A Relapsing Case Of Guillain-Barre Syndrome (GBS)- With Full Term Pregnancy

Dr Prashant, Dr.Vishal Sheth, Dr.Kanaklata Nakum, Dr Niti Bhatia.

Department of Obstratics and Gynecology , Government Medical College, Bhavnagar, Gujarat

Abstracts: Guillain-Barré syndrome (GBS)-complicating pregnancy is rare with estimated incidence between 1.2 and 1.9cases per 100,000 people annually.' and it is generally believed that it carries a high maternal and fetal risk. We reported a case of 25 year old3rdgrvida patient with relapse of predominantly motor GBS(affecting lower limb muscles) complicating pregnancy without history of antecedent infection. patient managed with IV corticosteroids and IVIG.Patient successfully delivered vaginaly with vaccume without any operative intervention with uneventful postpartum period. [Prashant NJIRM 2015; 6(4):119-120]

Key Words: Guillain-Barré Syndrome (GBS), full term pregnancy distraction.

Author for correspondence: Dr. Prashant Department of Obstratics and Gynecology , Government Medical College, Bhavnagar, Gujarat Email: drprashant@gmail.com

Introduction: Guillain-Barré syndrome (GBS)-complicating pregnancy is rare with estimated incidence between 1.2 and 1.9cases per 100,000 people annually.[1,2] and it is generally believed that it carries a high maternal and fetal risk. Guillain-Barré Syndrome (GBS) is an Acute Demyelating Polyneuropathy, characterized by progressive, ascending paralysis and areflexia with or without abnormal sensory function. Symptoms are preceded by an antecedent event in about two-thirds of patients.[3,4.] The disease has been linked to bacterial and viral infections, systemic diseases, neoplasia, pregnancy, traumatic injury, and organ transplant.

GBS has been considered a devastating disease because of its unusual and sudden onset. About one-third of the patients with GBS will require mechanical ventilation and most GBS-related deaths occur as a result of respiratory failure. In the developing world, where health facilities are limited, GBS has been shown to be an important cause of flaccid paralysis. In a cohort study, age-adjusted relative risks indicate that the risk for GBS is lower during pregnancy and increases after delivery[5]. It is known to worsen during the post-partum period due to a rapid increase in delayed-type of hypersensitivity during this period. Relapse during successive pregnancies has been reported[6].

The occurrence of disease in the third trimester carries the risk of respiratory complication and prematurity. There is no specific therapy for GBS; however, plasma exchange and intra-venous immunoglobulin (IVIG) administration have been shown to reduce the progression and severity of disease; in fact, it has been found to accelerate the recovery of these patients. This case is rare as we treated patient conservatively and delivered by vaginal route with good fetomaternal outcome.

Case Report:

A 25 year old G3P2A0L2 patient who diagnosed a case of GBS before1 yr.Presented at sir t hospital Bhavnagar, Gujarat on 11th September 2013 with chief complain oflower limb weakness which was gradually increase since 2 days with H/O 9 month amenorrhea.

On examination patient have decreased power of both lower limb which was grade 3 compare to upper limb which was grade 5 with sluggish reflexes. Power gradually decreasewhich was 0 in lower limb and 3 in upper limb after 2 day of admission, no sensory loss in either limb. Her blood investigation investigation is normal,CPK MB level was 15 U.Antenatal ultrasound on 12th September 2013shows A single viable intrauterine fetus in cephalic presentation, placenta fundo anterior adequate liquor,EFW 2.6 KG .EDD 14 October 2013.In obstetric history-patient having 2 full term normal vaginal delivered, 5 yr and 3 yr healthy child. patient admitted with similar neurological complain 1 yr back with MRI of spine was done that time, suggestive of the nerve roots at the cauda equine are thickened and reveal homogenous post contrast enhancement suggestive of GULLAIN BAR SYNDROME.

After admission patient treated conservatively with inj.methyl prednisolone 1 gram OD and Intra venous immunoglobulin 0.4 gm/kg for 5 days. After 16 day Patient had spontaneous onset of labor with having muscle power in upper limb 4 and 2 in lower

limb. Trial of normal vaginal delivery given.1st stage of labour patient monitored and augmentation with oxytocin done 2nd stage of labour cut short by vaccume.patient delivered a healthy female child of 2.5 kg with APGAR 8 at 1 minute and 9 at 5 minute.Her postpartum period followed which was uneventful.

Discussion: GBS is neurological disorder resulting primary in muscle paralysis, which in most cases is symmetrical[7].About 2/3 of patient have infection within previous 4 to 6 weeks most commonly flu like illness or gastroenteritis ,causative agent may include mycoplasma pneumonia, campylobacterjejuni, cytomegalo virus and ebstienbar virus[(8)].GBS occurring in pregnancy associated with decrease in cellular immunity and increase in humoral immunity this shift is because of production of IL-10.after pregnancy is terminated this is reversed and this accounts for the increased incidence and worsening of symptoms in postpartum period.

There have been reported of cases of GBS in pregnancy in all 3 trimester and postpartum period. there is high perinatal morbidity and mortality due to spinal anesthesia and cesarean section. GBS has no effect on uterine contraction or cervical dilatation[8].,in the acute phase, induction of labour or Caesarean section may provoke deterioration of the patient's condition. However as the ability to bear down will be weakened, vacuum extraction may be required[9]; otherwise unnecessary obstetric intervention should be discouraged [10].

In our case relapse of GBS occur In 3rd trimester that had been managed by steroids and IVIG , ventilator support not needed. we delivered this patient successfully by full term vaginal vaccume delivery without any operative intervention, her postpartum period was uneventful.

Conclusion: High index of suspicion for early diagnosis and prompt treatment with multidisciplinary approach. Normal vaginal delivery can be possible and by avoidinganesthesia and operative intervention we can decrease maternal morbidity and mortality.

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