An Uncommon Presentation of Guillain-Barré Syndrome: Considering the Broad Differential for Ileus
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Introduction:
- The etiology of ileus is typically multifactorial and often involves metabolic derangements, inflammation, and disruption of sympathetic and parasympathetic fibers.
- While often associated with the post-operative state, ileus can also be seen in systemic illnesses, such as Guillain-Barré syndrome (GBS).

Case:
Initial Presentation:
- A 32-year-old healthy man presented with periumbilical abdominal pain, nausea and vomiting after eating oysters on the Oregon coast.
- After a brief admission for management of dehydration, his symptoms improved.
- However, diffuse abdominal cramping and vomiting returned as well as failure to pass flatus so he was readmitted.

Readmission:
- On exam, soft, distended abdomen without bowel tones.
- Labs: Na=120 mmol/L and C-reactive protein=103.88 mg/L.
- CT scan with long segment, circumferential wall thickening of sigmoid and rectum concerning for colitis and diffuse small bowel distention consistent with ileus (Fig. 2).
- Flexible sigmoidoscopy with rectosigmoid inflammation with biopsies suggestive of inflammatory or infectious process (Fig. 3).
- Stool studies were unrevealing.
- His ileus persisted despite nasogastric decompression.

One Week into Readmission:
- He developed ascending paresthesias with subjective weakness in his lower extremities.
- Neurological exam revealed hyporeflexia to light touch, intact strength, absent reflexes, antalgic gait.
- CSF studies showed albuminoctrocytologic dissociation with protein of 106 mg/dL and WBC of 2.
- He was diagnosed with a sensory variant of GBS related to a preceding infectious colitis.
- Treated with intravenous immunoglobulin and promotility agents with gradual improvement in his symptoms.

Discussion:
- Adynamic ileus is a less commonly recognized feature of GBS. Ileus may occur due to dysautonomia related to immune-mediated inflammation and imbalance between sympathetic and parasympathetic nerve fibers.
- Ileus occurs in 2-9% of cases of GBS. It does appear to be more prevalent (~15%) in groups with more severe disease.
- Treatment includes nasogastric decompression, promotility agents and management of the underlying illness.
- This case highlights this unusual cause of ileus and underscores the importance of maintaining a broad differential diagnosis, particularly in patients with features atypical for infectious colitis.

Figures:

- Figure 1. supine view of abdominal X-ray demonstrating numerous air fluid levels throughout mildly dilated small and large bowel, consistent with mild adynamic ileus.
- Figure 2. Diffuse, long segment, circumferential wall thickening of the sigmoid colon and rectum, consistent with colitis, in addition to diffuse (A), ileal, and proximal cecal distention, consistent with ileus.
- Figure 3. Flexible sigmoidoscopy demonstrating underlying erythema, exudative erosions, edema, loss of vascularity in the sigmoid colon that is suggestive of moderate inflammation (A and B) and erythema, friability, and loss of vascularity in the rectum that is suggestive of mild inflammation (C).

References: