IAMJ

INTERNATIONAL AYURVEDIC MEDICAL JOURNAL

Case Report ISSN: 2320-5091 Impact Factor: 6.719

A CASE REPORT ON GUILLAIN BARRE SYNDROME: A SUCCESSFUL TALE OF MIRACULOUS RECOVERY THROUGH AYURVEDA

Sai Chinmayee T[1], Vinaykumar K N[2]

1. PG Scholar, Department of PG Studies in Panchakarma, Sri Kalabyraveshwara Swamy Ayurvedic Medical College, Hospital and Research Centre, Vijayanagar, Bengalaru-560104.
2. Professor and Head of Department, PG Studies in Panchakarma, Sri Kalabyraveshwara Swamy Ayurvedic Medical College, Hospital and Research Centre, Vijayanagar, Bengaluru - 560104.

Corresponding Author: chinmayibhat02@gmail.com

https://doi.org/10.46607/iamj4213042025

(Published Online: April 2025)

Open Access

Article Received: 08/02/2025 - **Peer Reviewed:** 29/03/2025 - **Accepted for Publication:** 11/04/2025.

Check for updates

ABSTRACT

Guillain-Barré Syndrome is an acute, often severe, and fulminant polyradiculoneuropathy of autoimmune origin. The syndrome affects approximately one in 100,000 individuals. It can impact any gender across all age groups, particularly those between the ages of 30 and 50; however, the risk increases with age. In 70% of patients, the syndrome develops 10 to 20 days after a viral infection, while in 10% of cases, it follows a surgical procedure. GBS leads to the demyelination of nerves, causing tingling sensations, muscle weakness, and paralysis. Almost all neurological conditions can be understood under the broad category of *Vatavyadhi*, in which *Vatoprakama* plays a crucial role. Here is a case report of a patient suffering from Guillain-Barré Syndrome who underwent *Panchakarma* treatment in two phases, consisting of *Sarvanga Udwartana, Sarvanga Dhanyamladhara, Agnichikitsa Lepa, Pizzhichil, Adhoshaka Jambeera Pinda Swedana, Adhoshaka Nadi Sweda, and Rajayapana Kala Basti.*

Keywords: Guillian Barre Syndrome, *Vatavyadhi, Panchakarma*

INTRODUCTION

Guillain-Barre Syndrome is a severe form of acute inflammatory demyelinating polyneuropathy that is autoimmune in nature. [1] There is a predominantly cell-mediated inflammatory response directed at the myelin protein of Spinal roots, peripheral and extra-axial cranial nerves, possibly triggered by mimicry between epitopes found in the cell walls of some micro-organisms and gangliosides in the Schwann cell and axonal membranes. The resulting release of inflammatory cytokines blocks nerve conduction and is followed by complement-mediated destruction of the myelin sheath and the associated axon.[2] This disease is characterised by acute ascending polyneuropathy. The disease often begins in the legs and ascends to involve the trunk, arms and head.[3] Patients with Guillain Barre Syndrome develop weakness and then flaccid paralysis. Distal paresthesia and limb pains preceded a rapidly ascending muscle weakness, more marked proximally than distally from the lower to upper limbs. Facial weakness, bulbar weakness and respiratory weakness commonly develop. There are several types of Guillain Barre Syndrome such as:

Table 1: Subtypes of Guillain Barre Syndrome

Subtype	Features	Pathology
Acute Inflammatory demyelinating polyneuropathy (AIDP)	Adults are affected more. Muscle weakness starts in the lower part of the body and moves upward. Rapid recovery.	The first attack on Schwan cell surface, widespread Myelin damage, macrophage activation and lymphocytic infiltration.
Acute Motor Axonal Neuropathy (AMAN)	More affected in children and young adults. Affects movements. Rapid recovery	First attacks at Nodes of Ranvier, macrophage activation, few lymphocytes, frequent peri-axonal macrophages.
Acute motor sensory axonal Neuropathy (AMSAN)	Mostly adults Characterized by marked muscle wasting and poor recovery	Affects the axons of the nerve that control movement and senses.
Miller Fisher Syndrome (MFS)	Both adults and children Triad–Ophthalmoplegia, Ataxia and Areflexia.	Affects axons and myelin sheath of nerve.

