patient was started on oral prednisolone with clinical and neurophysiological improvement.

Conclusion: In this case, we admit the presence of an isolated vasculitis of peripheral nervous system, and speculate that the trigger mechanism of the vasculitis is a late immunological process secondary to previous and persistent mycobacterium antigen exposition.

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Prognostic factor associated with rapid recovery in patients with Guillain–Barré syndrome

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Objectives: We aimed to study epidemiological, clinical, laboratory, and electrophysiological features and correlation of these parameters with prognosis in Guillain–Barré syndrome (GBS) patients with good outcome.

Methods: The 22 patients with GBS were enrolled, who were hospitalized and followed up at a tertiary hospital center during January 2005–October 2010. We described age, gender, antecedent infections, presenting symptoms, clinical severity with GBS disability scale, cranial nerve involvement, presence of respiratory distress, laboratory, electrophysiological findings and treatment, and analyzed the correlation between the data and prognosis in all patients with good outcome.

Results: Cerebrospinal fluid (CSF) protein level (correlation coefficient; 0.554, $p = 0.007$), clinical severity (GBS disability scale, correlation coefficient; 0.870, $p < 0.001$) and the timing of intravenous immunoglobulin G (IVIgG, correlation coefficient; 0.519, $p = 0.013$) treatment were strongly associated with recovery of illness. Ten patients with normal CSF protein rapidly improved to GBS disability scale 0 or 1 within 1 month, whereas other 12 patients with high CSF protein showed slow recovery. Additionally, the patients with low GBS disability scale or early IVIgG therapy rapidly improved, as contrasted with the other patients with high GBS disability scale or delayed IVIgG therapy.

Conclusion: The current study revealed significant prognostic factors in recovery of GBS, although the favorable prognostic factor in GBS patient calls for further large studies surveying biochemical analysis of CSF and longitudinal changes involving biochemical markers in extended GBS patients. Normal CSF protein, low GBS disability scale and early IVIgG therapy are strongly associated with rapid recovery in GBS patients with consequently good outcome.

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Posterior reversible encephalopathy syndrome and Guillain–Barré syndrome: diagnostic and therapeutic challenge

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Introduction: The autonomic dysfunction with fluctuating blood pressure is a common complication of Guillain–Barré syndrome (GBS). In turn, Posterior Reversible Encephalopathy Syndrome (PRES) is precipitated by hypertensive crisis and clinically characterized by encephalopathy, seizures, headaches, impaired vision, and symmetrical vasogenic edema observed preferentially in the posterior regions. A rare and reversible association of GBS / PRES has been described in the literature.

Case report: 67 years old woman, with background history of polyarthritis, observed by acute onset of malaise, anorexia and low back pain followed by vomiting and diarrhea, vision impairment, and disorientation beginning 1 day before admission. Objectively, she presented time and space disorientation, blindness and hypertension. Cerebral CT scan revealed questionable bilaterally occipital hypodensities. The cerebrospinal fluid (CSF) was normal and the electroencephalogram presented moderate encephalopathy. She was admitted in Neurology Department and treated with prednisolone (50 mg) for control of inflammatory arthropathy. Four days after admission she had left peripheral facial paresis and flaccid areflexic, predominantly proximal and of lower limbs, tetraparesis. New CSF showed elevated protein level, starting immunoglobulins. Marked hemodynamic instability with frequent hypertensive peaks was recorded. Magnetic Resonance Image showed marked cortico-subcortical signal abnormalities, involving occipital, parietal and frontal lobes, bilaterally, characteristic of vasogenic edema. The patient completed 5 days of treatment with immunoglobulin and methylprednisolone, without clinical response. By day 11, deterioration of consciousness occurred with correspondent increased extent of the imaging abnormalities. Steroids were restarted, without improvement. In day 15 she was admitted in the Intensive Care Unit for sudden respiratory failure, with apnea periods and respiratory arrest. The patient died on day 20.

Conclusions: This case raises two distinct important issues that requires our attention and without clear solution: a rare presentation of GBS with PRES, assuming that this usually reversible association is a consequence of autonomic dysfunction, and in other hand, the secondary increase of cerebral edema with therapy (immunoglobulins and steroids) also related with development of PRES.

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Asymptomatic posterior reversible encephalopathy syndrome-like brain MRI in a case of Guillain–Barré syndrome

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Background: Posterior reversible encephalopathy syndrome (PRES) was first reported in 1996 and consists of a reversible vasogenic oedema predominating in the cerebral posterior white matter. There are several known causes of PRES, including hypertension and intravenous immunoglobulin (IVIg) therapy. We report the case of an asymptomatic PRES during the course of a Guillain–Barré syndrome (GBS).

Case-report: A healthy 28-year-old woman presented with dysesthesias of the hands and feet which occurred two days after an upper respiratory tract infection. Initial examination revealed moderate distal sensory loss and proximal weakness of the four limbs, tachycardia and de novo hypertension (160/100 mmHg). Initially, cerebrospinal fluid (CSF) analysis and electrophysiological examination were normal. A brain MRI showed extensive bilateral fronto-parieto-occipital hyperintensities of the white matter and cortex in FLAIR and T2-weighted images. A second CSF analysis revealed elevated protein level with a normal cell count; a second electrophysiologic study demonstrated an axonal neuropathy, consistent with the diagnosis of axonal GBS. A neuromuscular biopsy showed only an axonal neuropathy. IVIg were infused for 2 days only because of an allergic reaction. The blood pressure was managed appropriately and was never higher than 160/100 mmHg. A new brain MRI performed 8 days after the first one showed near complete resolution of the signal abnormalities. One month after discharge, the neurological examination revealed a moderate sensory loss of the four limbs, no