challenges in conducting studies in periodic paralyses, more prospective studies are needed, in particular comparing acetazolamide and dichlorphenamide as well as other interventions for managing patients. Studies should include long-term follow-up, cost benefits of treatment, effects of treatment on permanent muscle weakness, adverse events, as well as efficacy. In the future, a better understanding of the genetics of these disorders may lead to improved treatment options.

Editorial support for this manuscript was provided by Richard Perry, PharmD, an independent contractor, and was funded by Strongbridge Biopharma, Trevose, PA. The authors retained full editorial control over the content of the manuscript, and all authors approved the final manuscript for submission.

Ethical Publication Statement: We confirm that we have read the Journal's position on issues involved in ethical publication and affirm that this report is consistent with those guidelines.

REFERENCES

1. Cannon SC. Channelopathies of skeletal muscle excitability. *Compr Physiol* 2015;5:761–790.
2. Fontaine B. Periodic paralysis. *Adv Genet* 2008;63:3–23.
3. Cavel-Greant D, Lehmann-Horn F, Jurkat-Rott K. The impact of permanent muscle weakness on quality of life in periodic paralysis: a survey of 66 patients. *Acta Myol* 2012;31:126–133.
4. Sansone VA, Ricci C, Montanari M, Apolone G, Rose M, Meola G; INQoL Group. Measuring quality of life impairment in skeletal muscle channelopathies. *Eur J Neurol* 2012;19:1470–1476.
5. Jurkat-Rott K, Lerche H, Weber Y, Lehmann-Horn F. Hereditary channelopathies in neurology. *Adv Exp Med Biol* 2010;686:305–334.
6. Vicart S, Sternberg D, Arzel-Hézode M, Franques J, Bendahhou S, Lory P, et al. Hypokalemic periodic paralysis. 2002 Apr 30 [updated 2014 Jul 31]. In: Pagon RA, Adam MP, Ardinger HH, Wallace SE, Amemiya A, Bean LJH, Bird TD, Ledbetter N, Mefford HC, Smith RJH, Stephens K, editors. *GeneReviews*[®] [Internet]. Seattle, WA: University of Washington, Seattle; 1993–2017.
7. Charles G, Zheng C, Lehmann-Horn F, Jurkat-Rott K, Levitt J. Characterization of hyperkalemic periodic paralysis: a survey of genetically diagnosed individuals. *J Neurol* 2013;260:2606–2613.
8. Sansone V, Tawil R. Management and treatment of Andersen-Tawil syndrome (ATS). *Neurotherapeutics* 2007;4:233–237.
9. Horga A, Raja Rayan DL, Matthews E, Sud R, Fialho D, Durran SC, et al. Prevalence study of genetically defined skeletal muscle channelopathies in England. *Neurology* 2013;80:1472–1475.
10. Venance SL, Cannon SC, Fialho D, Fontaine B, Hanna MG, Ptacek LJ, et al. The primary periodic paralyses: diagnosis, pathogenesis and treatment. *Brain* 2006;129:8–17.
11. Cannon SC, Brown RH Jr, Corey DP. A sodium channel defect in hyperkalemic periodic paralysis: potassium-induced failure of inactivation. *Neuron* 1991;6:619–626.
12. Cannon SC. Voltage-sensor mutations in channelopathies of skeletal muscle. *J Physiol* 2010;588(Pt 11):1887–1895.
13. Cummins TR, Zhou J, Sigworth FJ, Ukomadu C, Stephan M, Ptacek LJ, et al. Functional consequences of a Na⁺ channel mutation causing hyperkalemic periodic paralysis. *Neuron* 1993;10:667–678.
14. Jurkat-Rott K, Lehmann-Horn F. Genotype-phenotype correlation and therapeutic rationale in hyperkalemic periodic paralysis. *Neurotherapeutics* 2007;4:216–224.
15. Matthews E, Labrum R, Sweeney MG, Sud R, Haworth A, Chinnery PF, et al. Voltage sensor charge loss accounts for most cases of hypokalemic periodic paralysis. *Neurology* 2009;72:1544–1547.
16. Plaster NM, Tawil R, Tristani-Firouzi M, Canún S, Bendahhou S, Tsunoda A, et al. Mutations in Kir2.1 cause the developmental and episodic electrical phenotypes of Andersen's syndrome. *Cell* 2001;105:511–519.
