ACUTE-ONSET CIDP OR GBS-TREATMENT RELATED FLUCTUATIONS? A DECISION TO BE MADE

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INTRODUCTION Guillain-Barre syndrome (GBS) and chronic inflammatory demyelinating polyneuropathy (CIDP) have strict diagnostic criteria, that most importantly include the time to reach nadir and the course of disease progression. Nevertheless, 16% of CIDP patients have a rapid deterioration within 8 weeks, followed by chronic course, the so called acute CIDP (A-CIDP). 8-16% of GBS patients have 1 or more deteriorations after initial improvement, following treatment, described as treatment related fluctuations (TRF).

CASE REPORT A 39-years old male was admitted due to progressive proximal weakness, areflexia and paresthesiae of the lower limbs. He had a history of respiratory infection 20 days before. Within two days, the weakness ascended to affect all 4 extremities, both facial nerves and lower cranial nerves. CSF analysis showed cell albumin dissociation and GBS was highly suspected. Intravenous immunoglobulin (IVIg) started for 5 days and he progressively improved, within 10 days. After a week, he deteriorated developing quadriplegia, autonomic dysfunction and he was intubated, due to respiratory failure. The electrophysiological study revealed axonal damage and complete denervation. He was retreated with IVIg for 5 days. Respiratory function improved, but 6 months after his admission, was unable to walk.

DISCUSSION Distinguishing between A-CIDP and GBS-TRF is a matter of ongoing research. Recent prospective studies are trying to set prognostic and diagnostic criteria. The diagnosis of A-CIDP should be considered when a patient thought to have GBS deteriorates again, beyond 8 weeks from onset or when this occurs 3 times or more. Patients with sensory disturbances, no history of diarrhea, proximal onset of weakness are at risk of developing TRF. Our patient was diagnosed with GBS-TRF and he was retreated with IVIg. It is important to distinguish between these entities, because treatment strategies and prognosis differ.