Vata is the primary *Dosha* responsible for maintaining the normalcy and vitiation of *Pitta* and *Kapha doshas*. In general, neurological diseases can be categorised under the broad heading of "*Vatavyadhi*" in *Ayurveda*, considering the concepts of *Upastambhita/Nirupastambhita, Samaja/Niramaja,* and Dhatukshayaja/Avaraniya, with different treatment modalities to be incorporated accordingly.

Case Description

A 43-year-old male accompanied by his wife was brought to OPD of Sri Kalabyraveshwaraswamy Ayurvedic Medical College, Hospital and Research Centre, Vijayanagar, Bangalore, who presented with the complaints of:

- Reduced strength in both lower limbs for 26 days.
- Reduced strength in left upper limb for 20 days.
- Inability to walk for 15 days.

Associated complaints.

- a/c/o pain in the lower back and bilateral lower limb for 26 days.
- a/c/o numbness in feet, calf and posterior thigh region for 23 days.

History

The patient was healthy until the afternoon of 09/10/24. Subsequently, he experienced a sensation

akin to an electric shock, accompanied by pain in his lower back and both lower limbs. He ignored the pain and slept that night. Upon waking up the next day, he found he had difficulty walking and consulted a near-by clinic, where he received an intramuscular injection and medication for three days (details unknown). However, his symptoms did not improve. As a result, he was advised to undergo an MRI of the lumbar spine, which revealed disc bulges at L_3-L_4, L_4-L_5, and L_5-S_1, and he was prescribed medication for this condition (details unknown). On 17/10/24, his condition worsened, resulting in numbness in his foot, calf, and posterior thigh regions, rendering him unable to walk or move his fingers. The patient consulted a neuro centre, where they recommended, he undergo a nerve conduction test, which indicated motor axonal and demyelinating polyradiculoneuropathy, ultimately diagnosing him with AMSAN type of Guillain-Barré syndrome. The patient declined the treatment (details unknown) suggested at that centre. Subsequently, he noticed similar symptoms in his left upper limb and experienced increasing difficulty walking over the days. He opted to undergo plasma therapy as advised by the neurologist. He completed five sessions on alternate days, after which he could only move the fingers of his right leg, with no improvement observed in his left leg and left hand. Due to the lack of significant progress, he was referred to SKAMCH & RC, Bangalore, by the parent of a child previously treated.

Clinical Findings

Upon general examination, the patient appeared well-built and well-nourished. There was an absence of pallor, icterus, cyanosis, clubbing, lymphadenopathy, and oedema. No abnormalities were found during the systemic examination.

During the neurological examination, higher mental functions were found to be intact. Upon cranial examination, all cranial nerves were intact, except for the facial nerve, with the patient reporting an inability to blow. Superficial sensory functions, including pain, touch, and temperature perception, remained unaffected, while deep sensory functions related to position and joint sense were within normal limits. Abdominal, corneal, and conjunctival superficial reflexes were all normal, and Babinski's sign was negative.

