



Recurrent Guillain Barre Syndrome

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Background

Guillain-Barre Syndrome (GBS) is an immune polyradiculoneuropathy that presents with ascending bilateral lower extremity weakness and areflexia and that affects all age groups with a slight male predisposition. The natural history of GBS in infants and children is more variable and more benign than in adults. Infants may present with hypotonia, feeding difficulties, irritability due to pain, or reduced activity.

Recurrent Guillain-Barre Syndrome (RGS) can recur in 1–6% of patients, though it has been reported to occur in 1–10% of patients after asymptomatic period of several months to several years. Risk factors for RGS include age less than 30, milder symptoms, and history of Miller Fisher Syndrome variant. There appears to be no significant difference between RGS and GBS episodes with respect to similar clinical symptoms and similar or different triggering events. The episode appears to be shorter with half of the patients accumulating deficits.

We present the case of RGS of a different subtype 4 years after initial presentation.

Case Report

A 23-year-old boy, with prior history of GBS, presented to the emergency department with 5 days history of weakness in both upper limb and lower limb. insidious in onset, gradually progressive started over lower extremity gradually as sending bilateral symmetrical involvement .a/w Pain and numbness. Patient was not able to do his routine activity. Patient difficulty in swallowing and breathing since 3 days. Patient had a past history of AMAN variant of GBS 4 year back which was diagnosed with csf report suggestive of albuminocytological dissociation and Nerve conduction study suggestive of acute motor axonal neuropathy. Patient was treated with Plasmaphoresis. Patient recovered fully until recent complaint. Patient was tachypnic (44/min), vitally stable. Patient had are flexia and 0/5 power in all limbs. Patient was electively intubated i/v/o single breath count 12.lumbar puncture report on admission suggestive of total cell 1/cumm with CSF protein level 78 mg/dl. Patient was started on infusion immunoglobulines 25gm/day and inj methyleprednisone 1gm thrice/day. Patient was given 6 day course of immunoglobuline with methyleprednisone. patient CSF repeated after 1 week which s/o protein 100mg/dl and cell

1/cumm. Which confirm diagnosis of GBS. after completion of therapy patient was still intubated and he developed sudden hypotention with ECG changes s/o st elevation. Patient cardiac marker were raised with PROBNP level of >35,000. patient collapsed on same day.

Discussion

RGBS is a rare entity that has been reported in about 1–6% of all patients with GBS.¹ Those patients with multiple recurrences tended to have slower recovery and residual neurologic deficits. It is important to distinguish RGBS from two clinical entities (1) GBS with treatment related fluctuations (GBS-TRF), (2) Chronic inflammatory demyelinating polyneuropathy (CIDP). Since our patient had a long asymptomatic period, GBS-TRF is less likely but CIDP comes as a differential diagnosis. CIDP is suspected when progression of weakness lasts more than 8 weeks followed by a chronic course but it can be of steadily progressive, relapsing remitting or monophasic.

Risk factors for RGBS include age less than 30, milder symptoms, history of Miller Fisher Syndrome variant. Since our patient has negative GM1, GQ1b antibody AMAN, MILLER Fisher Syndrome is less likely. our patient presented with AMAN type variant 4 year back f/b AIDP type of variant recently.

Our patient develop myocardial injury after completion of immunoglobulines which is rare side effect associate with use of IVIG. occurs only in 0.15,1.2% of all cases.

It is important for clinicians to recognize diverse features of RGBS at recurrence. Patients can present with similar symptoms, different exam findings, clinical course, electro diagnostic studies.

Keywords: 1.Recurrent gbs.2.albuminocytological dissociation 3.immunoglobuline.

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