GB Syndrome ER and ICU management issues -

Moderator - Dr. Mihir Sarkar

Panelist – Dr. Agnisekhar Saha

Dr. Prabhas Prasun Giri

Dr. Rohit Bhowmik

Dr. Kaushik Maulik

History

- A 6 year old male, 20 kg
- Sudden onset weakness of lower limbs, inability to stand
- Progressed to UL over next 2 days
- Decreased volume of voice
- Sensorium was normal.
- No H/O – fever, trauma, immunization, diarrhea or seizure.

CNS – Alert, conscious.

Quadriparesis – power LL -1/5, UL- 2/5

Global areflexia.

No sensory loss.

Resp – RR-30/min, CVS – Hr- 110/min,

BP – 98/58 mmHg

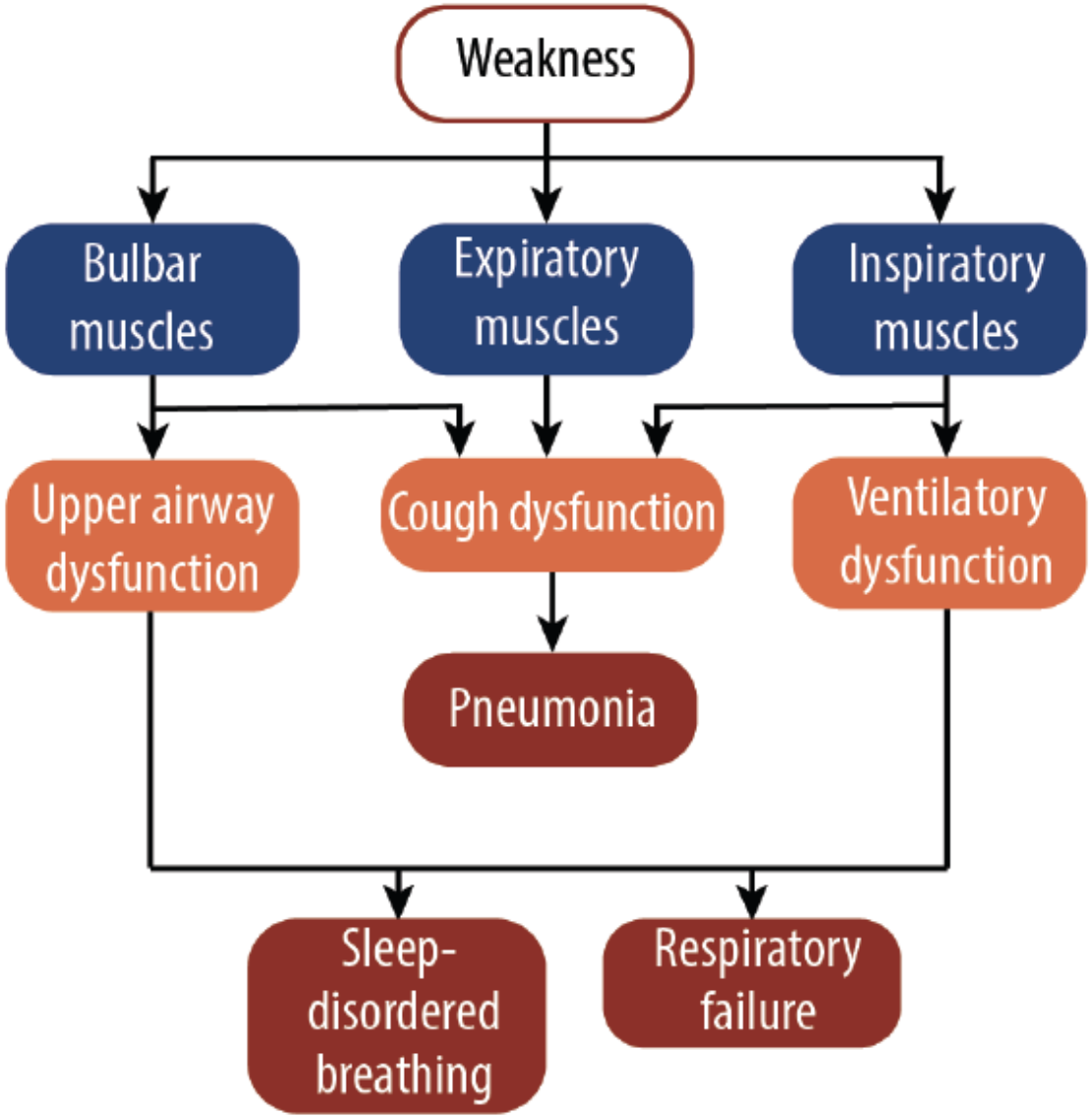
What is your working diagnosis ?

Kaushik

- **What are the Emergency issues a patient with GB Syndrome might have ?**

Rohit

Spectrum of Emergency Care



Dysautonomia – Labile BP, Arrythmia, ileus, bladder control, Cardiomyopathy

DVT

Pain

Anxiety

What are the indications of ICU admission in a patient f GB Syndrome ?

Prabhas

Indication to admission in PICU

- Rapid progression of motor weakness involving respiratory muscles
- Ventilatory insufficiency
- Pneumonia
- Severe bulbar weakness
- Autonomic instability: arrhythmia, or bradycardia
  - Autonomic dysfunction is an important cause of death due to hemodynamic instability and arrhythmias.

- How will you assess and monitor a patient of GB Syndrome in ER or PICU ?

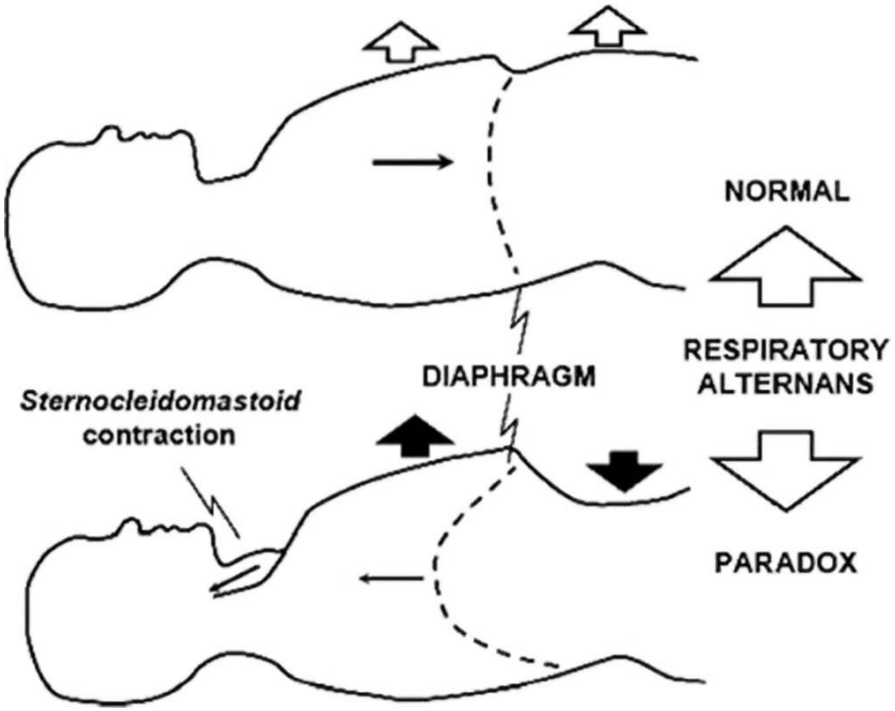
Agnida

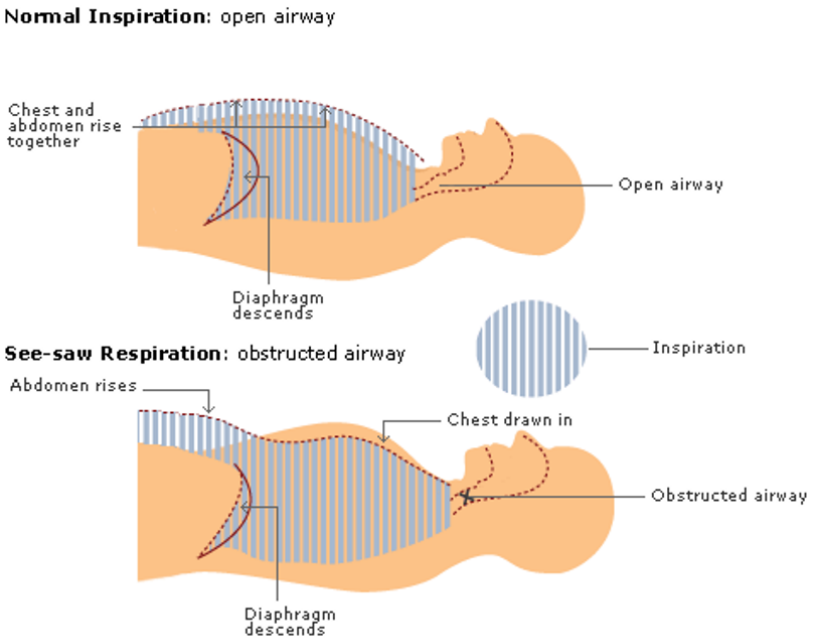
Assessment of Adequate Respiratory Function