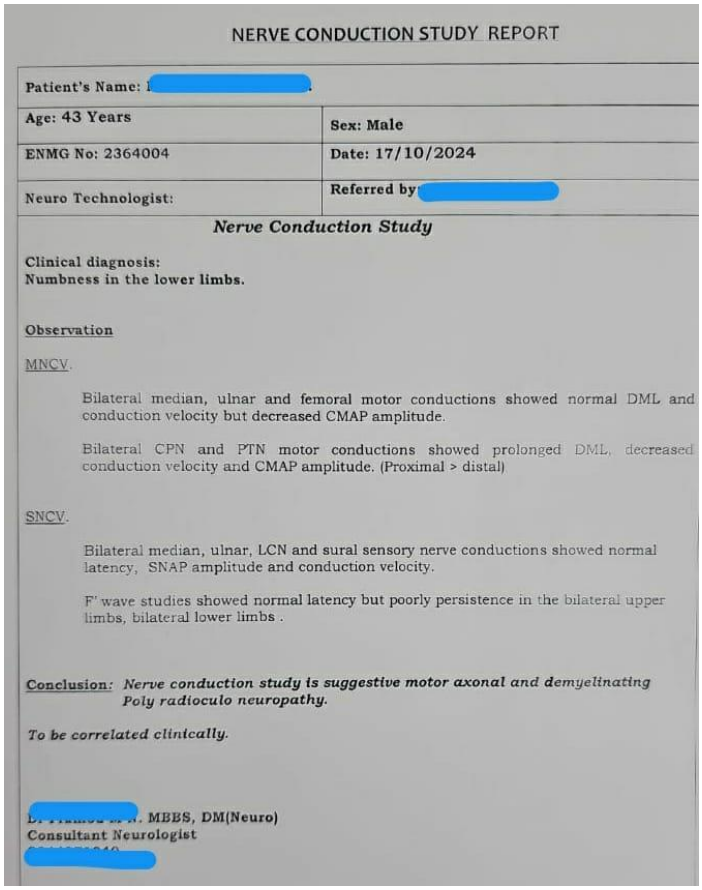
Table 2: Motor examination

Muscle Bulk		
	Right	Left
Mid-arm	32 cm	31 cm
Mid-thigh	53 cm	52 cm
Muscle Tone		
	Right	Left
Upper limb	Normotonic	Hypotonic
Lower limb	Hypotonic	Hypotonic
Muscle power		
	Right	Left
Upper limb	4/5	3/5
Lower limb	2/5	2/5
Deep Tendon Reflex		
	Right	Left
Biceps	2+	1+
Triceps	2+	1+
Supinator	2+	1+

Knee jerk	1+	1+
Ankle jerk	1+	1+

Diagnostic Assessments

- A nerve conduction study of all the limb dated 17th October,2024 was suggestive of motor Axonal and demyelinating Poly radiculo Neuropathy.



NERVE CONDUCTION STUDY REPORT

Patient's Name: [redacted]

Age: 43 Years	Sex: Male
ENMG No: 2364004	Date: 17/10/2024
Neuro Technologist:	Referred by [redacted]

Nerve Conduction Study

Clinical diagnosis:
Numbness in the lower limbs.

Observation

MNCV.

Bilateral median, ulnar and femoral motor conductions showed normal DML and conduction velocity but decreased CMAP amplitude.

Bilateral CPN and PTN motor conductions showed prolonged DML, decreased conduction velocity and CMAP amplitude. (Proximal > distal)

SNCV.

Bilateral median, ulnar, LCN and sural sensory nerve conductions showed normal latency, SNAP amplitude and conduction velocity.

F' wave studies showed normal latency but poorly persistence in the bilateral upper limbs, bilateral lower limbs .

Conclusion: ***Nerve conduction study is suggestive motor axonal and demyelinating Poly radioculo neuropathy.***

To be correlated clinically.

[redacted]. MBBS, DM(Neuro)
Consultant Neurologist
[redacted]

Treatment

The treatment was planned in two phases.

Phase 1(06/11/24 to 12/11/24):

- *Sarvanga Udwartana*[6,7] with *Triphala choorna*
- *Sarvanga Dhanyamladhara*[8]
- *Agnichikithsa Lepa* (both internal and external)
- *Rajayapana Kala Basti*[9]
- Physiotheraphy

Table 2: *Rajayapana Basti* ingredients and their quantity

Basti	Ingredients	Quantity
Matra basti	*Balashwagandhadi Taila*	30 mL

	Saindhava Lavana	1 pinch
Niruha basti	*Madhu*	60 mL
	Saindhava	6 g
	Murchita Ghritha	120 mL
	Rajayapana basti kalka	40 g
	Rajayapana basti qwatha Siddha ksheerapaka	130 mL
	Ajamamsa Rasa	130 mL

Phase 2 (13/11/24 to 21/11/24):

- *Pizzhichil:*
- *Abhyangartha – Balashwagandhadi Taila*
- *Sekartha – Moorchita Tila Taila*
- *Adhoshaka Jambeera Pinda Sweda*
- *Adhoshaka Nadi Sweda*
- *Rajayapana Kala Basti*(continued)
- Physiotheraphy

Oral medications prescribed:

- Cap Palsineuron, 1tid, A/F
- Tab Nuro D, 1tid, A/F
- Tab *Ekangaveera Rasa*, 1tid, A/F
- Tab *Vatagajankusha Rasa*, 1tid, A/F
- *Dhanadanayanadi Kashaya*, 2tsp tid with 6 tsp water, A/F

OBSERVATION AND DISCUSSION

An attempt is made to understand GB Syndrome from *Ayurveda* perspective[10]:

- *Sarvanga Gata Vata Vyadhi (Gatra sphurana, Gatra Bhanjana,Vedana,Sandhi sphutana)*
- *Mamsa Medogata Vata (Guru Anga, Athyartha Toda, Ruk, Atyarta Shramita)*
- *Kaphavrutha Vyana (Sarva Gatra Guruta, Sarva Sandhi Asthi Ruja, Ati gati Sangha)*
- *Kaphavrutha Udana (Dourbalya, Guru Gatra, Aruchi)*

Though different diseases in *Ayurveda* can be considered to correlate with GB syndrome, the absolute correlation may not be possible, and it is better to view it under the heading of *Anukta Vata Vyadhi*. The pathology starts with *Avarana's* condition associated with *Ama* manifestations exhibiting the symptoms of *Vata vyadhi*. In the present case, the initial approach was to dismantle the association of *Ama* and unwrap the *Avarana* caused the *Gati* of *Vata*. Thereafter, exclusive *Vata vyadhi chikitsa* mentioned for *Nirupastambhita Vata Vyadhi* is adopted as *Snehana*, *Swedana* and *Mridu samshodhana*.

As the patient had a history of fever, *Ama Nirharana*, *Deepana* and *Pachana* were carried out through *Sarvanga Agnichikithsa lepa*, *Sarvanga Dhanyamladhara* in Phase 1 of treatment. *Agnichikithsa lepa* and *Dhanyaamla* are formulations which are potent *ushna veerya* and *teekshna veerya* respectively. Both the *veerya* are responsible for deep penetration *(sukshma tara)* and clear the *avarana & sroto shodhana*. The *avarana* was overcomed via *Udwartana* that exerted *Rookshana*, "*Siramukha viviktatva*" and "*Twakstha Agni Tejana*"[11] affect that would result in enhancement of penetration capacity of *Aushadha veerya* via skin. *Rajayapana Basti* was adopted as it exerts both *Shodhana* and *Brihmana* action along with *Balya, Sajeevana* and *Shulanashana* actions.

In Phase 2, *Pizzhichil* is recommended in *Vata vyadhi* as *Snigdha* and *Ushna guna* alleviates *Vata dosha*. *Sechana Dravya* gets uniformly absorbed and the process causes vasodialation at the same time tones up the muscles.[12] The dual nature of *Jambeera pinda sweda*, combining both *Snehana* and *swedana* is helpful in diseases of severe *vata* aggravation, the warm, oily nature of the treatment helps pacify the *Vata dosha*, providing relief from pain and promoting mobility[13]. The application of *swedana* to the affected part has the potential to reduce the symptom of pain and stiffness due to effect of heat.

After phase 1 of treatment, the patient was able to move his fingers, numbness and pain reduced by 30%. After phase 2 of treatment, the patient shifted from wheelchair to walker, the patient was able to walk with support. The patient was able to stand for about 3 minutes without support. Patients have

gained confidence to walk and strength in bilateral lower limbs.

CONCLUSION

Guillain Barre Syndrome is a rare but potentially serious autoimmune disorder affecting the peripheral nervous system, leading to muscle weakness and paralysis.

The first line of treatment comprised *Sarvanga Udwartana* as *Rookshana chikitsa*, one of *Shadupakrama's* being indicated in diseases of *Kapha* and *Meda* predominance.[14] The *Agnideepana* and *Ama pachana* effect of *Agnichikithsa lepa* and *Dhanyamladhara* has contributed to the alleviation of heaviness, numbness and weakness in the present case and the first phase of treatment was mainly focused on it. The second phase focused on *Vatahara* and *Balya* action on the subject. *Basti* is considered as *Ardha chikitsa* for *Vata*.

GB Syndrome started with a history of *Jwara* presenting with significant involvement of *Ama* and *Avarana* pathology, resulting in *Dourbalya, Karma kshaya, Anga supti, Gati sanga, etc.*, which requires an approach of *Panchakarma* modalities of treatment, starting with *Rookshana, Deepana,* and *Pachana*, followed by exclusively *Brimhana* and *Snehana chikitsa* blended with *Basti karma*.

