A Review on Gullian Barre Syndrome and its Association with COVID 19

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Article Info:

Abstract

Guillain-Barré syndrome (GBS) is an immune-mediated disease that affects peripheral nerves and can lead to life-threatening consequences. It affects around 10,000 people per year worldwide. Since the outbreak of acute respiratory syndrome coronavirus-2 (SAR-CoV-2), the incidence of GBS has been increased with a fatality rate of 4.7%. The exact association between the SAR-CoV-2 and GBS is still unknown. GBS commonly presents after viral infections such as influenza virus, campylobacter jejuni, and zika virus. Clinical recognition of SCG-GBS is required in order to administer appropriate treatment on time and enhance the overall output of the infection. In most of the conditions patient was treated with intravenous immunoglobulins and outcome was seen within eight weeks of treatment. less outcome was seen in older age in line with previous findings for both GBS and COVID-19. Studies should be conducted to compare patients associated with GBS to those with concurrent non-COVID-19 GBS to see if the incidence of GBS is higher in those with COVID-19.

Keywords: Guillain-Barre syndrome, COVID-19, SAR-CoV2

INTRODUCTION

Coronavirus disease 2019 (COVID-19) caused by the severe acute respiratory distress syndrome coronavirus 2 (SARS-CoV-2) and was declared as a pandemic by world health organisation in march 2020. 1,2 Coronaviruses can cause a variety of systemic infections, the most significant of which are respiratory complications, which are similar to severe acute respiratory syndrome coronavirus (SARS-CoV). Fever, cough, dyspnea, myalgia, headache, and diarrhoea are the most common symptoms at the onset of disease after an incubation period of approximately 5 to 10 days. The symptoms of COVID-19 are dependent on the age and the patient’s underlying medical illness and also the condition of the immune system. 3,4

During the covid pandemic neurological complications has been established in those patient who were having severe infections. Gullian Barre Syndrome emerged as potentially serious complication among them and some other complications that include Bell's palsy, seizures, meningoencephalitis, cerebrovascular accidents, acute flaccid myelitis. 5 Around 70% of patients with GBS had an illness before developing GBS. Infectious agents such as Campylobacter jejuni, Influenza virus, Cytomegalovirus and more recently ZIka virus have been shown to trigger GBS in laboratory tests. 6-9

GBS is an intense immune-mediated illness affecting the peripheral nerves and nerve roots and is typically accompanied by a lung or gastrointestinal infection. It causes ascending symmetrical limb weakness and paresthesia, as well as areflexia or hyporeflexia and dimished or absent deep tendon reflexes, with or without involvement of the ventilatory and cranial nerves. are the hallmark clinical signs of GBS, which can last anywhere from a few days to several weeks. 10,11 Majority of the patients report air duct or gastrointestinal infection are mainly reported within 2-4 week before the inception of GBS neurological symptoms. 12 GBS is usually caused by a viral or bacterial infection. Because of the agent's structural similarities to axons and myelin, it stimulates the immune system and causes injury to the nerve roots and peripheral nerves. 13 GBS has a number of subtypes such as the basic type (acute inflammatory demyelinating neuropathy, or AIDP) and the subtypes AMAN (acute motor and axonal neuropathy) and AMSAN (acute motor and sensory axonal neuropathy), Miller-Fisher syndrome (MFS), polyneuritis cranialis (PNC), and the Pharyngeal-cervical-brachial (PCB) variant (Bickerstaff encephalitis) (BFE). GBS is typically diagnosed using the
The criterion of Brighton If there is symmetrical, progressive, flaccid lower > upper limb Para paresis, if tendon reflexes in weak limbs are decreased, if the disease course is monophasic and the interval between onset and nadir spans from 12 h to 28 days, and if cerebrospinal fluid (CSF) studies demonstrate a cell count, of 50 cells/L, if CSF protein is elevated (disease), and if nerve conduction studies show a demyelinating lesion of motor nerves acute inflammatory demyelinating neuropathy (AIDP) or an axonal lesion of motor nerves (AMAN), or an axonal lesion of motor and sensory nerves (AMANS) 14. All GBS variants are associated with a previous viral or bacterial infection. The subtype and clinical features of GBS are primarily determined by the type of infections that came before it. 15 The association between COVID-19 and Guillain-Barre syndrome is now frequently reported, although the degree and mechanism of the link, as well as the clinical and electro diagnostic patterns, are still unknown. 13

