myasthenia is suspected, titers for acetylcholine receptor antibodies can be obtained. Keep in mind that they are positive in only half of patients with ocular myasthenia. For this reason, Tensilon testing remains the gold standard in the diagnosis. Another fairly sensitive test is single-fiber electromyography (EMG). If you suspect myasthenia gravis, we would recommend that you refer the patient to a neurologist who can help in selecting the appropriate test.

A mild blepharoptosis of up to 3 mm is seen in most cases of Horner syndrome. As mentioned, patients usually have miosis. Additionally, the patient may have elevation of the lower eyelid, often referred to as upside down ptosis. Depending on the level of the lesion, anhidrosis of the affected side of the face may be reported. Check intraocular pressure carefully. Mild relative hypotony of 1 to 3 mm Hg is usually seen on the affected side and may be a very helpful clue in more subtle cases. Cocaine testing is used to confirm the diagnosis of Horner syndrome (Figure 9-4). If cocaine is unavailable, recent investigations have found apraclonidine to be helpful in confirming the presence of Horner syndrome. Apraclonidine, an α-adrenergic receptor agonist, has been reported to result in dilation of the miotic pupil due to denervation supersensitivity. However,