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"WHEN GUILLAIN-BARRÉ SYNDROME GETS CREATIVE: THE 'FACE-OFF' EDITION"

Neurology

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KEYWORDS

PATIENT PRESENTATION

A previously healthy male presented with a 5-week history of acute-onset bifacial weakness, characterized by lower motor neuron (LMN) involvement. 5 weeks prior to his presentation, he developed mild fever (temperature not exceeding 99°F), accompanied by a holocranial headache lasting for 5 days. The headache was not associated with nausea, vomiting, photophobia, or phonophobia.

One week later, the patient noticed difficulty holding water in his mouth and trouble spitting it out after brushing his teeth. He also had difficulty closing both eyes, with excessive lacrimation. Additionally, he experienced numbness over his lower lip and difficulty pronouncing certain words, particularly those requiring tongue movement.

Clinical Examination And Diagnostic Workup

The patient was admitted with a 5-week history of acute-onset bifacial weakness, suspected to be of LMN origin, localized below the level of the styloid foramen.

Differential Diagnosis:

- Guillain-Barré Syndrome (GBS) with a bifacial presentation
- Sarcoidosis
- Systemic Lupus Erythematosus (SLE)
- Sjögren's syndrome
- Lyme disease
- Viral infections (e.g., CMV, EBV, VZV)

On examination, the patient exhibited bifacial weakness without involvement of other cranial nerves.

Investigations:

- Facial nerve conduction velocity (NCV) study: Reduced amplitude in all facial muscles.
- Nerve conduction studies: Prolonged F-wave latencies in all limbs and reduced amplitude of bilateral mentalis muscles.
- Laboratory tests: Serum ACE levels, ANA, ANCA, and anti-ganglioside IgG/IgM panels were all negative.
- CSF analysis was performed, which showed acellularity, normal glucose and protein levels, and negative results for the infectious workup. There was also no cellularity on the malignant cytology.
- MRI of the brain and spine: Enhanced bilateral 7th cranial nerves.
- Contrast-enhanced CT (CECT) of the chest: Unremarkable.

Diagnosis

Given the patient's prodromal symptoms (fever and headache) followed by the acute onset of facial weakness, the clinical presentation was consistent with facial diplegia, a variant of Guillain-Barré Syndrome (GBS). This diagnosis was further supported by the negative laboratory and imaging results, helping to rule out other potential causes.

Management

The patient was managed with supportive care, and demonstrated signs of recovery with improvement in facial function. Key improvements included better eye closure, improved speech, and the ability to hold water in his mouth.

Discharge And Follow-Up

The Patient Was Discharged With The Following Recommendations:

- Continue prescribed oral medications.
- Regular follow-up with neurology to monitor progress.
- Return to the hospital if new or worsening symptoms develop, particularly those related to respiratory function or autonomic instability.

DISCUSSION

This case highlights a rare but significant manifestation of Guillain-Barré Syndrome (GBS), presenting with bifacial weakness. The patient's prodromal symptoms and neurological findings supported the diagnosis, while appropriate diagnostic workup helped to rule out other potential causes, including sarcoidosis, viral infections, and autoimmune conditions.

Early recognition and supportive care, including the potential use of IVIg (intravenous immunoglobulin therapy), were crucial in the patient's recovery. The case underscores the importance of considering Guillain-Barré syndrome in patients presenting with bifacial weakness, particularly following a viral infection.