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Guillain-Barre Syndrome Presenting as Bilateral Facial Palsy with Paresthesia and Brisk Reflexes in a Young Female: A Rare Variant

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Abstract

Guillain-Barré syndrome (GBS) classically presents with ascending paralysis and areflexia. However, rare variants such as bilateral facial diplegia with paresthesia and preserved or brisk reflexes have been documented. This case highlights an atypical presentation of GBS in a 27-year-old woman.

Keywords: Areflexia, Guillain-Barré Syndrome, Paresthesia, Triple Serology

Introduction

Guillain-Barré Syndrome (GBS) is an acute immune-mediated polyneuropathy with an incidence of 1–2 per 100,000 populations per year[1]. Although the classical form involves ascending weakness and areflexia, GBS has a heterogeneous spectrum including variants like Miller Fisher syndrome, pharyngeal–cervical–brachial variant, and bifacial weakness with paresthesia (BFP)[2]. Facial diplegia is uncommon and when present with preserved or brisk reflexes, it may lead to diagnostic confusion with central lesions[3,4].

This report presents a young female with BFP variant of GBS accompanied by paresthesia and brisk tendon reflexes—a combination that poses diagnostic challenges.

Case Presentation

A 27-year-old previously healthy female presented with a 10-day history of progressive facial weakness, initially on the left side, followed within 10 hours by right-sided involvement. This was associated with drooling of saliva, loss of taste, slurring of speech, and the inability to close both eyes completely. The symptoms were persistent since onset and had never occurred before. She denied any earache, hearing difficulties, tinnitus, recent trauma to head or neck, or any other weakness She reported associated paresthesia of the face and extremities but

denied limb weakness, diplopia, dysphagia, or sphincter disturbance.

On examination

- Conscious, oriented, vital signs stable.
- Bilateral lower motor neuron facial palsy (House-Brackmann grade IV).
- Other cranial nerves examinatiom normal.
- Brisk deep tendon reflexes (+++) in all four limbs.
- No motor weakness or sensory loss in limbs.
- Gait and coordination were normal.
- No neck rigidity or meningeal signs.

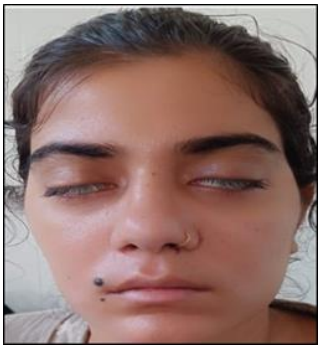

Figure 1: Incomplete closure of both eyelid (consent was provided by patient)

Figure 2: Standing photo s/o no weakness in limbs

Investigations

- Routine blood work: normal.
- Serum ACE: normal.
- Chest X-ray: normal.
- Lyme serology: negative.
- ANA with ENA Panel negative.
- Triple serology negative.
- Contrast-enhanced MRI brain and spine: normal.
- Nerve conduction studies: revealed bilateral facial nerve involvement with reduced CMAP amplitude and prolonged distal latency. Sensory and motor studies of limbs were within normal limits.
- CSF not done as patient refuse for lumbar puncture.

Based on clinical presentation, electrophysiology, and findings, a diagnosis of BFP variant of GBS was made.

Treatment

The patient received intravenous immunoglobulin (IVIg) 0.4 g/kg/day for 5 days.

Outcome

She showed gradual improvement in facial movements.

Discussion

Facial diplegia as a presentation of GBS is rare and often mimics other etiologies such as brainstem stroke, Lyme disease, sarcoidosis, or Bell's palsy[5,6]. The presence of paresthesia and preserved or brisk reflexes further complicates diagnosis, as these findings are uncharacteristic of classical GBS[7].

The BFP variant was first systematically described in the early 1990s. It is characterized by bilateral facial palsy, distal paresthesia, and minimal or no limb weakness[8]. Reflexes are usually diminished, but a subset may have preserved or even brisk reflexes—possibly reflecting early disease stage or a predominantly demyelinating process sparing reflex arcs[9].

MRI is crucial in ruling out central causes. abnormal NCS confirming facial nerve involvement support the diagnosis. IVIg remains the mainstay of treatment with favorable outcomes in most cases[10].

Conclusion

This case underscores the importance of considering GBS in patients with bilateral facial palsy, even when reflexes are preserved or brisk. Early electrophysiologic

studies are essential for diagnosis. Prompt treatment leads to excellent recovery in this rare variant.

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