Trabalhos Científicos

Título: Experience Of Rapid Detection Of Campylobacter By The Biofire® Filmarray ® Gastrointestinal Panel In Patients With Guillain Barré Syndrome (Gbs)

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Resumo: Introduction: GBS is an inflammatory, demyelinating, immunomediated, inflammatory polyradiculoneuropathy. It is the most frequent cause of polyneuropathy in childhood. Incidence of 0.5-1.5 / 100 000 inhabitants under 18 years of age. The immunological phenomena can be triggered by: Campylobacter jejuni in 23-40% of cases, especially associated with axonal forms and Miller-Fisher syndrome, being able to be detected in stool samples several weeks after the termination of diarrhea. Other infections: cytomegalovirus (10%), Epstein-Barr virus (2-10%), varicella zoster virus (5%), hepatitis virus, herpes simplex virus, Mycoplasma pneumoniae, Haemophilus influenzae and even vaccines can trigger GBS. We present here a series case report of two patients, from October 2017 to June 2018 that developed GBS where the presence of Campylobacter jejuni was demonstrated by the BioFire Gastrointestinal Panel (BGP) in a stool sample. Clinical case 1: a 37-month-old male who consulted for 2 days of functional impotence in the lower limbs (MMII), predominantly left, with a history of diarrhea weeks before admission. During hospitalization, muscular hypotonia and areflexia (MMII), right brachiocrural hemiparesis and generalized hyporeflexia are observed. Brain axial tomography: normal. Electromyogram: mixed polyneuropathy with axonal and myelinated involvement. Lumbar puncture (LP): cerebrospinal fluid (CSF), proteins: 130 mg /%, cells: 17 with 90% of lymphocytes (albumen-cytological dissociation). He was treated with gammaglobulin 1 gram / kg of weight for 2 days, with progressive improvement. Followed by Neurology and Kinesiology for continuing with gait disorders. Clinical Case 2: A 36-month-old male with a history of watery diarrhea, who consulted on guard for ataxia and muscular weakness in MMII with distal predominance and areflexia. PL: LCR 1 cell, proteinorraquia 0.6 mg /%. Normal electroencephalogram Gamma globulin 1 gram / kg of weight was performed for 2 days. Due to a good response to treatment, he remained hospitalized for 5 days and is currently without sequelae. Diagnosis: Acute demyelinating GBS. In both cases BGP allowed us to make an early detection of Campylobacter jejuni in about 1 hour. It is important to consider that the stool culture was negative also in both cases. Serology was performed in both patients for cytomegalovirus, Epstein Barr Virus and Mycoplasma pneumoniae and the result was negative. There were no signs of infections in the last weeks (infections by herpes virus, varicella virus or Zika virus) or vaccines in the previous 3 months. Conclusions: The BioFire® Filmarray® Gastrointestinal Panel allowed us to detect Campylobacter quickly in approximately 1 hour against the suspicion of GBS. No other possible trigger agent was found. The time and resources required for stool culture, as well as the special growth conditions required by Campylobacter sp., demand the need for more sensitive and specific diagnostic methods.