Clinical

- Respiratory rate—Good index of response to hypoventilation caused by muscular weakness; tachypnea is the earliest response
- Swallowing and handling of secretions
- Quality of cough
- Volume of speech
- Single-breath count
- Chest expansion
- Presence of tachycardia/diaphoresis (nonspecific)
- Use of accessory muscles
- Orthopnea
- Inward movement of abdomen during inspiration
- Breathing pattern alternates between accessory and major respiratory muscles, signifying weakness of major respiratory muscles
- Change in status when sleeping—accessory muscle tone decreases
- Rate of progression of generalized weakness

Paradoxical vs Sea Saw Breathing





Laboratory

- Vital capacity
- Maximum inspiratory pressure
- Maximum expiratory pressure
- Sao_2, Pao_2, $Paco_2$, pH
- Chest radiograph

Count up to 10 in one breath, the FVC is at least 15–20 mL/kg.
Can count up to 25, the vital capacity is ~30–40 mL/kg.

Monitoring the trend in single-breath counting may help to determine disease progression

Ability to FLEX the neck

Increasing trend of PaCo2

Are there any predictors of need of Mechanical Ventilation ?

Kaushik

ORIGINAL CONTRIBUTION

Anticipating Mechanical Ventilation in Guillain-Barré Syndrome

Nicholas D. Lawn, FRACP; Dade D. Fletcher, MD; Robert D. Henderson, FRACP; Troy D. Wolter, MS; Eelco F. M. Wijdicks, MD

1. Rapid disease progression,
2. Bulbar dysfunction,
3. Bilateral facial weakness, or dysautonomia
4. Vital capacity of less than 20 mL/kg,
5. Maximal inspiratory pressure less than 30 cm H_2O,
6. Maximal expiratory pressure less than 40 cm H_2O.
7. Reduction of more than 30% in vital capacity

“20/30/40 rule” – In Adults

Original Article

Clinical predictors of mechanical ventilation in Guillain-Barré syndrome

Birinder S. Paul, Rohit Bhatia[1], Kameshwar Prasad[1], M. V. Padma[1], Manjari Tripathi[1], M. B. Singh[1]

Department of Neurology, Dayanand Medical College and Hospital, Ludhiana, Punjab, [1]Department of Neurology, All India Institute of Medical Sciences, New Delhi, India

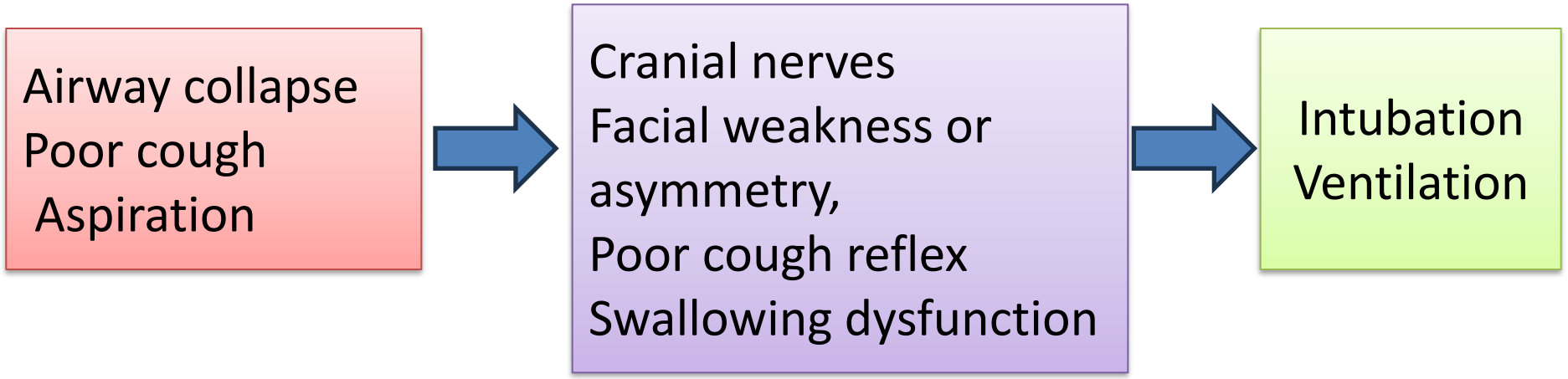
- Simultaneous weakness of upper (UL) and lower (LL) limbs as the initial symptom ($P<0.001$);
- UL power less than Grade 3/5 at nadir ($P<0.001$);
- Presence of neck and bulbar weakness ($P<0.001$);
- Shorter duration from onset to bulbar weakness and confinement to bed ($P=0.001$)
- Bilateral facial involvement ($P<0.01$)
- **An elective endotracheal intubation may prevent sudden respiratory arrest and its consequences**

NIV vs Mechanical Ventilation – What and Whom ?

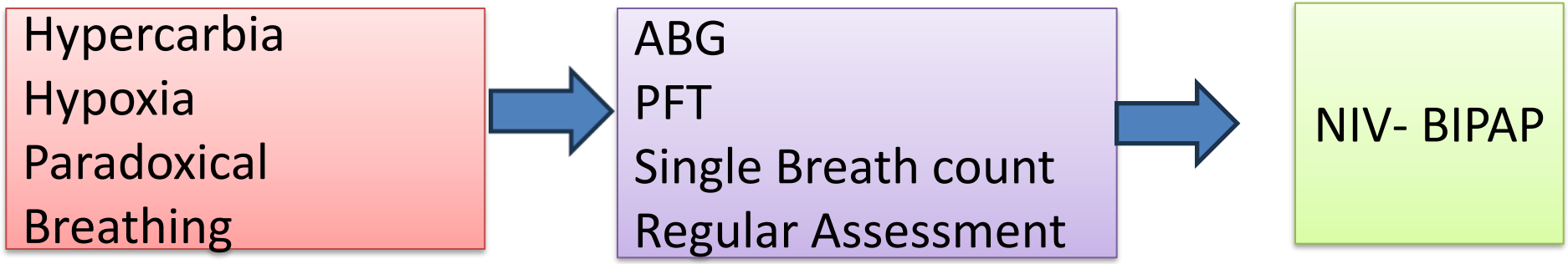
Rohit

Assessing Ventilation and the Need for Urgent Intubation and Ventilatory Support

Oropharyngeal weakness –



Diaphragmatic and intercostal muscle weakness



What precautions will you take during intubation ?

Prabhas

Special considerations for intubation

- Dysautonomia may exaggerate the hemodynamic responses to the drugs

Emergency intubation (with full stomachs or ileus)

- Modified RSI technique – **Apnea Oxygenation, cricoid pressure**
- Prepare atropine/glycopyrrolate, fluids, and vasopressors (risk of associated autonomic instability

- **Avoid use of succinylcholine**. Consider 1.0–1.4 mg/kg rocuronium. Reduce the dose in MG and myopathis
- **Volatile aneasthetic agents are preferable**
- A titrated or reduced dose of a sedative and analgesics

What strategy will you take while ventilating this patient ?

Agnida

Ventilator Settings

- Volume-controlled / SIMV + PS ventilation
- Normal V T (8 ml/kg) and Respiratory rate.
- Although high V T have been recommended by some authorities, not necessary for most patients.
- Set V T and respiratory rate that the patient considers comfortable.
- Low pressures and a low FiO2
- PEEP is set (eg, 5 cm H_2O) to prevent atelectasis.

Weaning

- Train the diaphragm and respiratory muscle
- Gradual weaning
- Initially Day time PS mode and Night time controlled mode
- Gradually decrease the PS , even can reduce to ZERO PS and.....gradually night PS also
- Can give T-Piece trail

Patient is not moving at all - Sedation and analgesia does it require ?

Kaushik

Pain is often overlooked feature of GBS, occurring in 55% to 89% of patients. Anxiety occurs in 82% of patients.

Cause - Inflammation of proximal nerve roots,

Sensory nerve fiber dysfunction

Musculoskeletal pain from immobility

Analgesics options – Opiates - ileus may limit their use

Gabapentine, Carbamapazemines.

