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NAIDANIK VICHAR IN GUILLAIN–BARRÉ SYNDROME: A CASE STUDY

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ABSTRACT

Background: Guillain–Barré Syndrome (GBS) is an acute immune-mediated inflammatory polyradiculoneuropathy causing rapidly progressive weakness and areflexia. Although not described as a distinct disease in Ayurveda, it may be conceptually interpreted as *Vatavyadhi* with predominant *Majjavaha Srotodushti*. **Case Presentation:** A patient with clinically diagnosed GBS presented with progressive quadriparesis, paresthesia, diminished deep tendon reflexes, and gait impairment following an antecedent infection. **Methods:** The patient was assessed using modern neurological evaluation and Ayurvedic diagnostic principles, including *Nidana Panchaka*, *Dashavidha Pariksha*, and assessment of *Majjavaha Srotodushti Lakshanas*. **Results:** Predominant *Vata Dosha* vitiation with probable *Ama* involvement and *Majjavaha Srotodushti* was observed. Classical *Lakshanas* showed conceptual correlation with the neurological manifestations of GBS. **Conclusion:** Assessment of *Majjavaha Srotodushti Lakshanas* may provide a structured *Ayurvedic* diagnostic perspective in GBS. Further studies are needed to validate this approach.

KEYWORDS: Guillain–Barré syndrome, *Majjavaha Srotodushti*, *Vatavyadhi*.

INTRODUCTION

Guillain–Barré Syndrome (GBS) is an acute immune-mediated inflammatory polyradiculoneuropathy characterized by rapidly progressive symmetrical limb weakness, areflexia, sensory disturbances, and autonomic dysfunction. It commonly follows a recent past infection and remains one of the leading causes of acute flaccid paralysis. Early diagnosis and appropriate management are essential to improve clinical outcomes.[5,2]

Although GBS is not described as a distinct disease entity in Ayurveda, its clinical manifestations can be conceptually interpreted through the principles of *Vatavyadhi* with predominant involvement of *Majjavaha Srotas*. Classical descriptions of *Majjavaha Srotodushti* include weakness, impaired movement, sensory abnormalities, and loss of strength, which resemble several neurological features of GBS.

Most published Ayurvedic reports on GBS focus on its management, while systematic assessment of *Majjavaha Srotodushti Lakshanas* has received limited attention. Therefore, the present case study aimed to assess the classical *Majjavaha Srotodushti Lakshanas* in a patient with Guillain–Barré Syndrome and to explore their conceptual correlation with the clinical manifestations of the disease.

3. CASE PRESENTATION

A 23-year-old male, student, presented to the outpatient department with complaints of progressive weakness of both lower limbs, followed by upper limb weakness, associated with tingling sensation and numbness in both upper and lower limbs and difficulty in walking.

Chief Complaints

Table no - 1

Sr. No.	Chief Complaints	Duration
1	Progressive weakness of all four limbs	2 days
2	Pain in both lower limbs	2 days
3	Tingling sensation and numbness in both upper and lower limbs	2 days
4	Difficulty in walking	1 day
5	Difficulty in performing activities of daily living (ADL)	1 day

History of Presenting Illness

The patient developed 4–5 episodes of vomiting and 7–8 episodes of loose stools without fever 4 days before admission. One day prior to admission, he experienced tingling in both legs, followed by rapidly progressive lower limb weakness. The next morning, he fell in the

bathroom due to severe weakness, which subsequently progressed to involve both upper limbs. There was no history of trauma or loss of consciousness. The patient was admitted and diagnosed with Guillain–Barré Syndrome based on clinical examination and relevant neurological investigations.

Antecedent Infection

History of acute gastroenteritis, with 4–5 episodes of vomiting and 7–8 episodes of loose stools without fever, 3–4 days before the onset of progressive limb weakness.

Past History

No history of diabetes mellitus, hypertension, tuberculosis, thyroid disorders, previous neurological illness, or similar episodes. No history of major surgery or recent vaccination

Family History

No significant family history of neurological, autoimmune, or hereditary disorders.