**METHODS:**
COVID-19-associated Guillain-Barré syndrome was studied in all categories of published studies. Individual case reports and some case series, as well as cohort studies, were found through a search of PubMed and Google Scholar databases, as well as individual case reports and some case series. Google Scholar and PubMed were used to find full-text articles. RT PCR (reverse transcriptase polymerase chain reaction), blood tests, chest X rays were performed and for the detection of GBS, CSF, electromyography and immunological studies that were performed.

**EPIDEMIOLOGY OF GBS:**
GBS has a recorded incidence rate of 1 to 2 cases per 100,000 individuals and 0.4 to 1.4 cases for every 100,000 children each year. Age-related increases in Guillain-Barre syndrome (0.06 per 100,000 children and 0.27 per 100,000 elderly people above the age of 80) and the disease is slightly more common in men than in women. 16 The prevalence of GBS did not rise between March 2020 and May 2020 in a UK study of 47 Sars-cov-2 associated Guillain-Barre syndrome (SC2-GBS) patients compared to the years 2016–2019. In contrast, a retrospective, multi-centre investigation of 34 SC2-GBS patients from northern Italy found that the anticipated incidence of GBS has increased from 0.93/100000/year in 2019 to 2.43/100000/year in 2020. 17

**DIAGNOSIS AND DETECTION OF GBS IN COVID 19 PATIENTS:**

<table>
<thead>
<tr>
<th>Assessment scales</th>
<th>Level of Diagnostic Certainty</th>
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<tr>
<td><strong>Brighton Diagnostic Criteria for GBS</strong></td>
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<tr>
<td>Symptoms</td>
<td>1</td>
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<tr>
<td>Bilateral and flaccid weakness of limbs</td>
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<tr>
<td>Decreased or absent deep tendon reflexes in weak limbs</td>
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<tr>
<td>Monophasic course and time between onset-nadir=12hrs to 28 days</td>
<td>+</td>
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<tr>
<td>Absence of alternative diagnosis for weakness</td>
<td>+</td>
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<tr>
<td>CSF cell count &lt;50/ml</td>
<td>+</td>
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<tr>
<td>CSF protein concentration=60mg/dl</td>
<td>+</td>
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<tr>
<td>Nerve conduction study findings consistent with one of subtypes of GBS</td>
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Gullian-Barre syndrome (GBS) is normally easy to diagnose in people who have typical symptoms, however it might be challenging to distinguish GBS in patients who have atypical symptoms. A lumbar puncture is suggested even in individuals with typical symptoms to exclude diseases other than GBS. 10,18-21

Suspected GBS may include some of the clinical presentation such as Rapidly progressive bilateral limb weakness with or without sensory impairments, hyporeflexia or areflexia, facial or bulbar palsy, ophthalmoplegia, and gait problems. The diagnosis entails evaluating the diagnostic criteria and ruling out other possible sources of similar neurological symptoms. To diagnose the syndrome and its types, routine blood testing, cerebrospinal fluid tests, lumbar puncture, muscle and nerve electrophysiology studies and antiganglioside antibodies testing should be performed. Increased amount of mononuclear or polymorphonuclear cells (>50 cells per L) in spinal fluid, 22-24

The Brighton diagnostic criteria is also used for diagnosing GBS conforming to the clinical symptoms of the patient. The Brighton criteria assign four stages of diagnosing surety to GBS, ranging from level 1-4 (highest to the lowest). The completeness of the diagnostic criteria is important when using the Brighton criteria to diagnose patients with suspected GBS. 24