Sedation and Anxiolytic - Benzodiazepines, SSRI

Ruts L, Rico R, van Koningsveld R, et al. Pain accompanies pure motor Guillain-Barré syndrome. J Peripheral Nervous System. 2008;13(4):305–306

D - 2

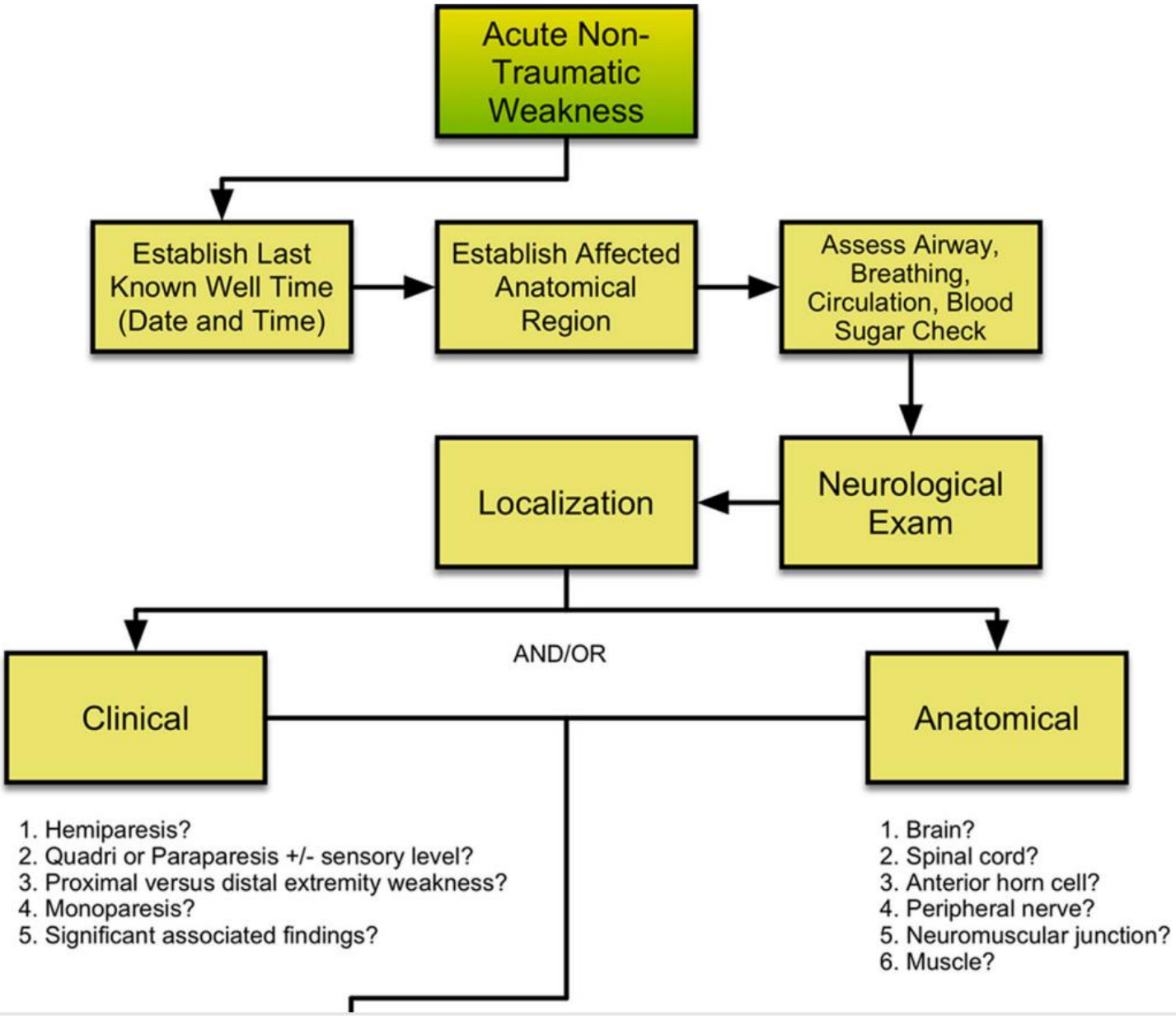
- Patient had sudden onset of tachycardia (HR – 180), hypotension (BP- 70/40 mmHg) and profuse perspiration .
- What are the possibilities ?
- How will manage the situation ? Rohit
- Autonomic dysfunction - occurs in 2%–10% of patients
- Volume repletion, and if refractory to fluids, a pure α-agonist such as phenylephrine.
- Fluctuating BP - Monitor ABP to guide fluid.

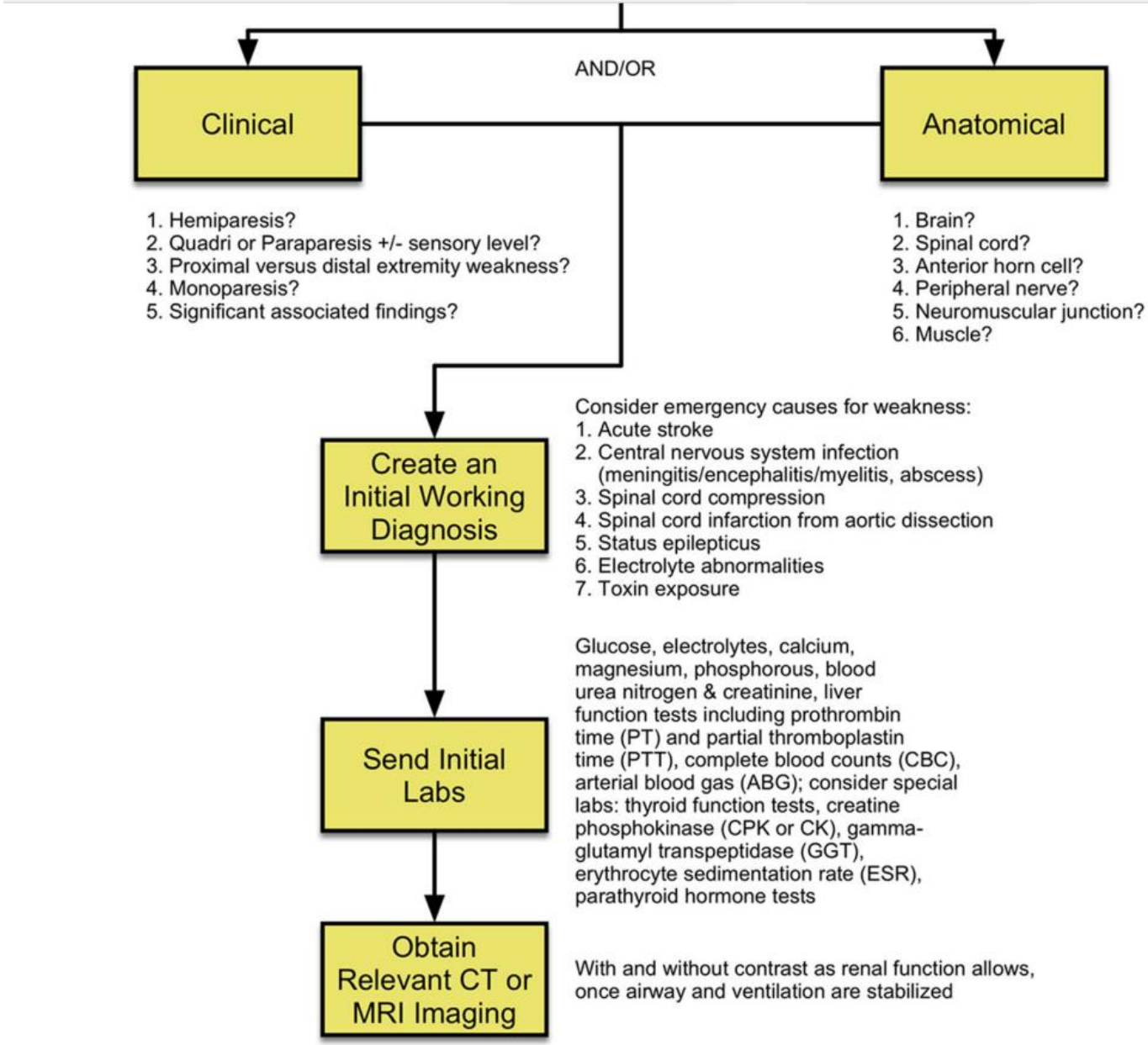
What are the Lab tests will you do ?

