Guide for Primary Care Physicians and General Neurologists

Diagnosing Guillain-Barre Syndrome (GBS) or Acute Inflammatory Demyelinating Polyradiculoneuropathy (AIDP), Chronic Inflammatory Demyelinating Polyradiculoneuropathy (CIDP), and other Variants

Diagnosis should be suspected when patients (all ages) present with symptoms* developing over the course of a few days to weeks. This condition commonly occurs after an infection or other toxin, which serves as a triggering event. If untreated, nerve damage can be severe and recovery can be incomplete.

1. Generally symmetric weakness or paralysis of legs, arms, and/or neck
    - commonly ascending
    - interferes with motor function
        - ataxic gait
        - loss of balance
        - difficulty washing/combing hair, holding fork, toothbrush, pencil, glass, etc.
        - difficulty reaching for objects, buttoning, zipping, grasping a door knob, etc.
        - difficulty stooping and lifting heavy objects
        - difficulty walking, climbing stairs or standing from a chair
        - difficulty breathing
2. Cranial weakness
    - Facial muscle weakness/drooping or inability to smile
    - Difficulty swallowing, talking, or eating
3. Paresthesia (unusual sensations) and
    - Prickling, tingling or sensation of pins-and-needles
    - Numbness of the feet, hands, and/or face
    - Sensory changes – hot, cold, rough, inaccurate perception of the position of the limb, etc.
    - Sensitivity to touch
    - Sensation of electrical pulses or vibrations
    - Formications - sensation of insects crawling on/under skin
    - “Asleep” feeling
    - Cramping (sometimes severe)
    - Pain in the back and limbs

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4. Dysautonomia
    - Diarrhea/constipation
    - Urinary retention
    - Increased/slowed heart rate
    - Sweat dysregulation

5. Reflexes diminished or absent in weakened limbs
    - Loss of tendon reflexes
6. Fatigue
7. Double vision or loss of vision (Miller-Fisher variant)
8. Weakness of distal muscles in the upper limbs initially (Multifocal Motor Neuropathy variant)
9. Presenting first with cranial nerves, or phrenic nerve(s) *(uncommon)*
10. A slower onset and longer progression of disability over more than eight weeks (CIDP)

Diagnosis of GBS is supported by loss of reflexes on clinical examination and Nerve Conduction Study-Electromyography testing, which determines if the conduction of the nerve signal is slow or blocked. It is further supported by elevated cerebrospinal fluid protein with a normal cell count. Therapies that shorten the course of GBS, such as plasma exchange and high-dose IVIG, should be started as soon as possible. Early recognition and treatment are important to ensure proper recovery.

**The time course of GBS typically differs from a stroke in that the maximal deficit of the latter can develop faster, namely, over a few seconds.*

References:

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