or gastrostomy tube to ensure adequate feeding. It is also important to consider the possibility of stress ulcers in such patients and administer a proton pump inhibitor. Immobilization, which occurs with GBS, decreases GI function; therefore, attention to problems such as decreased gastric emptying, constipation, and feeding residuals requires nursing assessment and appropriate collaborative interventions. Temporary urinary catheterization may be required; urinary retention is common, and appropriate assessment of urinary output is vital. Sensory impairment and paralysis in the lower extremities make the child susceptible to skin breakdown; therefore, attention should be given to meticulous skin care. Passive range-of-motion exercises and application of orthoses to prevent muscle contracture are important when paralysis is present. Prevention of DVT is accomplished with pneumatic compression (antiembolism) devices, administration of a low-molecular-weight heparin, and early mobilization and ambulation. Autonomic dysfunction may be life threatening; thus, close monitoring of vital signs in the acute phase is essential.

A key to recovery in the child with GBS is the prevention of muscle and joint contractures, so passive range-of-motion exercises must be carried out routinely to maintain vital function. Although the child may have a generalized paralysis, cognitive function remains intact; therefore, it is important for nursing care to involve communication with the child or adolescent regarding procedures and treatments that may be frightening, especially if mechanical ventilation is required. Encourage parents to talk to the child and make eye and physical contact and to reassure the child during this phase of the illness.

Pain management is crucial in the care of children with GBS. Although neuromuscular impairment may make pain perception more difficult to accurately evaluate, objective pain scales should be used. Gabapentin and carbamazepine may be used to manage neuropathic pain in patients with GBS.

Physical therapy may be limited to passive range-of-motion exercises during the evolving phase of the disease. Later, as the disease stabilizes and recovery begins, an active physical therapy program is implemented to prevent contracture deformities and facilitate muscle recovery. This may include active exercise, gait training, and bracing.