Acute weakness checklist for the first hour

- ☐ Assess airway, breathing, and circulation
- ☐ Characterize the weakness by detailed exam
- ☐ Build an initial differential diagnosis of the causes of weakness
- ☐ Consider emergency causes in the differential diagnosis
- ☐ Initial labs: Glucose, electrolytes, Ca, Mg, PO4, BUN/Cr, LFTs, PT, PTT, CBC, and ABG
- ☐ Special Labs: TFTs, CPK or CK, ESR, parathyroid hormone, GGT
- ☐ Relevant MRI and CT imaging

Nerve Conduction Study, CSF Analysis


Acute Non-Traumatic Weakness
Establish Last Known Well Time (Date and Time)
Establish Affected Anatomical Region
Assess Airway, Breathing, Circulation, Blood Sugar Check
Neurological Exam
Localization
AND/OR
Clinical
Anatomical
1. Hemiparesis?
2. Quadri or Paraparesis +/- sensory level?
3. Proximal versus distal extremity weakness?
4. Monoparesis?
5. Significant associated findings?
1. Brain?
2. Spinal cord?
3. Anterior horn cell?
4. Peripheral nerve?
5. Neuromuscular junction?
6. Muscle?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3. Anterior horn cell?
4. Peripheral nerve?
5. Neuromuscular junction?
6. Muscle?
Create an Initial Working Diagnosis
Consider emergency causes for weakness:
1. Acute stroke
2. Central nervous system infection (meningitis/encephalitis/myelitis, abscess)
3. Spinal cord compression
4. Spinal cord infarction from aortic dissection
5. Status epilepticus
6. Electrolyte abnormalities
7. Toxin exposure
Send Initial Labs
Glucose, electrolytes, calcium, magnesium, phosphorous, blood urea nitrogen & creatinine, liver function tests including prothrombin time (PT) and partial thromboplastin time (PTT), complete blood counts (CBC), arterial blood gas (ABG); consider special labs: thyroid function tests, creatine phosphokinase (CPK or CK), gamma-glutamyl transpeptidase (GGT), erythrocyte sedimentation rate (ESR), parathyroid hormone tests
Obtain Relevant CT or MRI Imaging
With and without contrast as renal function allows, once airway and ventilation are stabilized

Course

- Nerve conduction study - low CMAP amplitudes in all 4 limbs suggestive of Acute Motor Axonal Neuropathy (AMAN) variety

.

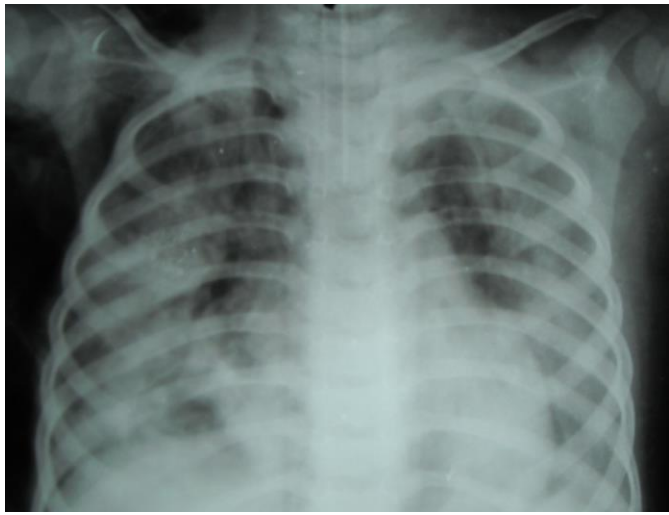
- Cerebrospinal fluid (CSF) analysis done on day 10 of weakness showed albumin-cytological dissociation

Child received intravenous immunoglobulin (IVIG) 2 g/kg over 5 days on Day 2 and 3 of admission - no clinical improvement

Plasma Exchange done after 10 days

D-7

- Child worsened
- Fall in saturation to 85%, heart rate increased to 180/min, although BP was normal. High rade fever with profuse secretion in ET.
- EtCO2-56, expiratory tidal volume corresponding to inspiratory tidal volume, ventilator working well.
- Apparently chest movements normal on both sides, Crepitation bilateral .



What is happening ?

Agnida

Outcome depends on smooth sailing throughout the long course.

- **What are the complications of prolonged Mechanical Ventilation?** **Agnida**

What are the complications of prolonged Mechanical Ventilation?

- Nosocomial pneumonia
- Atelectasis

Long-term, invasive ventilation may result in

- Tracheomalacia,
- Tracheoesophageal fistula formation, or
- Tracheal stenosis.
- Adhere to VAP Bundle .Practice sterile techniques during suctioning.

General Supportive Care – Key to Success ?

Kaushik

- Regular physiotherapy,
- Provision of splints to prevent joint contractures,
- Prevention of deep vein thrombosis
- Careful positioning and repositioning.
- Early Enteral nutrition - Inadequate calories and protein may result in ventilator dependence.
- Handwashing, strict policies regarding intravenous and urinary catheter asepsis and antimicrobial stewardship.

Nutrition – How will you go about it ?

Rohit

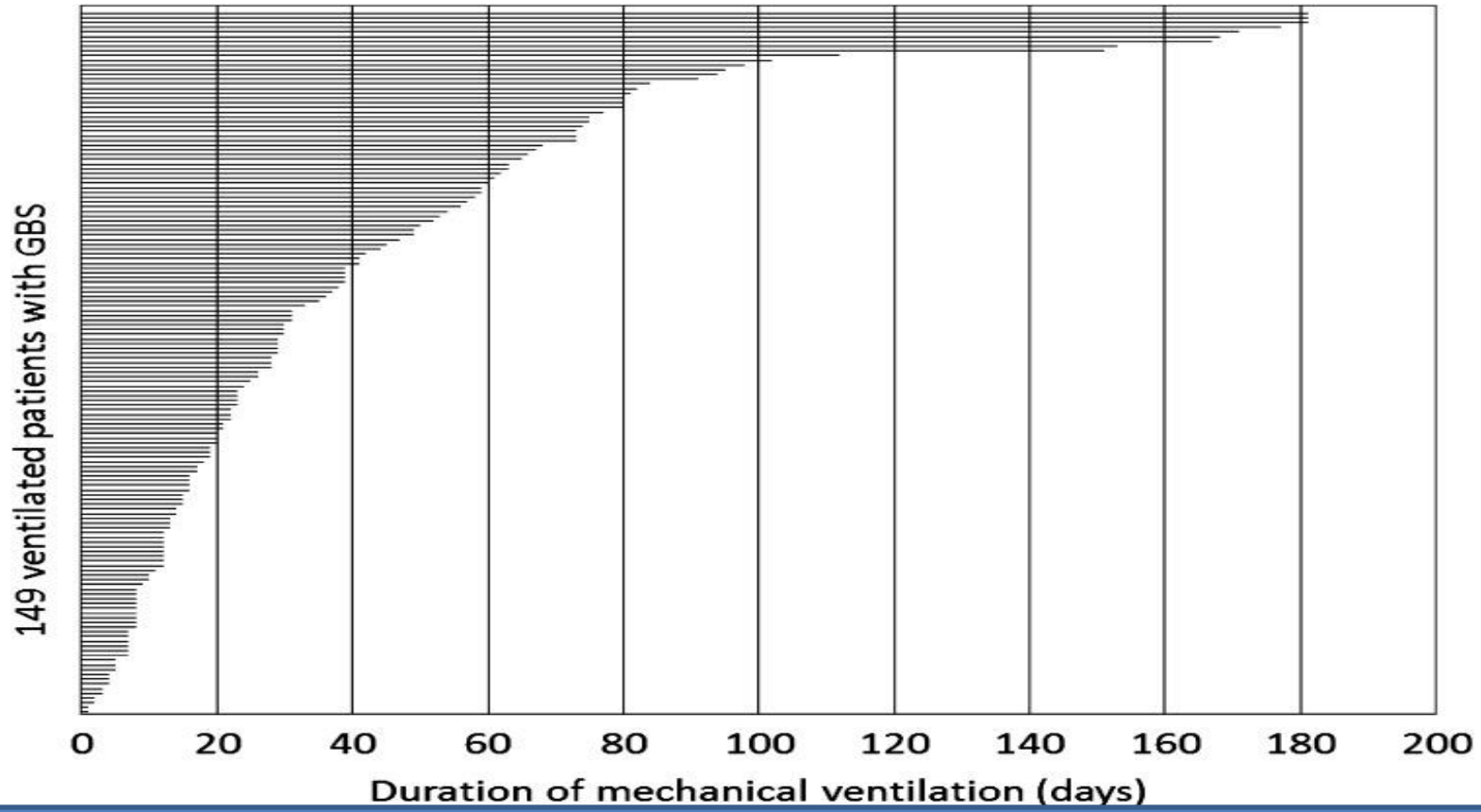
- GBS is a hypermetabolic and hypercatabolic state .
- Inadequate nutrition -

  Fluid and electrolyte abnormalities,

  Decubitus ulcers, as well as

  Nosocomial infections
- Early enteral feeding.
- High-protein diet at 1.3 to 1.5 × their calculated basic energy expenditure (BEE) plus an additional 30% to 50% for weight.
- Monitor nitrogen balance, prealbumine, transferrin.
- Bowel care – Prevent constipation

Duration of MV



The figure indicates the Duration of mechanical ventilation in 149 patients with GBS. Median duration of mechanical ventilation was 28 days, interquartile range of 12–60 days, absolute range 1 to >181 days (follow-up of the studies ended at 181 days)

Let's talk about tracheostomy

Why Tracheostomy ?

