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Case Series

A Case Series of Atypical Clinical Presentations of Guillain Barre Syndrome in a Tertiary Care Teaching Centre in Western Maharashtra

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Abstract

GBS was described by Landry in 1859, but the full extent of the disease and its characteristics were described by Guillain, Barré and Strohl in 1916. GBS is now the world's most common cause of acute neuromuscular paralysis. GBS affects about 0.4-2.4/100,000 people annually with a bimodal incidence in early and late adulthood, however affecting young adults greater than the elderly. GBS also has a slightly greater male preponderance with a ratio of 1.25–1.5:1. GBS usually involves a prodromal event such as an upper respiratory infection, vaccination, surgery, or a gastrointestinal infection. It is thought that up to 88% of those affected by GBS have a prodromal infection. One to six weeks after the prodromal event, the patient will experience a sub-acute ascending peripheral weakness with decreased or absent deep tendon reflexes. Four subtypes are classified under the umbrella of GBS; these are acute inflammatory demyelinating polyneuropathy (AIDP), acute motor axonal neuropathy (AMAN), acute motor and sensory axonal neuropathy (AMSAN), and the Miller Fisher Syndrome (MFS). Treatment of GBS includes plasmapheresis or intravenous immunoglobulin (IVIg), as well as respiratory support when needed. Plasmapheresis and IVIG in GBS have been shown to be equal in efficacy; however, the ease of use of IVIG has made this the treatment of choice.

Keywords: GBS, Acute Neuromuscular Paralysis.
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Introduction

Case 1:

23/Female resident of Pimpri admitted on 25/01/25 came with c/o Severe Back ache since 2 days followed with difficulty to get up from squatting position. Past H/o fever and sore throat 1 week back. No known comorbidity.

On admission power of both upper and lower limbs was 4/5. Deep tendon reflexes (Biceps, triceps, knee and ankles) were 2+ in bilateral upper and lower limbs and Plantar reflex was normal bilaterally. MRI Spine was done to rule out compressive myelopathy but it was within normal limits. CSF studies were WNL. NCS was planned which was s/o AIDP variant of GBS and patient was started on IVIG. After 5 days course of IVIG patient was shifted to general ward and was discharged on 24/02/25.

Case 2:

35/Male resident of Khetewadi admitted on 30/01/25 came with c/o difficulty in swallowing followed by weakness in B/L lower and upper limbs the next day. No any h/o fever, sore throat, or loose stools in the past 15 to 20 days. No known comorbidities. On admission power was 2/5 in all four limbs and deep tendon reflexes (Biceps, triceps, knee and ankle) were absent in bilateral upper and lower limbs and plantar reflex was absent bilaterally

CSF studies were WNL. On the basis of clinical findings patient was started on IVIG. NCS was done later which was s/o AMAN variant of GBS. The patient was shifted to the general ward and was discharged on 12/03/25.

Case 3:

15/Female resident of Wagholi admitted on 03/06/25 came with c/o breathlessness for 1 day which was followed with bilateral upper and lower limb weakness. History of fever with sore throat 1 Day prior to hospitalization. No known comorbidities. On admission power was 2/5 in all four limbs and deep tendon reflexes (biceps, triceps, knee and ankle) were 1+ in all four limbs and plantar reflex was normal bilaterally.

On admission ABGA was suggestive of ARDS and patient was taken on Mechanical ventilator support in view of low Oxygen saturation. CSF studies were WNL. NCS was done in view of bilateral lower and upper limb weakness which was suggestive of AMAN variant of GBS.

The patient was started on PLEX after a Neurophysician opinion. However, the patient succumbed to death on 09/06/25 due to severe respiratory distress despite being on mechanical ventilator.

Case 4:

55/Male resident of Pimpri admitted on 15/06/25 came with c/o difficulty in speaking followed by buckling of knees and weakness in bilateral upper limbs for 3 to 4 days. No history of fever, sore throat, loose stools in the past 15 to 20 days. Known case of HTN under treatment for the past 5 years.

On admission power was 3/5 in bilateral upper limbs and 4/5 in bilateral lower limbs and deep tendon reflexes (biceps, triceps, knee and ankle) were absent in all four limbs and plantar reflex was absent bilaterally. The patient was electively intubated i/v/o loss of gag reflex. CSF studies were suggestive of Albuminocytologic dissociation. NCS was done which was suggestive of AIDP variant of GBS, Patient was started on IVIG therapy for 5 days and tracheostomy was done in view of need for prolonged ventilatory support.

Case 5:

29/Female resident of Bhosari admitted on 20/06/25 came with c/o difficulty in gripping objects and difficulty in getting up from squatting position for the last 4 to 5 days. No history of fever, loose stools, sore throat in the last 15 to 20 days. No known comorbidities. On admission power was 4/5 in all four limbs and deep tendon reflexes (biceps, triceps, knee and ankle) were normal in all four limbs and plantar reflex was normal bilaterally. MRI Brain and Spine was done to rule out compressive myelopathy but it was within normal limits. CSF studies were within normal limits. NCS was planned which was suggestive of AMAN variant of GBS. Patient was managed conservatively as her weakness was non progressive. The patient was discharged on 29/06/25.

Table 1: Clinical Characteristics, Investigations, Treatment, and Outcomes of Guillain–Barré Syndrome Cases

Cases	Chief Complaint	Power And Reflex	CSF Study	NCV Study	Treatment Given And Outcome
Case 1	Back ache	Power 4\5 in all limbs and reflexes 2+ in all limbs	WNL	AIDP	IVIG given and discharged
Case 2	Difficulty in swallowing	Power 2\5 in all limbs and reflexes absent in all limbs	WNL	AMAN	IVIG given and discharged
Case 3	Breathlessn ess	Power 2\5 in all limbs and reflex 1+ in all limbs	WNL	AMAN	PLEX done but patient succumbed to death
Case 5	Difficulty in speech	Power 3\5 in upper and 4\5 in lower limbs and reflexes absent in all limbs	Albumi no-Cytological dissociation	AIDP	IVIG given and discharged
Case 5	Difficulty in gripping objects	Power 4\5 in all limbs as well as reflexes 1+	WNL	AMAN	Managed conservatively Discharged

Discussion

Out of the 5 patients admitted under the Medicine department none of them presented with typical symptoms of GBS as expected. Patient 1 had presented with chief complaints of backache which on day 2 of admission progressed to lower limb weakness along with areflexia hence was then suspected to be GBS.

Patient 2 presented with chief complaints of difficulty in swallowing which on the next day progressed to bilateral lower and upper limb weakness along with areflexia hence was then suspected of GBS.

Patient 3 presented with severe breathlessness and was taken on Mechanical ventilator i/v/o ABG suggestive of ARDS, later her NCS was done i/v/o weakness in all four limbs and was suggestive of AMAN variant of GBS.

Patient 4 had presented chief complaints of difficulty in speaking followed by weakness in proximal lower limbs and upper limbs, CSF showed

Albuminocytologic dissociation, NCS was suggestive of AIDP variant of GBS.

Patient 5 had presented with difficulty in gripping objects associated with weakness in proximal lower limbs. Her MRI Brain and Spine was WNL. NCS was suggestive of AMAN variant of GBS

Out of the patients listed above 4 of them had normal CSF studies and only 1 patient showed Albuminocytologic dissociation also apart from Patient 1 and 3 none of them had any antecedent history of any fever, loose stools or sore throat.

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