Personal History

- **Diet:** Mixed
- **Appetite:** Normal
- **Bowel:** Regular
- **Bladder:** Normal
- **Sleep:** Disturbed
- **Addictions:** Nil

- **Clinical Examination**

General Examination

Table no. 2.

Parameter	Findings
Pulse	82 beats/min, regular
Blood Pressure	140 /80 mmHg
Temperature	98.2°F (Afebrile)
Respiratory Rate	20 breaths/min
Oxygen Saturation	98 % Room air
General Condition	Moderate
Pallor	Absent
Icterus	Absent
Cyanosis	Absent
Clubbing	Absent
Lymphadenopathy	Absent
Pedal Edema	Absent

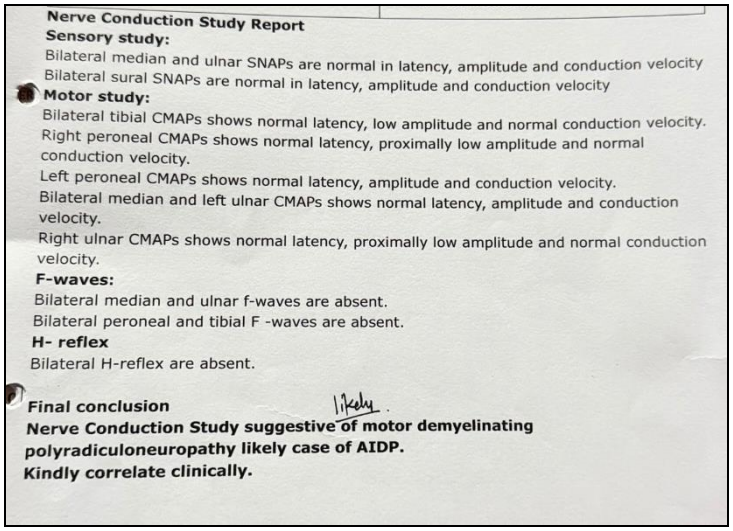
Neurological Examination in Guillain–Barré Syndrome (GBS)

Table no. 3.

Parameter	Clinical Findings
Higher Mental Functions	Normal
Consciousness	Conscious and oriented to time, place and person
Muscle Power (MRC Grade)	Right UL: 5/5; Left UL: 5/5; Right LL: 2/5; Left LL: 2/5
Muscle Tone	Hypotonia in bilateral lower limbs
Deep Tendon Reflexes	Diminished in bilateral lower limbs
Plantar Reflex	Bilaterally flexor
Sensory Examination	Paresthesia with reduced distal sensations.
Cranial Nerves	No cranial nerve involvement
Coordination	Upper-limb coordination normal; lower-limb assessment limited due to weakness
Gait	Unable to walk independently
Respiratory Involvement	Assess respiratory muscle weakness; document oxygen or ventilatory support requirement
Bulbar Function	No dysphagia or dysarthria.
Autonomic Function	No autonomic dysfunction.

5. Investigations

- Routine hematological and biochemical investigations were within normal limits, except for **mild neutrophilia (74%)** and **low serum phosphorus (2.0 mg/dL).** Liver function tests, Renal function tests, blood glucose, and serum electrolytes were within normal limits.
- **Nerve conduction studies (26 June 2026)** - demonstrated **normal sensory responses with reduced motor CMAP amplitudes, absent F-waves, and absent bilateral H-reflexes**, consistent with **acute inflammatory demyelinating polyradiculoneuropathy (AIDP)**, the most common variant of Guillain–Barré syndrome.
- **CSF examination** was not performed.



Nerve Conduction Study Report

Sensory study:

Bilateral median and ulnar SNAPs are normal in latency, amplitude and conduction velocity

Bilateral sural SNAPs are normal in latency, amplitude and conduction velocity

Motor study:

Bilateral tibial CMAPs shows normal latency, low amplitude and normal conduction velocity.

Right peroneal CMAPs shows normal latency, proximally low amplitude and normal conduction velocity.