- To prevent laryngeal and upper airway damage due to prolonged translaryngeal intubation
- To allow easy or frequent access to the lower airway for suctioning and secretion removal
- To provide a stable airway in a patient who requires prolonged mechanical ventilation or oxygenation support

- When will you consider tracheostomy and how will you approach ? Prabhas

neurocritical care society Neurocrit Care (2017) 26:6–13
DOI 10.1007/s12028-016-0311-5

CrossMark

ORIGINAL ARTICLE

Tracheostomy or Not: Prediction of Prolonged Mechanical Ventilation in Guillain–Barré Syndrome

Christa Walgaard[1] · Hester F. Lingsma[2] · Pieter A. van Doorn[1] · Mathieu van der Jagt[3] · Ewout W. Steyerberg[2] · Bart C. Jacobs[1,4]

Conclusions -
Ventilated GBS patients who are unable to lift the arms from the bed and patients who have axonal degeneration(AMAN) or unexcitable nerves at 1 week are at high risk of prolonged MV, and tracheostomy should be considered in these patients.

WHEN ?

- Published recommendations and experts' opinions mostly consider 10 to 15 days as the optimal delay for performing tracheotomy .
- Tracheotomy after 21 days might be associated with longer ICU stay and higher mortality.

- **Tracheotomy: why, when, and how?** *Respir Care* 2010, **55:** 1056-1068.

Benefits of Changing From a Translaryngeal Endotracheal Tube to a Tracheostomy Tube

Benefit	Type and Quality of Literature Support Showing Benefit
Improved patient comfort	Uncontrolled reports, clinical opinion
Less need for sedation	Several RCTs
Lower work of breathing	Theoretical analysis, one small study
Improved patient safety	Clinical belief but minimal data
Improved oral hygiene	Clinical observation
Oral intake more likely	Opinion only
Earlier ability to speak	Uncontrolled reports
Faster weaning from mechanical ventilation	One RCT
Lower risk of ventilator-associated pneumonia	Controversial, data support for both sides
Shorter intensive care unit and hospital stay	Several meta-analyses

Rehabilitation and permanent disability

Agnida

- **Early Mobilization**:
- **Physical Therapy**:
- **Occupational Therapy**:
- **Respiratory Therapy**:
- **Speech and Swallowing Therapy**:
- **Emotional and Mental Support**:

Course

Tracheostomy done on D-18

Need MV for 55 days (2 VAP episode)

Decannulation on D- 70

Discharged on D-75

D -90 follow up – Able to walk with support, Feeding and voice normal . D -120 – Able to walk independently

Key Points

- Asses the early indications of ICU admission and Mechanical Ventilation
- Stabilize the patient before transport and continue support during transport
- Be aware of autonomic dysfunction
- Prevent nosocomial infection
- Good and meticulous supportive care is the key to success