17. Miller TM, Dias da Silva MR, Miller HA, Kwicinski H, Mendell JR, Tawil R, et al. Correlating phenotype and genotype in the periodic paralyses. *Neurology* 2004;63:1647–1655.
18. Statland JM, Barohn RJ. Muscle channelopathies: the nondystrophic myotonias and periodic paralyses. *Continuum* 2013;19:1598–1614.
19. Dalakas MC, Engel WK. Treatment of "permanent" muscle weakness in familial hypokalemic periodic paralysis. *Muscle Nerve* 1983;6:182–186.

20. Griggs RC, Engel WK, Resnick JS. Acetazolamide treatment of hypokalemic periodic paralysis. Prevention of attacks and improvement of persistent weakness. *Ann Intern Med* 1970;73:39–48.
21. Links TP, Zwarts MJ, Wilmink JT, Molenaar WM, Oosterhuis HJ. Permanent muscle weakness in familial hypokalemic periodic paralysis. Clinical, radiological and pathological aspects. *Brain* 1990;113(Pt 6):1873–1889.
22. Sansone VA, Burge J, McDermott MP, Smith PC, Herr B, Tawil R, et al. Randomized, placebo-controlled trials of dichlorphenamide in periodic paralysis. *Neurology* 2016;86:1408–1416.
23. Sansone V, Meola G, Links TP, Panzeri M, Rose MR. Treatment for periodic paralysis. *Cochrane Database Syst Rev* 2008;1:CD005045.
24. Statland JM, Tawil R, Venance SL. Andersen-Tawil Syndrome. 2004 Nov 22 [updated 2015 Sep 3]. In: Pagon RA, Adam MP, Ardinger HH, Wallace SE, Amemiya A, Bean LJH, Bird TD, Ledbetter N, Mefford HC, Smith RJH, Stephens K, editors. *GeneReviews*[®] [Internet]. Seattle, WA: University of Washington, Seattle; 1993–2017.
25. Tristani-Firouzi M. Andersen-Tawil syndrome: an ever-expanding phenotype? *Heart Rhythm* 2006;3:1351–1352.
26. Yoon G, Oberoi S, Tristani-Firouzi M, Etheridge SP, Quitania L, Kramer JH, et al. Andersen-Tawil syndrome: prospective cohort analysis and expansion of the phenotype. *Am J Med Genet A* 2006;140:312–321.
27. Delannoy E, Sacher F, Maury P, Mabo P, Mansourati J, Magnin I, et al. Cardiac characteristics and long-term outcome in Andersen-Tawil syndrome patients related to KCNJ2 mutation. *Europace* 2013;15:1805–1811.
28. Koppikar S, Yoo H, Konopka I, Pizzarelli N, Baranchuk A, Acunzo R. Andersen-Tawil Syndrome: a retrospective analysis of clinical and electrocardiographic characteristics. *J Innov Card Rhythm Manag* 2015;6:2179–2185.
29. Zhang L, Benson DW, Tristani-Firouzi M, Ptacek LJ, Tawil R, Schwartz PJ, et al. Electrocardiographic features in Andersen-Tawil syndrome patients with KCNJ2 mutations: characteristic T-U-wave patterns predict the KCNJ2 genotype. *Circulation* 2005;111:2720–2726.
30. Tristani-Firouzi M, Jensen JL, Donaldson MR, Sansone V, Meola G, Hahn A, et al. Functional and clinical characterization of KCNJ2 mutations associated with LQT7 (Andersen syndrome). *J Clin Invest* 2002;110:381–388.
31. Fournier E, Arzel M, Sternberg D, Vicart S, Laforet P, Eymard B, et al. Electromyography guides toward subgroups of mutations in muscle channelopathies. *Ann Neurol* 2004;56:650–661.
32. Ryan DP, da Silva MR, Soong TW, Fontaine B, Donaldson MR, Kung AW, et al. Mutations in potassium channel Kir2.6 cause susceptibility to thyrotoxic hypokalemic periodic paralysis. *Cell* 2010;140:88–98.