Left peroneal CMAPs shows normal latency, amplitude and conduction velocity.

Bilateral median and left ulnar CMAPs shows normal latency, amplitude and conduction velocity.

Right ulnar CMAPs shows normal latency, proximally low amplitude and normal conduction velocity.

F-waves:

Bilateral median and ulnar f-waves are absent.

Bilateral peroneal and tibial F -waves are absent.

H- reflex

Bilateral H-reflex are absent.

Final conclusion

Nerve Conduction Study suggestive of motor demyelinating polyradiculoneuropathy likely case of AIDP.

Kindly correlate clinically.

6. Ayurvedic Assessment

6.1 Dashavidha Pariksha

Table no. 4.

Sr. No.	Parameter	Findings
1	*Prakriti*	*Pitta-Vata*
2	*Vikriti*	*Vata Pradhana Tridosha Dushti*
3	*Sara*	*Rasa Sara*
4	*Samhanana*	*Madhyama*
5	*Pramana*	*Madhyama*
6	*Satmya*	*Madhyama*
7	*Satva*	*Madhyama*
8	*Ahara Shakti*	*Avara*
9	*Vyayama Shakti*	*Avara*
10	*Vaya*	*Yuva*

6.2. Ashtavidha Pariksha

Table no. 5.

Sr. No.	Pariksha	Findings
1	*Nadi*	*Pitta Pradhana*
2	*Mutra*	*Prakrita* – 4–5 times/day
3	*Mala*	*Prakrita* – Once/day
4	*Jihva*	*Sama* (coated tongue)
5	*Shabda*	*Prakrita*
6	*Sparsha*	*Vikrita* (tingling and numbness in all four limbs)
7	*Drik*	*Prakrita*
8	*Akriti*	*Madhyama*

6.3. Ayurvedic Assessment – (Samprapti Ghataka)

Table no - 6

Parameter	Findings
Dosha	*Vata Pradhana Tridosha Dushti*
Dushya	*Majja Dhatu, Mamsa Dhatu, Rasa Dhatu, Snayu* and *Kandara*
Jatharagni	*Mandagni*
Dhatvagni	*Majja Dhatvagni Dushti*
Ama	Probable *Ama* involvement, considering antecedent infection, *Mandagni* and clinical presentation
Mala	*Purisha – Prakrita*
Srotas	*Rasavaha, Mamsavaha and Majjavaha Srotas*
Srotodushti	*Sanga (probable)*
Udbhava Sthana	*Amashaya*
Sanchara Sthana	*Rasavaha and Majjavaha Srotas*
Vyaktasthana	*Sarvanga, particularly lower limbs*
Rogamarga	*Madhyama Rogamarga*
Adhisthana	*Majja Dhatu and Snayu*

6.4. Samprapti (Probable)

Flow chart no -1

Antecedent Infection
↓
Agnimandya
↓
Ama Formation
↓
Srotorodha
↓
Probable Kapha/Ama Avarana of Vata
↓
Vata Prakopa
↓
Majjavaha Srotodushti
↓
Snayu & Mamsa Dhatu Dushti
↓
Angasada • Bala Kshaya • Cheshta Hani
Supti • Sparsha Jnana Hani • Gati Vaikalya
↓
Clinical Manifestations of Guillain–Barré Syndrome

Majjavaha Srotodushti Lakshana[6,7,8]

Table no. 7.

Majjavaha Srotodushti Lakshana	Clinical Correlation in GBS
1. Bhrama	Not observed in this case
2. Murchha	Not observed in this case
3. Angasada	Severe generalized muscle weakness
4. Bala Kshaya	Marked reduction in muscle strength
5. Sparsha Jnana Hani	Impaired touch sensation/paresthesia
6. Cheshta Hani	Difficulty or inability to perform voluntary movements
7. Gati Vaikalya	Unable to walk without assistance
8. Supti	Tingling and numbness of limbs
9. Vedana	Mild neuropathic pain
10. Kampa	Not observed in this case