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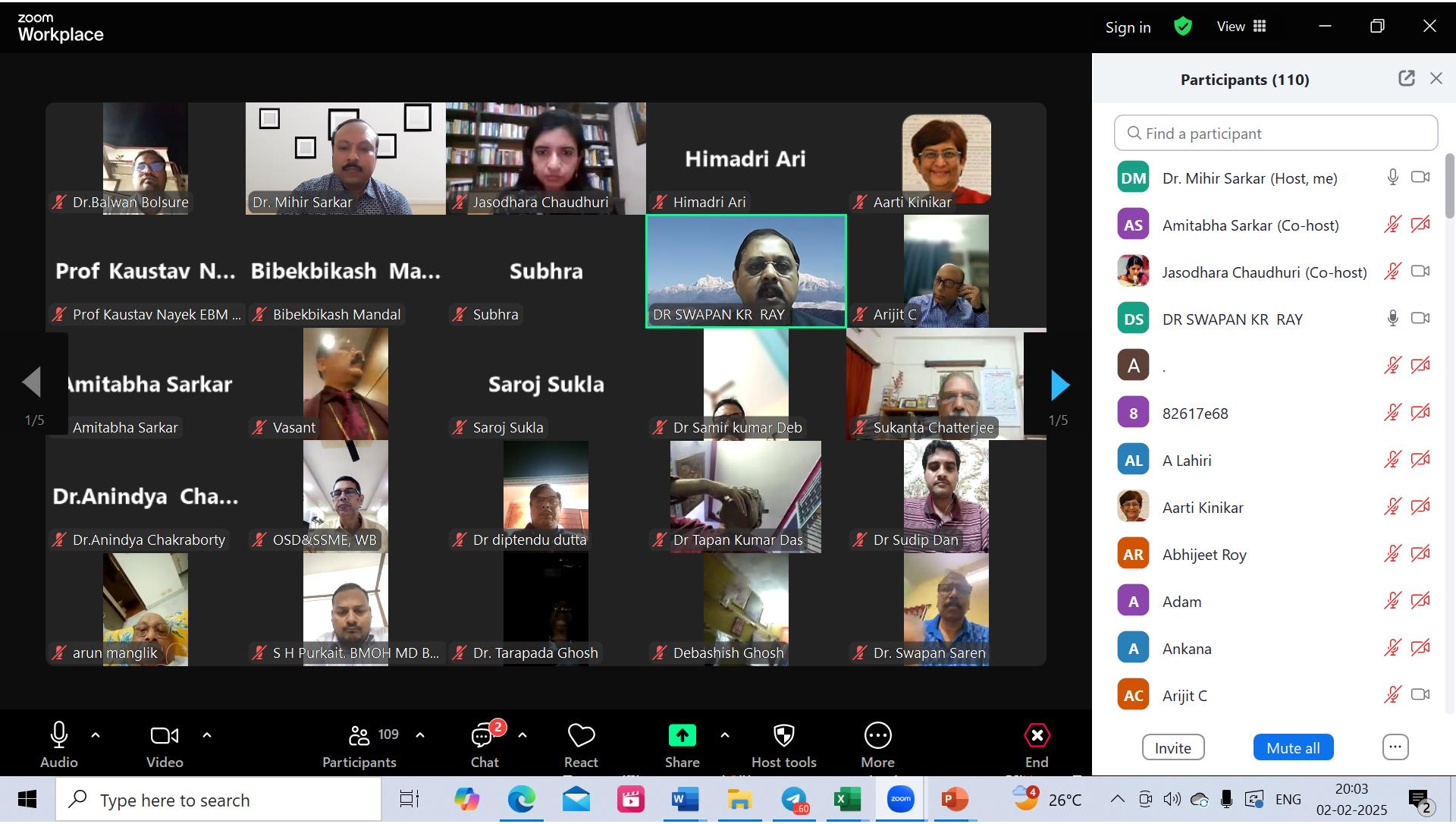
January, 2026 Venue: Kolkata, India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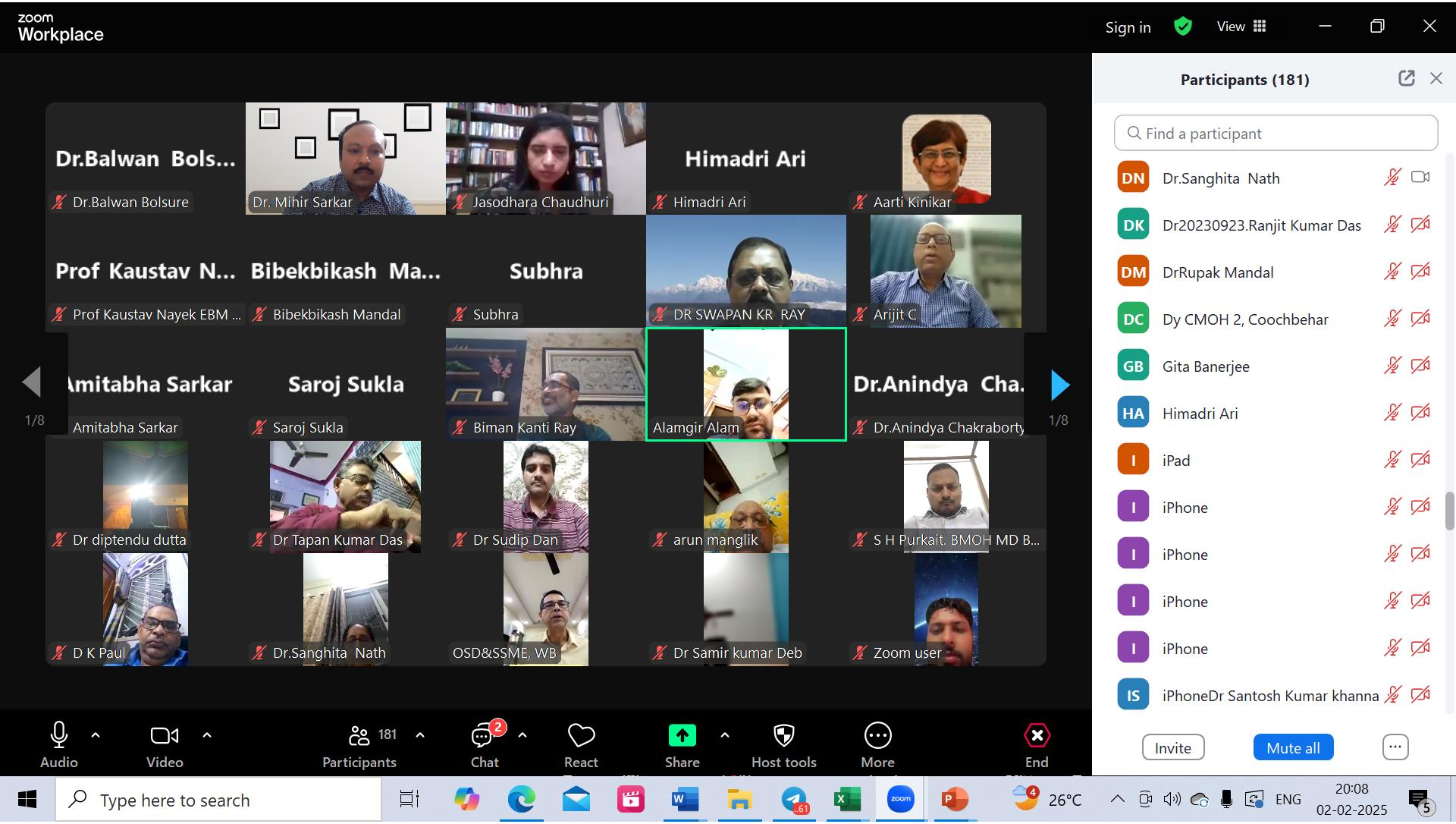
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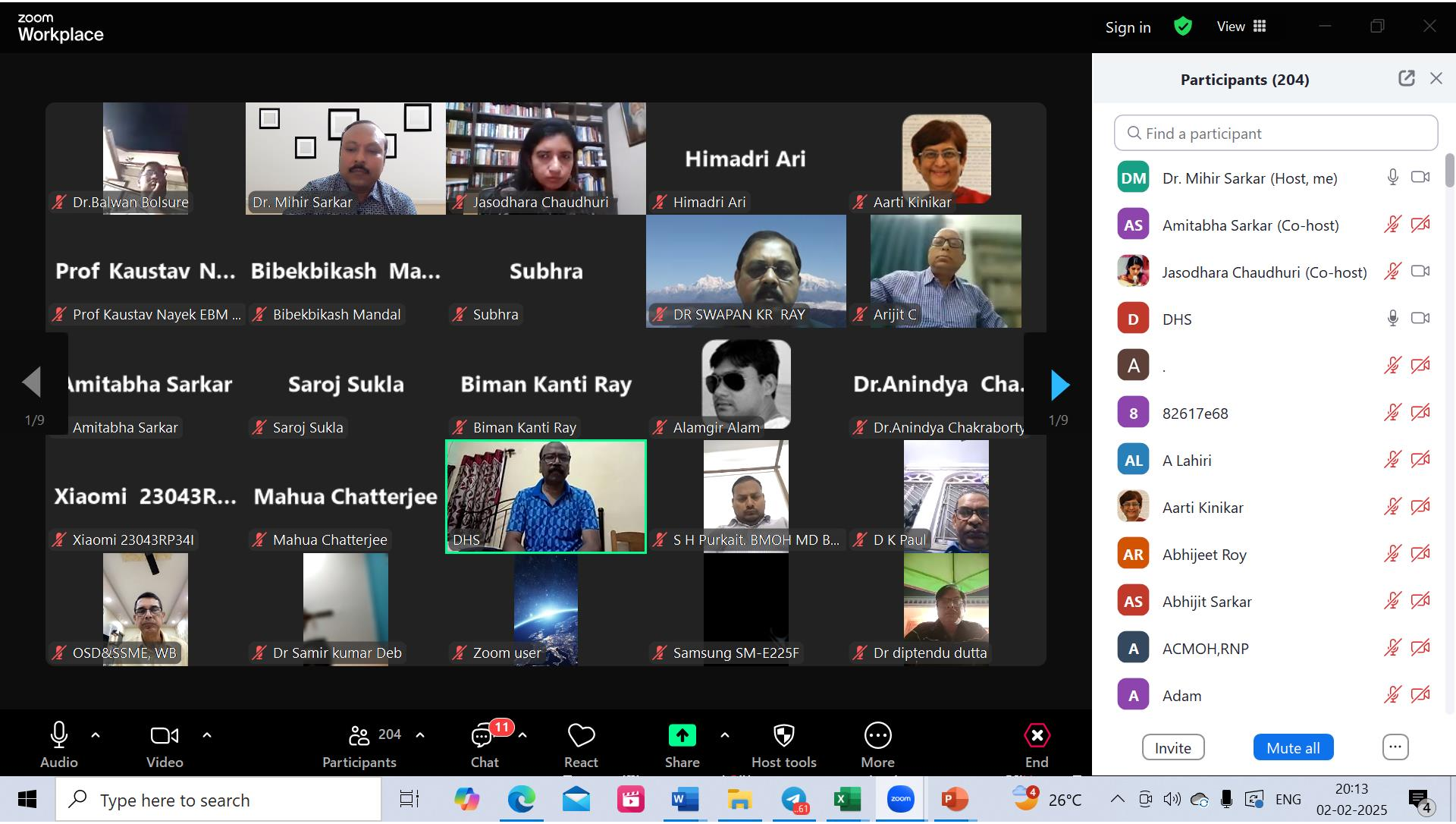
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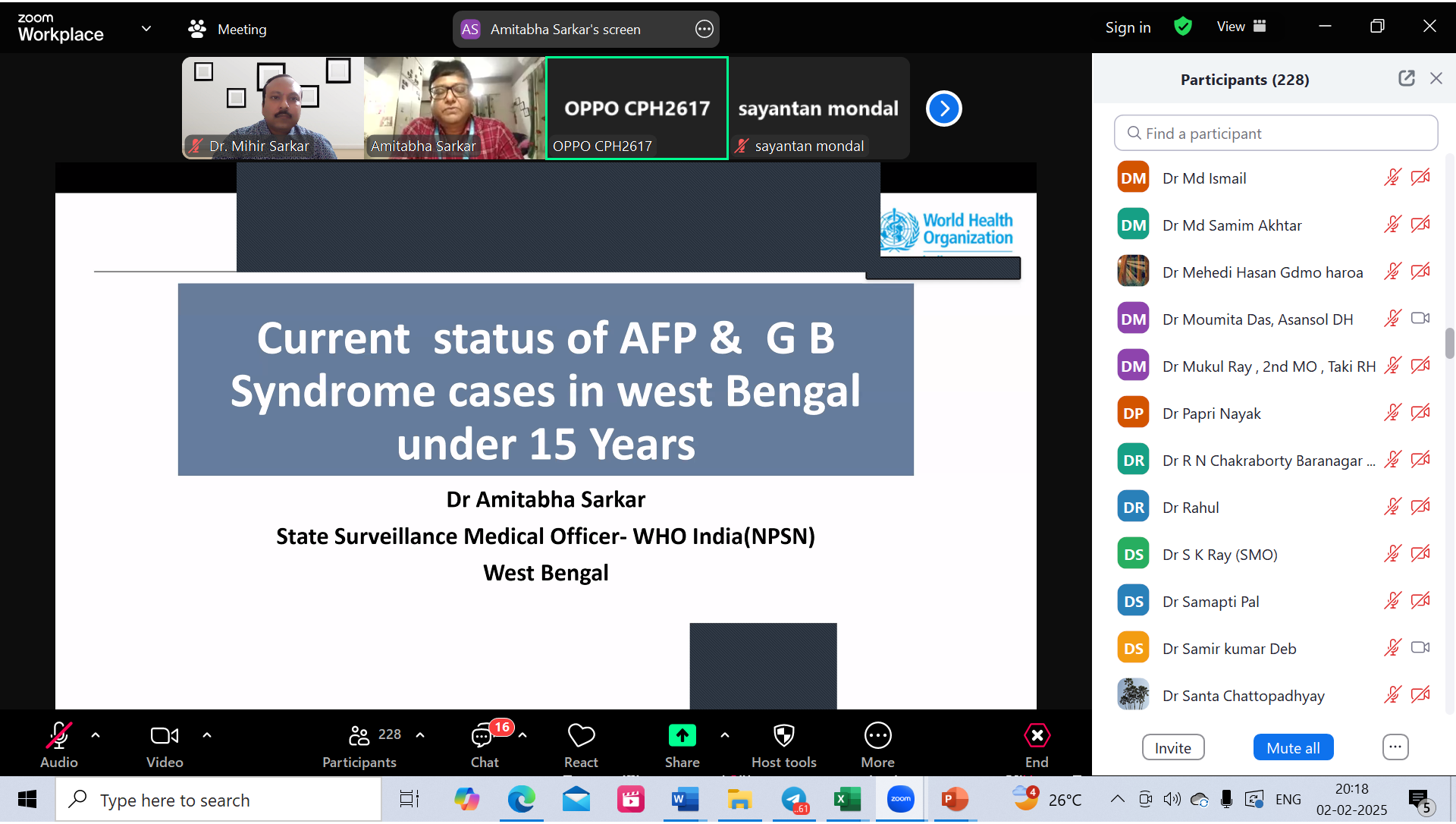
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State Surveillance Medical Officer- WHO India(NPSN)
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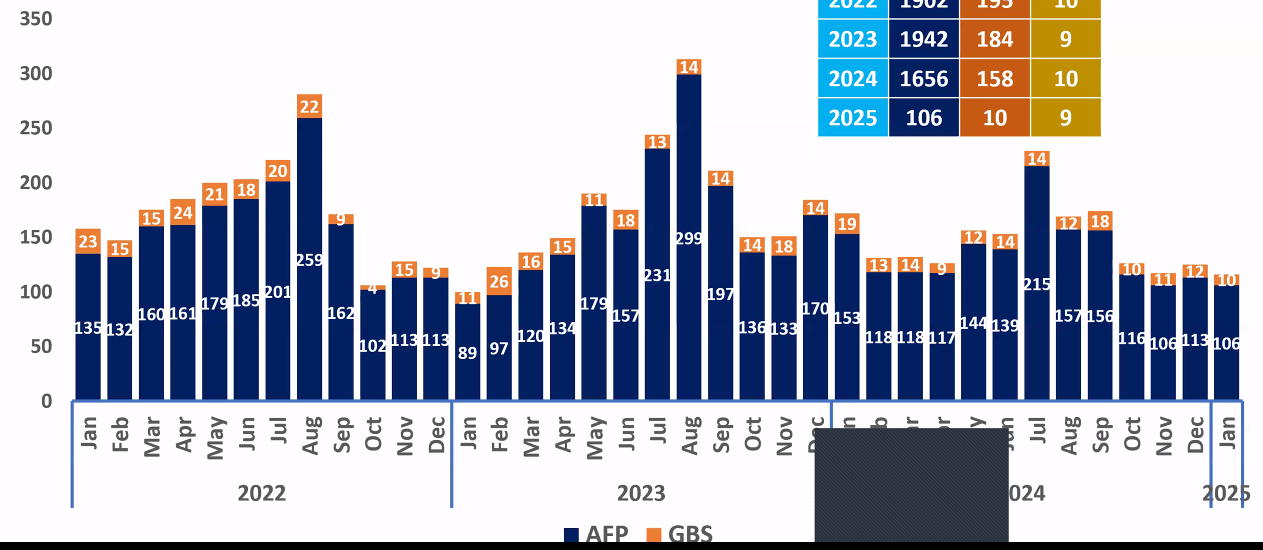
AFP & GBS cases under 15 years, WB, 2022-25