Infectious infections, malignancy, and abnormalities of the neuromuscular junction are among the differential diagnoses for GBS. Differential diagnoses such as Cytomegalovirus (CMV) or HIV (human immunodeficiency virus)-related spinal root inflammation, musculoskeletal problems, Lyme disease, leptomeningeal malignancy, or poliomyelitis should be evaluated in patients with a high CSF cell count. Myasthenia gravis, polymyositis, and dermatomyositis, poliomyelitis, hypermagnesaemia, porphyria, botulism, and lead or organophosphate poisoning are all conditions that should be explored. 19-21

GBS presents differently in children than it does in adults, and diagnosing childhood GBS, especially in young children under the age of six, can be difficult. The most common presenting symptoms in children are pain, difficulty walking, or refusal to walk, all of which should raise suspicion of GBS. Only one-third of preschool children with GBS are diagnosed correctly at admission. GBS can be misdiagnosed in young children as meningitis, coxitis, or malaise caused by viral illnesses. When the diagnosis is delayed for more than 2 weeks in students less than <6 yrs of age during this period emergency intubation and even death may occur. 25-29
PATHOPHYSIOLOGY OF COVID 19 AND GBS

COVID-19 has a variety of neurological mechanisms. The virus spreads to ACE2 protein on cells in the CNS via olfactory neurons and hematogenous dissemination. When the virus’s receptor connects to ACE2, it causes a cytokine storm and a disruption of the blood-brain barrier. Dizziness, headache, changed mental status, stroke, ataxia, seizure, anosmia, visual abnormalities, nerve pain, skeletal muscle injury linked with sepsis, and multiple organ injury are some of the neurological consequences of Covid. (13) An immune mechanism that may include SARS-CoV-2 can trigger an immunological response involving an increase in interleukin-6 (IL-6), which increases the inflammatory cascade and destroys tissues. As a result, inflammatory variables may play a significant role in the organ dysfunction of patients infected with Covid 19. The majority of neurological symptoms are most likely caused by these immune mechanisms. 30-32 In patients with co-morbidity condition such as Diabetes mellitus (DM) can worsen the clinical and electrophysiological features of coexisting peripheral neuropathies, including GBS The specific mechanism underlying the DM-induced aggravation is unknown; however, it could be linked to the chronic inflammatory diseases associated with DM, as well as peripheral nerve neurovascular impairment. 33

TYPES OF GBS:
There are mainly 4 variants of GBS that include AIDP (Acute Inflammatory Demyelinating Polyneuropathy) is the first. Inflammatory demyelinating is thought to begin at the nerve roots, resulting in electrophysiological conduction slowness and conductivity blockages, as well as acute muscle weakness. Peripheral nerves can undergo remyelination. It is primarily the most prevalent subtype of this illness that manifests. The second form Acute Motor Sensory Axonal Neuropathy (AMSAN), one of most extreme form of AMAN, Axon degeneration is most likely to impact sensory motor neuron fibres, resulting in delayed and poor recovery that can be reversible or irreversible. Acute Motor Axonal Neuropathy is functionally similar, albeit with additional sensory complaints. The third form is Miller Fisher Syndrome (MFS) which is characterised by ataxia, difficulty with eye movement, and areflexia. Antibodies that is against GQ1b (a ganglioside element of the nerve) are found in the majority of patients with this variation. Anti-GQ1b ganglioside is a common antigenic target which is not proportionally visible in the motor neurons that do not directly innervate peripheral muscles. AMAN (Acute Motor Axonal Neuropathy) differs from AIDP. Demyelinating Polyneuropathy in that it affects just motor nerves and has a distinct electrophysiological pattern of axonal involvement. 34,35 In terms of the distribution of GBS electrophysiological variations, the findings revealed that COVID-19-related GBS is most commonly linked with AIDP and, to a smaller extent, AMSAN and AMAN, similar to classic GBS in Western countries. 23,36 AIDP affects 60–80 percent of patients with GBS in Europe and the United States, while AMAN affects only 6–7%. This number is about 30–65 percent across Asia, Central and South America. This has to do with the population’s genetic traits and its exposure to various pathogens. 37

