

Headache as Presenting Feature of Gullian Barre Syndrome

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Abstract: Gullian Barre Syndrome is immune mediated inflammatory disorder of peripheral nervous system that produces rapidly progressive demyelination & axonal loss. Unexplained headaches as a presenting symptom of GBS has been extremely rare in literature. However only 2 cases in English language literature have been reported earlier by Kanchan Kanel et al (2011) .The patient besides headache noted to have isolated ptosis without ophthalmoplegia,subsequently developed descending weakness.The ptosis as an initial occurrence without ophthalmoplegia in GBS is also extremely rare. We are presenting a case of Gullian Barre Syndrome with such rare presentations of ptosis & headache as initial features of the disease.

Key words : Headache , Ptosis, Gullian Barre Syndrome

I. Case Report:

H.P, 40 yrs old women with past medical history of type 2 diabetes mellitus controlled on oral hypoglycaemic agents presented with bilateral intractable temporo-occipital throbbing headache for past 15 days. 8 days before admission to our hospital she has had neurologic & psychiatric consultations & was provided palliative therapy with analgesics & antipsychotics without any fruitful outcome. On presentation she was alert & fully oriented & persistently complaining of severe headaches and generalized weakness.She had no vomiting , diplopia.General examination was unremarkable.Neurologic examination on presentation showed ptosis (right side) with global depressed deep reflexes except left ankle which was normal with preserved distal motor strength & 3/5 in proximal group.By day 3 , patient has had again neuropsychiatric problems in the form of anxiety , emotional disturbances , feelings of hopelessness & depressive symptoms .She denied any bladder or any sensory abnormalities , or any apparent difficulty in breathing. However her single breath count was 10 to 12 per min. Funduscopy was normal. Lab findings of haemogram magnetic resonance imaging of brain along with magnetic resonance venography were normal .Cerebrospinal fluid examination showed albumino - cytologic dissociation.Csf protein : 115 mg%, sugar : 63 mg% , chloride normal - , blood sugar at the time of lumbar puncture : 116 mg%.Microscopic examination revealed 3 to 4 lymphocytes per high power field .Nerve conduction studies revealed “ slow conduction, demyelination consistent with the diagnosis of polyneuropathy & axonopathy. She was provided with intravenous immunoglobulin in the dose of 400 mg/kg/day for 5 days. She showed improvement in the neuro psychiatric condition remarkably & headache disappeared altogether. However her ptosis & limb weakness persisted though improved. Patient was discharged on request in stable condition after 10 days.

II. Discussion :

GBS is a immune mediated heterogenous condition commonly characterized by combination of limb paresthesias, generalized weakness & areflexia with motor, sensory & autonomic dysfunction. The immune pathologic findings being endo neural inflammation in spinal nerve roots , distal nerve root segments or around nerve entrapment sites.The target antigens are perhaps common to axon , myelin sheath or both.The psychiatric symptoms are not uncommon in persons with GBS which develop during early period of the disease¹.Psychiatric symptoms include anxiety,depressive symptoms, reactive psychosis , hopelessness & these features may occur independently or in combinations as a feature of subacute confusional state².Our patient has had neuropsychiatric abnormalities in the form of anxiety , emotional disturbances , feelings of hopelessness & depressive symptoms. The features were reviewed by senior physician & through the staff and patients family members.Our patient received tricyclic antidepressants and benzodiazepines & showed modest improvement with above therapy which was also combined with immunoglobulins.The observation suggests that person with anxiety and affective lability in GBS may be benefitted from judicious use of pharmacotherapy with TCAs and benzodiazepines combinations & immunoglobulins. Ocular muscle weakness may provide a challenge to distinguish Gullian Barre syndrome from myasthenia gravis. Ptosis as an initial presentation of Gullian Barre syndrome without ophthalmoplegia has been extremely rare ³. (Kanchan Kanhel (2011) ⁴ reported 2 cases in a week who presented in emergency department for unexplained headaches. The lumbar puncture revealed the unexpected findings of albumino-cytological dissociation and further investigations in the case led to the diagnosis of GBS variant. Headache as presenting symptom of GBS has been extremely unusual as aptly noted

in the world literature^{4,5}. Present case under discussion had only headache as the presenting symptom of GBS. Inflamed cranial nerves, spinal roots, peripheral nerves may cause aching and throbbing pains. Any patient with acute unexplained headache & areflexia with or without ptosis, a possibility of GBS needs to be considered as major differential diagnosis.

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