Sir

We read with great interest the article by Dhadke et al1 “Clinical profile of Guillain Barre Syndrome” describing epidemiological, clinical and electrophysiological features of 40 patients of Guillain Barre Syndrome (GBS). In their study, commonest age group was between 21-40 years of age, antecedent infection was present in 55% cases and 13 (32.5%) patients required ventilatory support. Out of 40 patients, 18 patients received specific therapies in form of intravenous immunoglobulin or plasmapheresis and 8 (20%) patients died due to various complications. This mortality of 20% is quite high as compared to previous Indian and western studies as mentioned by authors. In another Indian series from NIMHANS, patients with severe GBS, all requiring mechanical ventilation, had mortality rate of (10.4%).2 Apart from it, subgroup classification into acute inflammatory demyelinating neuropathy (AIDP) or Axonal forms (AMAN, AMSAN) was not described by electrophysiological features of patients and none of their patients had variant GBS except one patient with paraparesis.

A retrospective analysis of 45 adult patients of GBS at our centre showed high incidence (40%) in young adults between 18 years and 29 years. Seasonal preponderance in winter (October-January) and summer (April-June) was found. Male patients (71.1%) significantly outnumbered females. Preceding events were identified in 16 (35.5%) cases. Cerebrospinal fluid analysis showed albuminocytological dissociation in 84% of the patients. Utilising clinical and electrophysiological data, these 45 patients with Guillain-Barre syndrome were subclassified using Albers and Kelly 1989 criteria3 and Ho et al criteria.4 12 (26.6%) patients had (AIDP), 10 (22.2%) patients had axonal forms of GBS and 1 (2.2%) had Fisher’s syndrome. 22 (48.8%) patients remained unclassified due to mixed features on nerve conduction studies. Various clinical variants of GBS were noted in our patients including paraparetic in 7 patients, bibrachial in 1 patient and overlapping GBS in 1 patient. In addition to general medical management, 35 (77.78%) patients received specific treatments: 16 (35.55%) steroids alone, 18 (40%) IVIg alone and in 1 (2.2%) patient plasmapheresis was done. Only 3 (6.6%) patients required mechanical ventilation and no mortality occurred during hospitalisation. Follow up of 39 patients disclosed that all of them recovered satisfactorily, no patient was persistently disabled.

So in our experience GBS in Indian adults showed peculiar age, seasonal distribution and high frequency of axonal forms. Both axonal and demyelinating subtypes shared common clinical features and had fair prognosis.

References

Sir,

We thank Dr. R.S. Jain et al for keen interest in our article. In response to comment by them on our article “Clinical profile of Guillain Barre Syndrome”, we would like to clarify following points.

1. In the present study, commonest age group was 21-40 years with male preponderance (1.5:1), antecedent infection was present in 55% cases. These findings correlate with various other studies as per references given in the article. Variation may be possible due to geographic constraints.

2. As present study carried out mainly with aims and objectives to study clinical presentation, hospital course and outcome of treatment, we have not studied about seasonal variation and have not mentioned AMAN and AMSAN variants in tables. We got one patient with paraparesis and one with oculomotor nerve involvement (clinically Miller Fisher variant).

3. Intravenous immune globulin (IVIG) and plasma exchange are specific modalities for treatment of GBS. We have not used glucocorticoids in treatment of GBS.1,2

4. In our country, major determining factor is cost of treatment and availability of specific therapy. Out of 40 patients in our study, 22 received supportive care without specific therapy like IVIg or plasmapheresis. Major cause of mortality in eight patients died, all were mechanically ventilated, was ventilator associated pneumonia and sepsis. Delayed hospitalisation, increased age are the contributory factors for mortality rate of 20% in our study.

References