33. Kokunai Y, Nakata T, Furuta M, Sakata S, Kimura H, Aiba T, et al. A Kir3.4 mutation causes Andersen-Tawil syndrome by an inhibitory effect on Kir2.1. *Neurology* 2014;82:1058–1064.
34. Matthews E, Hanna MG. Muscle channelopathies: does the predicted channel gating pore offer new treatment options for hypokalemic periodic paralysis? *J Physiol* 2010;588:1879–1886.
35. Lin SH. Thyrotoxic periodic paralysis. *Mayo Clin Proc* 2005;80:99–105.
36. McManis PG, Lambert EH, Daube JR. The exercise test in periodic paralysis. *Muscle Nerve* 1986;9:704–710.
37. Tan SV, Matthews E, Barber M, Burge JA, Rajakulendran S, Fialho D, et al. Refined exercise testing can aid DNA-based diagnosis in muscle channelopathies. *Ann Neurol* 2011;69:328–340.
38. Ahlawat SK, Sachdev A. Hypokalemic paralysis. *Postgrad Med J* 1999;75:193–197.
39. Kuntzer T, Flocard F, Vial C, Kohler A, Magistris M, Labarre-Vila A, et al. Exercise test in muscle channelopathies and other muscle disorders. *Muscle Nerve* 2000;23:1089–1094.
40. Matthews E, Portaro S, Ke Q, Sud R, Haworth A, Davis MB, et al. Acetazolamide efficacy in hypokalemic periodic paralysis and the predictive role of genotype. *Neurology* 2011;77:1960–1964.
41. Weber F, Jurkat-Rott K, Lehmann-Horn F. Hyperkalemic periodic paralysis. 2003 Jul 18 [updated 2016 Jan 28]. In: Pagon RA, Adam MP, Ardinger HH, Wallace SE, Amemiya A, Bean LJH, Bird TD, Ledbetter N, Mefford HC, Smith RJH, Stephens K, editors. *GeneReviews*[®] [Internet]. Seattle, WA: University of Washington, Seattle; 1993–2017.
42. Tricarico D, Camerino DC. Recent advances in the pathogenesis and drug action in periodic paralyses and related channelopathies. *Front Pharmacol* 2011;2:8.
43. Lehmann-Horn F, Küther G, Ricker K, Grafe P, Ballanyi K, Rüdell R. Adynamia episodica hereditaria with myotonia: a non-inactivating sodium current and the effect of extracellular pH. *Muscle Nerve* 1987;10:363–374.
44. Tricarico D, Barbieri M, Mele A, Carbonara G, Camerino DC. Carbonic anhydrase inhibitors are specific openers of skeletal muscle BK channel of K⁺-deficient rats. *FASEB J* 2004;18:760–761.
45. Lehmann-Horn F, Jurkat-Rott K, Rüdell R; Ulm Muscle Centre. Diagnostics and therapy of muscle channelopathies—guidelines of the Ulm Muscle Centre. *Acta Myol* 2008;27:98–113.
46. Ikeda K, Iwasaki Y, Kinoshita M, Yabuki D, Igarashi O, Ichikawa Y, et al. Acetazolamide-induced muscle weakness in hypokalemic periodic paralysis. *Intern Med* 2002;41:743–745.
47. Torres CF, Griggs RC, Moxley RT, Bender AN. Hypokalemic periodic paralysis exacerbated by acetazolamide. *Neurology* 1981;31:1423–1428.
48. Bendahhou S, Cummins TR, Griggs RC, Fu YH, Ptáček LJ. Sodium channel inactivation defects are associated with acetazolamide-exacerbated hypokalemic periodic paralysis. *Ann Neurol* 2001;50:417–420.
49. Sternberg D, Maisonobe T, Jurkat-Rott K, Nicole S, Launay E, Chauveau D, et al. Hypokalemic periodic paralysis type 2 caused by mutations at codon 672 in the muscle sodium channel gene SCN4A. *Brain* 2001;124(Pt 6):1091–1099.
50. Lichter PR, Newman LP, Wheeler NC, Beall OV. Patient tolerance to carbonic anhydrase inhibitors. *Am J Ophthalmol* 1978;85:495–502.
51. Tawil R, Moxley RT III, Griggs RC. Acetazolamide-induced nephrolithiasis: implications for treatment of neuromuscular disorders. *Neurology* 1993;43:1105–1106.
