International Journal of Science and Research (IJSR)
ISSN: 2319-7064
SJIF (2022): 7.942

A Rare Case of Acute Motor Axonal Neuropathy- A Subtype of Guillain Barre Syndrome in Pregnancy

Dr. Kategru Pavani[1], Dr. Suchitra P[2], Dr. Srilatha[3]

[1]Post Graduate, Department of Obstetrics and Gynaecology, Sri Venkateswara Medical College, Tirupati, India

[2]Post Graduate, Department of Obstetrics and Gynaecology, Sri Venkateswara Medical College, Tirupati, India

[3]Assistant Professor, Department of Obstetrics and Gynaecology, Sri Venkateswara Medical College, Tirupati, India

Corresponding Author Email: *pavanikhatri17[at]gmail.com*

1. Introduction

Guillain-Barré syndrome (GBS) is rare in pregnancy with an estimated incidence between 1.2 and 1.9 cases per 100,000 people annually. Guillain-Barré syndrome (GBS) represents a heterogeneous group of immune mediated peripheral neuropathies. A feature common to all GBS variants is a rapidly evolving polyradiculoneuropathy preceded by a triggering event, most often an infection. GBS generally manifests as a symmetric motor paralysis with or without sensory and autonomic disturbances. GBS should be considered in any pregnant patient complaining of muscle weakness, general malaise, tingling of fingers and respiratory difficulty[1].

2. Case Report

20 year old Primigravida with 22 weeks Gestational age came with chief complaints of bilateral lower limb weakness since 10 days, gradual in onset increasing in severity. History of frequent falls, with difficulty in sitting and standing from supine position was not able to maintain erect posture. Detail clinical history was taken. There is no history of upper limb weakness, bowel and bladder disturbances. There is no history of fever, cold, cough, loose stools, difficulty in breathing, palpitations, chest pain, syncope. Her present pregnancy: conceived spontaneously 3 months after marriage, diagnosed pregnancy at 2 months amenorrhea. First trimester was uneventful.At the time of admission.

Clinical examination
Clinical examination shows Vitals are stable .Temperature was normal ,pulse rate was 106/min, BP was 100/60mmhg, Spo2- 98% with room air. ECG showed Sinus tachycardia. Neurological examination Revealed power of ⅖ in lower limbs and ⅘ in upper limbs, hypotonia, bilateral flexor plantar response and mild sensory involvement noticed. Higher mental functions, speech were normal and no cranial nerve involvement. A provisional diagnosis of GBS was made. Neurologist opinion taken and advised ENMG (Electromyography).

Investigations
Completete hemogram, S. Vitamin B12 levels, S. Electrolytes, Nerve conduction studies, ABG analysis has done, which are normal. ENMG revealed ACUTE MOTOR AXONAL NEUROPATHY involving bilateral common peroneal nerves.

Management:
Patient received treatment in the form of physiotherapy and inj. Vitamin B1 and multivitamin injections for 14 days with close observation of signs and symptoms, to which she gradually responded with respect to power and sense of well-being over next 72 hours, without need for IVIG or immunomodulatory drugs. Patient was discharged at request after 2 weeks of treatment and hospital stay with power of 5/5 in upper limbs and 4/5 in lower limbs. Close follow up was done till delivery. Patient had normal vaginal delivery at term gestation and a live female 3.1 kg baby was born. Delivery and postpartum was uneventful.

3. Discussion

GBS is thought to be immune mediated. But it's pathogenesis remains unclear. About two thirds of patients have an infection within the previous 4-6 weeks, most commonly flu like illness or gastroenteritis. Implicated infectious agents include Mycoplasma pneumoniae, Campylobacter jejuni, Cytomegalovirus, and Epstein Barr virus[2]. The preceding infection may cause an autoimmune response against the various components of peripheral nerve myelin, sometimes the axon. GBS classically presents with pain, numbness, paresthesia, or weakness of the limbs and this can be mistaken for psychological complaint, leading to delay in diagnosis and treatment[3].

GBS can occur in any trimester of pregnancy and a maternal mortality of 7% has been reported. The management of GBS in pregnancy is similar to that of non pregnant women and includes intravenous immunoglobulins (IVIG), plasmapheresis and ventilatory support wherever required[4].

4. Conclusion

A high index of suspicion for early diagnosis and prompt intensive multidisciplinary supportive care in a GBS complicated pregnancy improve the prognosis.

References

[1] Zafar MS, Naqash MM, Bhat TA, Malik GM. Guillain-barré syndrome in pregnancy: An unusual case. Journal of Family Medicine and Primary Care. 2013 Jan; 2(1):90.
[2] Hughes RA, Cornblath DR. Guillain-barre syndrome. The Lancet. 2005 Nov 5;366(9497):1653-66.
[3] Vijayaraghavan J, Vasudevan D, Sadique N, Rajeswari KS, Pondurangi M. A rare case of Guillain-Barre syndrome with pregnancy. Journal of the Indian Medical Association. 2006 May 1;104(5):269-70.
[4] Elovaara I, Apostolski S, Van Doorn P, Gilhus NE, Hietaharju A, Honkaniemi J, Van Schaik IN, Scolding N, Soelberg Sørensen P, Udd B. EFNS guidelines for the use of intravenous immunoglobulin in treatment of neurological diseases: EFNS task force on the use of intravenous immunoglobulin in treatment of neurological diseases. European Journal of Neurology. 2008 Sep;15(9):893-908.