OUTCOME AND TREATMENT OF GBS IN COVID 19 PATIENTS:
Among the various GBS variant and subtypes found most of the patient infected with GBS were male. Latency between the onset of disease among the patient with covid 19 and GBS is 10-90 days’. GBS patients can receive IVIG or plasma exchange treatment. 38 Treatment is typically reserved for patients who are unable to walk independently, have increasing symptoms, bulbar weakness, or have respiratory compromise. Intravenous immunoglobulin (IVIG) at a dose of 2g/kg/ per day for 5 days was administered within 24 hours of the patient’s arrival at the hospital. Previous case studies have demonstrated that Intravenous Immune Globulin treatment has had variable results, with certain patients reporting complete recovery and others indicating modest or delayed responses. 39,40 Treating with Intra Venous Immune Globulin is associated with thromboembolic events as COVID-19 may be associated with a pro-thrombotic state, there may be concern about administering Intravenous Immune globulin but none of the reports described thrombotic complications. 41,42

Plasmapheresis and steroids were administered among the patient and they are best when offered within 4 weeks of onset of the symptoms but the largest effect is seen when treatment is started within the first 2 weeks. 43-46 According to some research, patients with AMAN may have better outcomes with plasma exchange treatment than with Intravenous Immune Globulin therapy, and plasma exchange seems to be the most cost-effective approach. Plasma exchange followed by Intravenous Immune Globulin isn’t considerably superior than either plasma exchange or Intravenous Immune Globulin on its own. In people with GBS, oral steroids and intravenous methylprednisolone are ineffective. Eighty-five percent of patients are able to return to their previous level of function. Long-term issues like 20% of patients, including severe impairment, pain, and exhaustion, with a 5% mortality rate. During the admission process to the hospital, 20-30% of patients require mechanical ventilation and intubation. 43,47-49 Plasma exchange (PLEX) was used to treat GBS without reported complications in two patients that we reviewed, but Plasma exchange is associated with hypotension in a small percentage of patients and can also affect the balance of clotting factors potentially leading to thromboembolic events. 50,51

In contradiction to those with a positive prognosis, patients with no improvement or a poor outcome had a somewhat greater (but not statistically significant) incidence of clinical history and/or a radiological image of COVID-19 pneumonia (73.7%) and further, the first group of patients was much older than the latter (mean age 51.8 16.6 years), but had similar sex and electrophysiological subtype distributions, as well as similar delay between COVID-19 and GBS (p = 0.588) and nadir (p = 0.825). 52

Rehabilitation, physiotherapy, Logopaedic help, Psychological support are the treatment plan for people who are disabled as a result of Guillain-Barré syndrome. The rehabilitation is important to be started as early as possible. 53

Treatment options are influenced by both patient-related and socioeconomic factors. Plasma exchange, for example, necessitates specialised equipment that is not always available in all hospitals. Furthermore, plasma exchange can be difficult to execute in young children, and due to the substantial volume shifts required in the plasma exchange operation, caution should be exercised in patients with autonomic cardiovascular instability 54,55

DISCUSSION:
GBS is a rare but catastrophic post-infectious neuropathy that has a 3-13 percent fatality rate. 56 with a rapidly progressive immune theory mediated polyradiculoneuropathy. It is usually associated with post infections
GBS can develop in persons who are generally asymptomatic or have mild COVID-19 signs. Moreover, the severity of GBS is unrelated to the severity of COVID-19. The prevalence/incidence of GBS most likely differs from non-SC2-GBS patients in terms of clinical manifestations or therapy, but their outcomes are similar to classic GBS. Diagnosis can be difficult and time-consuming, particularly in asymptomatic patients or those who have had a mild respiratory illness week before. Early detection and treatment can help to enhance the clinical result.

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