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MADISON NEUROLOGY LLC

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Neurology Care 7 days a Week. Because Your Brain Matters.

Multifocal Motor Neuropathy (MMN)

Patient education guide · Nerve & Muscle · Madison Neurology LLC

What is it?

Multifocal motor neuropathy is a rare, treatable autoimmune disorder in which the immune system attacks the insulation of motor nerves at multiple sites, causing slowly progressive, asymmetric weakness — often starting in a hand (weak grip, wrist drop) or a leg (foot drop) — without numbness. It mimics ALS but, unlike ALS, is treatable and non-fatal, making accurate diagnosis critical.

How does it happen?

Antibodies (frequently anti-GM1) and immune attack damage myelin at focal points along motor nerves, creating 'conduction block' — signals can't pass the inflamed segments. The sensory nerves are spared, hence no numbness. The trigger is unknown; it is not inherited.

Common symptoms

- Slowly progressive weakness in one or a few limbs, often asymmetric — wrist drop, weak grip, foot drop
- No significant numbness or sensory loss (a key distinguishing feature)
- Muscle twitching (fasciculations) and cramps in affected muscles
- Wasted muscles in chronically affected regions
- Normal sensation examination despite weakness

How is it diagnosed?

Nerve conduction studies demonstrating motor conduction block with preserved sensory responses are diagnostic; anti-GM1 antibodies support it; ultrasound can show enlarged nerve segments. The crucial distinction is from ALS — the presence of conduction block and the slow, asymmetric, sensory-sparing pattern point to MMN.

How is it treated?

IVIG (intravenous immunoglobulin) is the established, effective treatment — most patients improve within weeks of starting, particularly in recently affected muscles. Treatment is typically ongoing (every few weeks, sometimes home subcutaneous immunoglobulin), because stopping leads to decline. Rituximab is an option for some. Steroids, notably, do not work and may worsen MMN. Physical and occupational therapy maintain function.

What does the future hold?

With sustained IVIG, most patients maintain strength and near-normal lives; treatment works best on recent weakness, while long-standing atrophied muscles recover less — another reason early diagnosis matters. MMN does not shorten life and does not become ALS.

Questions patients commonly ask

Q: My doctor mentioned ALS — should I be terrified?

A: MMN is the great ALS mimic, but the nerve studies tell them apart; MMN is treatable and non-fatal, which is exactly why the distinction is pursued so carefully.

Q: Will I need infusions forever?

A: Most patients need ongoing IVIG (or home subcutaneous IG), with intervals individualized to the longest gap that keeps you stable.

Q: Why not just take steroid pills?

A: Steroids don't help MMN and can worsen it — a unique feature of this condition.

National support groups & resources

- **GBS/CIDP Foundation International** — gbs-cidp.org
- **National Organization for Rare Disorders** — rarediseases.org — 1-800-999-6673
- **American Academy of Neurology — Brain & Life patient resources** — brainandlife.org

(Organization contact details were current at the time of compilation; please verify online.)

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