52. Daudon M, Jungers P. Drug-induced renal calculi: epidemiology, prevention and management. *Drugs* 2004;64:245–275.
53. Tawil R, McDermott MP, Brown R Jr, Shapiro BC, Ptacek LJ, McManis PG, et al. Randomized trials of dichlorphenamide in the periodic paralyses. *Ann Neurol* 2000;47:46–53.
54. Imbrici P, Liantonio A, Camerino GM, De Bellis M, Camerino C, Mele A, et al. Therapeutic approaches to genetic ion channelopathies and perspectives in drug discovery. *Front Pharmacol* 2016;7:121.
55. Griggs RC, Resnick J, Engel WK. Intravenous treatment of hypokalemic periodic paralysis. *Arch Neurol* 1983;40:539–540.
56. Dejthevaporn C, Papsing C, Phakdeekitcharoen B, Jaovisidha S, Phudhichareonrat S, Witoonpanich R, et al. Long-term effectiveness of acetazolamide on permanent weakness in hyperkalemic periodic paralysis. *Neuromuscul Disord* 2013;23:445–449.
57. Resnick JS, Engel WK, Griggs RC, Stam AC. Acetazolamide prophylaxis in hypokalemic periodic paralysis. *N Engl J Med* 1968;278:582–586.
58. Vroom FW, Jarrell MA, Maren TH. Acetazolamide treatment of hypokalemic periodic paralysis. Probable mechanism of action. *Arch Neurol* 1975;32:385–392.
59. Links TP, Zwarts MJ, Oosterhuis HJ. Improvement of muscle strength in familial hypokalemic periodic paralysis with acetazolamide. *J Neurol Neurosurg Psychiatry* 1988;51:1142–1145.
60. Wu F, Mi W, Cannon SC. Bumetanide prevents transient decreases in muscle force in murine hypokalemic periodic paralysis. *Neurology* 2013;80:1110–1116.
61. Wu F, Mi W, Cannon SC. Beneficial effects of bumetanide in a CaV1.1-R528H mouse model of hypokalemic periodic paralysis. *Brain* 2013;136(Pt 12):3766–3774.
62. Bendheim PE, Reale EO, Berg BO. Beta-adrenergic treatment of hyperkalemic periodic paralysis. *Neurology* 1985;35:746–749.
63. Hanna MG, Stewart J, Schapira AH, Wood NW, Morgan-Hughes JA, Murray NM. Salbutamol treatment in a patient with hyperkalemic periodic paralysis due to a mutation in the skeletal muscle sodium channel gene (SCN4A). *J Neurol Neurosurg Psychiatry* 1998;65:248–250.
64. Wang P, Clausen T. Treatment of attacks in hyperkalemic familial periodic paralysis by inhalation of salbutamol. *Lancet* 1976;1:221–223.
65. Tawil R, Venance SL. Andersen-Tawil Syndrome. *GeneReviews*. March 19, 2007
66. Tristani-Firouzi M, Etheridge SP. Kir 2.1 channelopathies: the Andersen-Tawil syndrome. *Pflugers Arch* 2010;460:289–294.
67. Miyamoto K, Aiba T, Kimura H, Hayashi H, Ohno S, Yasuoka C, et al. Efficacy and safety of flecainide for ventricular arrhythmias in patients with Andersen-Tawil syndrome with KCNJ2 mutations. *Heart Rhythm* 2015;12:596–603.
68. Bökenkamp R, Wilde AA, Schalij MJ, Blom NA. Flecainide for recurrent malignant ventricular arrhythmias in two siblings with Andersen-Tawil syndrome. *Heart Rhythm* 2007;4:508–511.
69. Fox DJ, Klein GJ, Hahn A, Skanes AC, Gula LJ, Yee RK, et al. Reduction of complex ventricular ectopy and improvement in exercise capacity with flecainide therapy in Andersen-Tawil syndrome. *Europace* 2008;10:1006–1068.
70. Pellizzón OA, Kalaizich L, Ptáček LJ, Tristani-Firouzi M, González MD. Flecainide suppresses bidirectional ventricular tachycardia and reverses tachycardia-induced cardiomyopathy in Andersen-Tawil syndrome. *J Cardiovasc Electrophysiol* 2008;19:95–97.