GUILLAIN BARRE SYNDROME: ROLE OF SECOND INFUSION OF HUMAN INTRAVENOUS IMMUNOGLOBULIN (IVIG): CON VIEW

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Human intravenous immunoglobulin (IVig) is a treatment which is recommended for patients with Guillain Barre syndrome(GBS). Treatment with IVIg improves functional outcome, but not overall mortality[1]. Plasma exchange (PE) is an equally effective treatment for GBS, but clinical trials of IVIg following PE was not more effective when compared with PE alone or IVIg alone[2]; immunoadsorption followed by IVig also appears to be no more effective than IVIg alone [3].

Evidence from several randomised clinical trials confirm the view that a single course of immunotherapy with PE or IVig alone is equally effective in GBS and there is no advantage of a second course of immunotheraopy in non-relapsing patients. Early relapses or treatment related fluctuations occur in about 10% of treated GBS patients and the rate of relapse for PE and IVig is comparable. These fluctuations are considered to reflect the characteristics of individual patient's immune activation rather than the timing of initial immunotherapy[4], and are often seen about six weeks after the initial treatment[5]. Patients who experience sustained neurological deterioration after initial treatment and respond favourably to a second course of immunotherapy are likely to be diagnosed with subacute or chronic inflammatory demyelinating polyneuropathy (CIDP).

In the absence of an adequately powered randomised clinical trial with well defined outcome measures, a second course of IVIg is not to be presently recommended in GBS based on anecdotes alone. A further course of IVIg in GBS is likely to increase the cost of therapy as well as infusion-related complications (stroke and renal failure), and would effectively negate any possible marginal benefit seen in some patients.

References

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