10. DISCUSSION

Modern Interpretation

Guillain–Barré Syndrome (GBS) is an acute immune-mediated inflammatory polyradiculoneuropathy that commonly follows a respiratory or gastrointestinal infection. Molecular mimicry between microbial antigens and peripheral nerve components triggers an autoimmune response, resulting in demyelination and, in some cases, axonal degeneration. These pathological changes impair nerve conduction, leading to progressive symmetrical muscle weakness, areflexia, sensory disturbances, and autonomic dysfunction. The patient's clinical features, neurological examination, and supportive investigations were consistent with the diagnosis of GBS.[3]

Although CSF analysis demonstrating albuminocytological dissociation is a supportive feature of Guillain–Barré syndrome, it was not performed in the present case. The diagnosis was based on the characteristic clinical presentation and electrophysiological findings consistent with the acute inflammatory demyelinating polyradiculoneuropathy (AIDP) variant.[4]

Ayurvedic Interpretation

Although GBS is not described as a distinct disease entity in *Ayurveda*, its clinical manifestations can be conceptually interpreted under *Vatavyadhi* with predominant involvement of *Majjavaha Srotas.*

Majjavaha Srotodushti

The patient exhibited classical features such as *Angasada, Bala Kshaya, Cheshta Hani, Supti,*

Sparsha Jnana Hani, and *Gati Vaikalya*, suggesting involvement of *Majjavaha Srotas.* These *Lakshanas* closely resemble the motor and sensory deficits observed in GBS.

Vata Prakopa

The progressive onset of weakness, loss of motor function, impaired gait, and diminished reflexes indicates predominant *Vata Dosha* vitiation. Since *Vata* governs all neurological and motor activities, its derangement may explain the rapid progression of neuromuscular dysfunction.

Ama

The antecedent infectious illness preceding the onset of neurological symptoms may be interpreted as causing *Agnimandya*, leading to the formation of *Ama. Ama*, due to its *guru*, *picchila*, and *srotorodhaka* properties, may contribute to obstruction of normal physiological pathways and aggravation of Vata.

Avarana

The disease process may be conceptually understood as probable *Kapha/Ama Avarana of Vata*. Obstruction of *Vata* by *Ama* and *Kapha* may initially impair its normal functions, followed by *Vata Prakopa*, resulting in progressive motor and sensory deficits. This interpretation provides an Ayurvedic explanation for the evolution of neurological manifestations in GBS.

Snayugata vata

In Ayurveda, **Snayu** are responsible for maintaining stability and facilitating movement. The marked weakness, reduced voluntary movements, and gait impairment observed in the patient suggest functional involvement of *Snayugata vata*, correlating conceptually with peripheral nerve dysfunction.

Madhyama Rogamarga

GBS predominantly affects structures such as Majja, Snayu, and neuromuscular tissues, which are included under Madhyama Rogamarga. Diseases involving this Rogamarga are generally associated with significant functional impairment and often require prolonged recovery, a feature commonly observed in patients with GBS.

Overall, this case demonstrates a close conceptual correlation between the neurological manifestations of Guillain–Barré Syndrome and the Ayurvedic concepts of **Majjavaha**

Srotodushti, **Vata Prakopa**, **Ama**, **Avarana**, and **Snayugata vata involvement**. Although these correlations are interpretative and not direct disease equivalents described in the classical texts, they provide a structured Ayurvedic diagnostic framework for understanding GBS. Further observational studies involving larger patient populations are required to validate the diagnostic applicability of these concepts.

Modern Finding	Ayurvedic Interpretation
Peripheral nerve demyelination	Majja Dushti (conceptual)
Motor weakness	Vata Prakopa
Sensory loss	Majjavaha Srotodushti
Areflexia	Vyana Vata Dushti
Respiratory weakness	Prana Vata Dushti

CONCLUSION

Guillain–Barré Syndrome may be conceptually interpreted *Majjavaha Srotodushti* and *Vata Prakopa*. Assessment of *Majjavaha Srotodushti Lakshanas* may complement Ayurvedic diagnostic evaluation of GBS. However, this interpretation is conceptual and requires validation through larger observational studies.

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