Guillain–Barré syndrome and ulceroglandular tularemia

C. Zhou · Y. Yang · H. Zhang

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To the Editor,

Ylipalosaari and colleagues [1] reported an interesting case of Guillain–Barré syndrome (GBS) in a patient with ulceroglandular tularemia. Similar cases have been reported in the authors' hospital [2] and another institution [3].

Clinically, GBS is characterized by the acute or subacute onset of varying degrees of weakness in limbs or cranial nerve-innervated muscles, associated with characteristic albuminocytologic dissociation in the cerebrospinal fluid (CSF). GBS is usually preceded by various infections. About two-thirds of cases are preceded by symptoms of upper respiratory tract infection or diarrhea [4]. In this case, however, the clinical course of weakness of limbs and respiratory muscles paralleled that of ulceroglandular tularemia too perfectly. This is concomitant with the ineffectiveness of intravenous immunoglobulin. Moreover, the characteristic albuminocytologic dissociation in the CSF was absent for this patient. As mentioned by the authors, there have been reports of tularemia meningitis and intracranial abscesses [5]. The elevated number of white blood cells in the CSF (we believe that the real number should be $47 \times 10^6/L$, instead of 47/L in the text) strongly suggests direct involvement of the nervous system

by pathogens. Taken together, the atypical clinical manifestations of the patient prompt us to consider other differential diagnoses, including infectious polyneuritis, critical illness polyneuropathy (CIP) and myopathy (CIM), etc.

Conflict of interest The authors declare that there is no actual or potential conflict of interest in relation to this article.

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C. Zhou · Y. Yang · H. Zhang (✉)
Department of Neurology, The First Hospital of Jilin University,
No. 71 Xinmin Street, Changchun 130021, China
e-mail: drzhl@hotmail.com