Treatment of GBS is primarily supportive. In the acute phase, patients are hospitalized because respiratory and pharyngeal involvement may require assisted ventilation, sometimes with a temporary tracheostomy. Treatment modalities include aggressive ventilatory support in the event of respiratory compromise, intravenous immunoglobulin (IVIG), and sometimes steroids; plasmapheresis and immunosuppressive drugs may also be used. Plasmapheresis has been shown to decrease the length of recovery in patients with severe GBS yet is expensive, and the side effects include hypotension, fever, bleeding disorders, chills, urticaria, and bradycardia. Some evidence reports equal benefits to treatment of GBS with IVIG administration or plasmapheresis; both sped up recovery time in studies reviewed (Hughes and Cornblath, 2005). There is evidence, however, of significant improvement in children with high-dose IVIG therapy (vs. supportive treatment alone) (Hughes, Swan, and van Doorn, 2012).

IVIG is now recommended as the primary treatment of GBS when administered within 2 weeks of disease onset (Hughes, 2008). Corticosteroids alone do not decrease the symptoms or shorten the duration of the disease.

Medications that may be administered during the acute phase include a low-molecular-weight heparin to prevent deep vein thrombosis (DVT), a mild laxative or stool softener to prevent constipation, pain medication such as acetaminophen, and a histamine-antagonist to prevent stress ulcer formation. Chronic neuropathic pain after GBS may be treated with gabapentin, which is reported to be more effective than carbamazepine (Sarnat, 2016c).

Rehabilitation after the acute phase may involve physical therapy, occupational therapy, and speech therapy. Additional consideration should be given to problems of general weakness and retraining for toileting and feeding (Lyons, 2008).

Course and Prognosis

Better outcomes are associated with younger age, no requirement for mechanical respiratory assistance, slower progression of disease, normal peripheral nerve function on EMG, and treatment with either IVIG or plasmapheresis. Recovery usually begins within 2 to 3 weeks, and most patients regain full muscle strength. The recovery of muscle strength progresses in the reverse order of onset