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Unusual Case of Guillin Barre Syndrome - Acute Quadriparesis with Dysphagia and Dysarthria

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Abstract: ***This article report on atypical presentation of GBS. Patient presented in pmch emergency with acute onset quadriparesis since last 10 days which is more in left lower limb and right upper limb with dysarthria and dysphagia and single breath count Is 8 with no antedecent history of looze stool and high glucose meal intake. On CSF analysis no A - C disproportionation but on clinically basis diagnosed polyradiculopathy and ivig given. Patient improved and discharged with advice of physiotherapy of all limbs and chest and maintain hygiene.***

Keywords: Guillian barre syndrome, polyradiculopathy, Acute inflammatory demyelinating polyradiculopathy Acute motor axonal neuropathy, acute motor sensory axonal neuropathy, Miller Fischer syndrome, Chronic inflammatory demyelinating polyradiculopathy

1. Introduction

GBS is an acute onset bilateral symmetrical sensory (motor) flaccid areflexic ascending type of paralysis. It acquired nadir within 4weeks (28 days). it has 4subtypes – AIDP, AMAN, AMSAN, MFS And many it's variants. It is happened due to molecular mimicry. If its nadir come after 8weeks then it is called CIDP and also mode of treatment changed. Brighton 's criteria used to diagnose GBS which includes clinical criteria, investigation and exclusion criteria

2. Case Report

35-year-old female presented with acute onset flaccid weakness from 10days which makes unable to walk and hold object in hand and shortness of breath from last 1day O/e bilateral planter non responsive, deep tendon reflex (biceps triceps knee and ankel) absent lower limb power 1/5 in both lower limbs. Upper Limb – 3/5 in firearm and 2/5 in arm both sides CSF - cell - 30, sugar - 177, protein - 39, ada - 0.20 fT3 fT4 TSH 2.04/19.34/0.695 hbsag hiv and hcv - non reactive WBC 13500 hb 14.1gm/dl platelets 3.35 sodium and potassium 145/4.5

Diagnosis:
polyradiculopathy (GBS) was made and treated with ivig - 2gm/kg[at]0.4 gm /kg/day for 5 days

3. Conclusion

GBS is a polyradiculopathy, not always present with symmetrical type of weakness can also present as atypical weakness. it is a progressive disease and due to facial nerve and bulbar involment patient may have respiratory distress and chance of aspirations so according to Brighton' criteria – if we are clinically suspecting GBS and after excluded other disease even electro diagnostic (CSF and NCV) report not supporting the disease, we can treat patient with ivig with proper monitoring

4. Discussion

A typical presentation is very rare. Normally patient presented with bilateral symmetrical and ascending type of weakness but some patient may present with unequal weakness. Different subtype have different triggering factor. NCV and CSF study may or may not support your diagnosis but if other diagnosis is ruled out and clinically suspecting GBS then can be treated

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