World Health Organization

Year	AFP	GBS	[redacted]
2022	1902	195	10
2023	1942	184	9
2024	1656	158	10
2025	106	10	9



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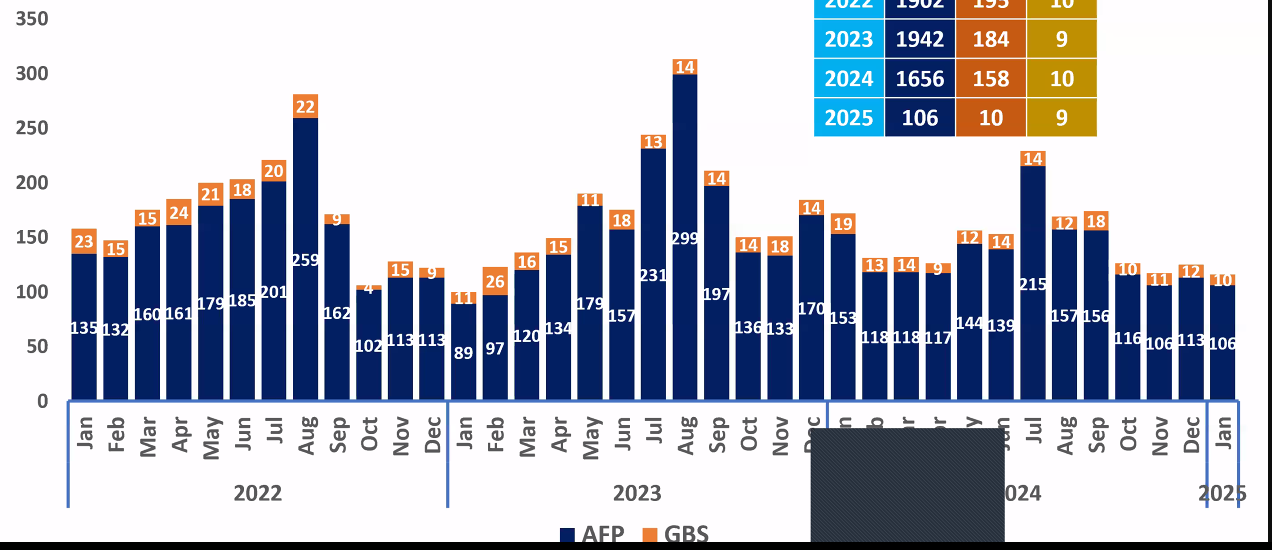