REFERENCES

1. Harsh Mohan. Textbook of Pathology. 9th edition, 2023, published by Jaypee Brothers Medical Publishers (P) Ltd, New Delhi. p.919.
2. Sir Stanely Davidson, Davidson's Principles and Practice of Medicine, 21st Edition, 2010, Edited by Nicki R Colledge, Brian R Walker, Stuart H Ralston, Published by Elsevier Limited. p. 1229.
3. Boyd's, Textbook of Pathology, 1oth Edition, 2013, Edited by JR Bharadwaj, Prabal Deb, Published by Wolters Kluwer Pvt. Ltd., New Delhi. p. 1581.
4. Pandit Parashurama Shastri, Vidyasagar, Sharangadhara Samhita by Sharangadhara, with Deepika commentary of Adhamalla and Gudartha Deepika of Kashirama. Purvakhanda Chapter 5, verse 25, Varanasi: Chaukhamba Orientalia, Reprint edition, 2012.p. 50.
5. Dr. Midhun Mohan, Dr. Vinay Kumar K.N., Dr. Swati S. Deshpande, Dr. Kiran M. Goud, "Panchkarma: A Hope for LGBS – Landry Guillain-Barré Syndrome: A Case Report," International Journal of Bioassays, vol. 4, no. 03, February 2015, pp. 3770-2.
6. Vaghbhata, Arunadatta, Hemadri. Sutra Sthana, 2nd Chapter Dinachar yadhyaya Adhyaya, Verse 15. In: Hari Sadashiva Shastri Paradakara Bhisagacharya (Edi.), Ashtanga Hrudaya with Sarvanga Sundari and Ayurveda Rasayana Commentary. Reprint Edition: 2022. Varanasi: Chaukhamba Subharti Prakashana. 2022. 28.
7. Sushruta, Dalhana, Gayadasa. Chikithsa Sthana, 24th Anagathabadhapratishedha Adhyaya, Verse 21. In: Acharya YT, Narayana Ram (Edi.), Sushruta Samhita with Nibandha Sangraha and Nyayachandrika Panjika Commentary. Reprint Edition: 2021. Varanasi: Chaukhamba Orientation. 2021. p. 224.
8. Agnivesha, Charaka, Drudabala, Chakrapanidatta. Sutra Sthana, 27th Chapter Annapana Vidhi Adhyaya Verse 286-87. In: Acharya YT (Edi.), Charaka Samhita with Ayurveda Deepika Commentary. Reprint Edition: 2021. Varanasi: Chaukhamba Orientalia. 2022. p.169-70.
9. Sushruta, Dalhana, Gayadasa. Chikithsa Sthana, 38th Niruhakrama chikithsa Adhyaya, Verse 111. In: Acharya YT, Narayana Ram (Edi.), Sushruta Samhita with Nibandha Sangraha and Nyayachandrika Panjika Commentary. Reprint Edition: 2021. Varanasi: Chaukhamba Orientation. 2021. p. 544.
10. Dr Shruthi K Kamath, Dr Vinaykumar K N, A case report on Guillain Barre Syndrome(G B Syndrome) in child- A successful approach in Ayurveda, International Ayurvedic Medical Journal, September 2020, p.4556-9.
11. Sushruta, Dalhana, Gayadasa. Chikithsa Sthana, 24th Anagathabadhapratishedha Adhyaya, Verse 52. In: Acharya YT, Narayana Ram (Edi.), Sushruta Samhita with Nibandha Sangraha and Nyayachandrika Panjika Commentary. Reprint Edition: 2021. Varanasi: Chaukhamba Orientation. 2021. p. 544.
12. Dr Poornima Bhat. In: Traditional Ayurvedic treatments of Kerala. Third edition: 2010. Varanasi: Chowkhamba Krishnadas Academy. 2010.p.13.
13. Dr Bhavani challal, Dr Kshipra Rajoria, Dr Sarvesh Kumar Singh, Dr Anshu, Conceptual Study on Jambeera Pinda Sweda: A Review Article, International Journal of Research Publication and Reviews, Vol(5), Issue(8), August (2024), p.2865.
14. Agnivesha, Charaka, Drudabala, Chakrapanidatta. Siddhi Sthana, 27th Chapter Annapana Vidhi Adhyaya

Verse 286-87. In: Acharya YT (Edi.), Charaka Samhita with Ayurveda Deepika Commentary. Reprint Edition: 2021. Varanasi: Chaukhamba Orientalia. 2022. p.169-70.

Source of Support: Nil
Conflict of Interest: None Declared

How to cite this URL: Sai Chinmayee T & Vinaykumar K N: A case report on guillain barre syndrome: a successful tale of miraculous recovery through ayurveda. International Ayurvedic Medical Journal {online} 2025 {cited April 2025}