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GBS cases status-Dec 2024 to Jan 2025-West Bengal
World Health Organization
Year | WK | AFP cases | GBS
2024 | WK no-49-52 | 106 | 10
2025 | WK no-1-4 | 115 | 10
40
35
30
25
20
15
10
5
0
27
0
24
0
30
4
25
6
28
3
32
3
37
4
18
0
WK-49
WK-50
WK-51
WK-52
WK-1
WK-2
WK-3
WK-4
2024
AFP Case
GBS
Participants (245)
Find a participant
Dr. Mihir Sarkar (Host, me)
Amitabha Sarkar (Co-host)
Jasodhara Chaudhuri (Co-host)
82617e68
831 1924 8370
A
A Lahiri
Aarti Kinikar
Abhijeet Roy
Abhijit Sarkar
ACMOH,RNP
Adam
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Mute all
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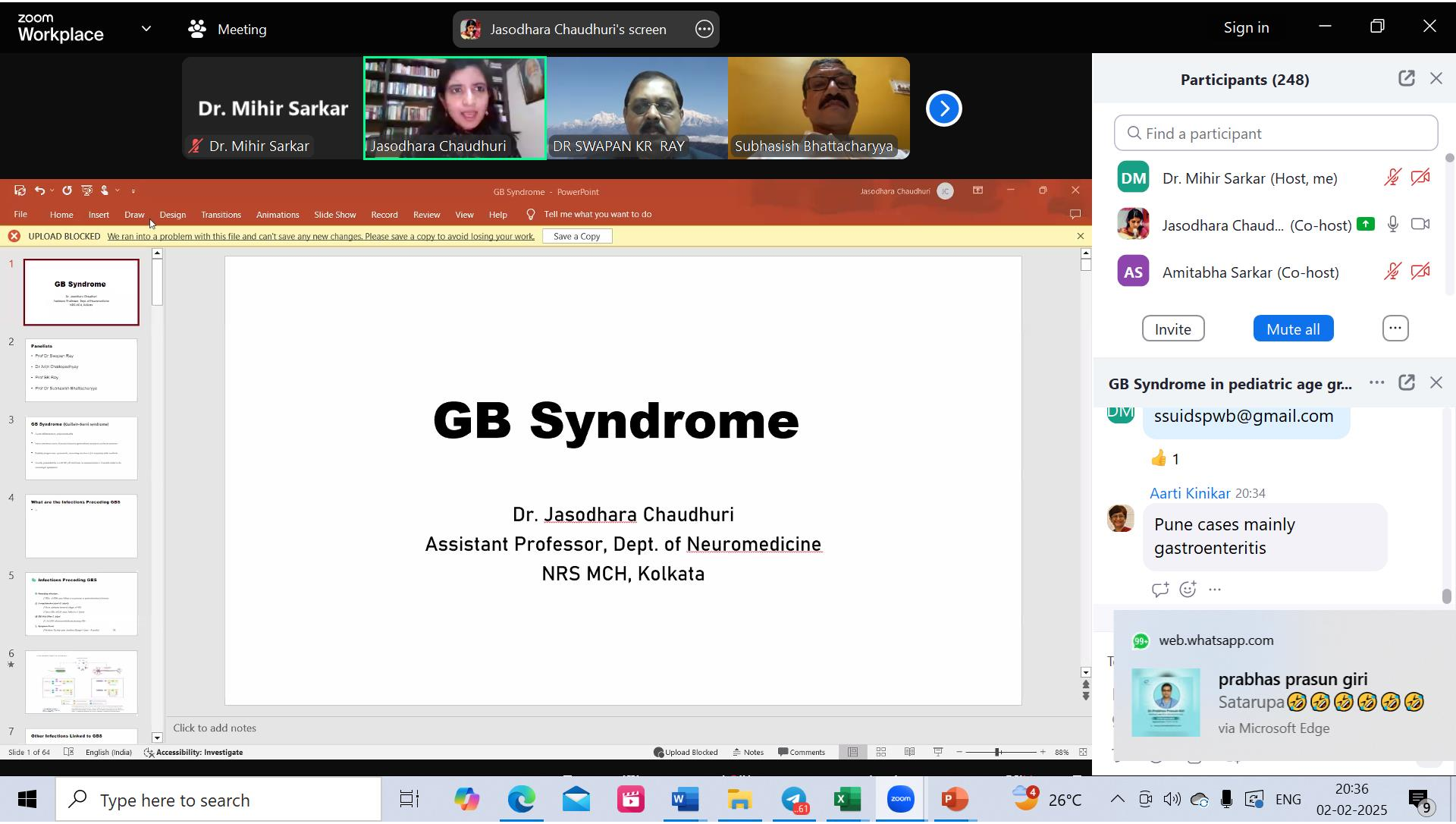
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Meeting
Jasodhara Chaudhuri's screen
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Dr. Mihir Sarkar
Dr. Mihir Sarkar
Jasodhara Chaudhuri
DR SWAPAN KR RAY
Subhasish Bhattacharyya
GB Syndrome - PowerPoint
Jasodhara Chaudhuri
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Dr. Jasodhara Chaudhuri
Assistant Professor, Dept. of Neuromedicine
NRS MCH, Kolkata
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Slide 1 of 64
English (India)
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Amitabha Sarkar (Co-host)
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GB Syndrome in pediatric age gr...
ssuidspwb@gmail.com
1
Aarti Kinikar 20:34
Pune cases mainly gastroenteritis
web.whatsapp.com
prabhas prasun giri
Satarupa
via Microsoft Edge
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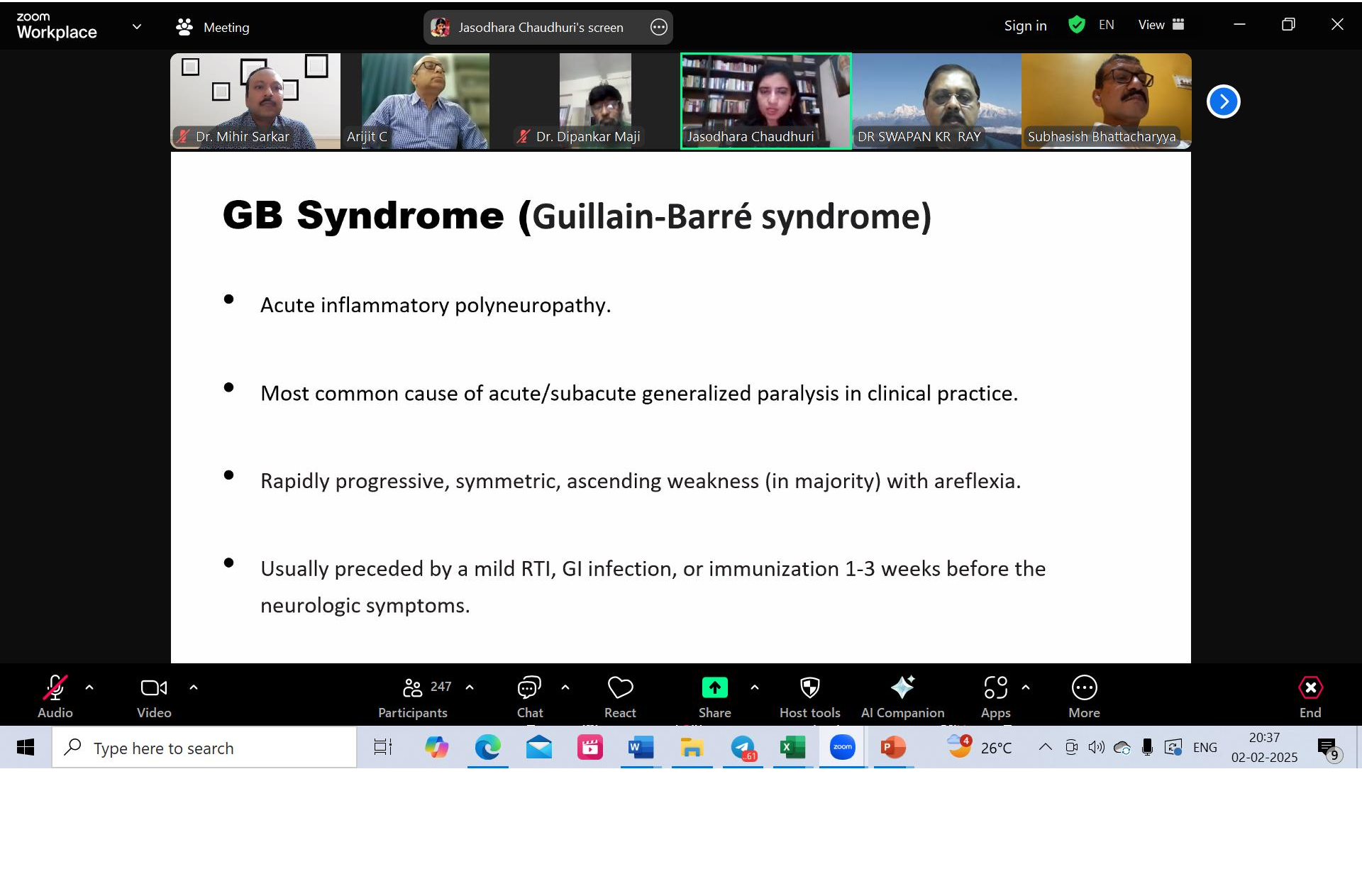
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Meeting
Jasodhara Chaudhuri's screen
Sign in
EN
View
Dr. Mihir Sarkar
Arijit C
Dr. Dipankar Maji
Jasodhara Chaudhuri
DR SWAPAN KR RAY
Subhasish Bhattacharyya
GB Syndrome (Guillain-Barré syndrome)
Acute inflammatory polyneuropathy.
Most common cause of acute/subacute generalized paralysis in clinical practice.
Rapidly progressive, symmetric, ascending weakness (in majority) with areflexia.
Usually preceded by a mild RTI, GI infection, or immunization 1-3 weeks before the neurologic symptoms.
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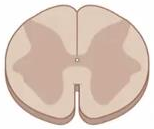
Guillain-Barré syndrome: Differentials

BKR

Nerve / nerve root	Muscle	Neuromuscular junction	Spinal cord	Higher CNS diseases
				
Acute onset CIDP	Hypokalaemic Periodic Paralysis	Myasthenia Gravis	Acute transverse myelitis	Brainstem stroke
Autoimmune nodopathy	Acute viral myositis	LEMS	MOGAD-related conus medullaris syndrome	Rhombencephalitis
Vasculitic neuropathy	Acute colchicine myopathy	Botulism		Wernicke's encephalopathy
Haematological malignancy / carcinomatosis with nerve root infiltration		Organophosphate intoxication		
Acute infection / HIV seroconversion				
Acute intermittent porphyria				
Nutritional (thiamine deficiency)				
Heavy metals poisoning				

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