of paralysis, with lower extremity strength being the last to recover. Poor prognosis with subsequent residual effects in children is reportedly associated with cranial nerve involvement, extensive disability at time of presentation, and intubation.

Most deaths associated with GBS are caused by respiratory failure; therefore, early diagnosis and access to respiratory support are especially important. The rate of recovery is usually related to the degree of involvement and may extend from a few weeks to months. The greater the degree of paralysis, the longer the recovery phase.

Nursing Care Management

Nursing care is primarily supportive and is the same as that required for children with immobilization and respiratory compromise. The emphasis of care is on close observation to assess the extent of paralysis and on prevention of complications, including aspiration, ventilator-associated pneumonia (VAP), atelectasis, DVT, pressure ulcer, fear and anxiety, autonomic dysfunction, and pain.

During the acute phase of the disease, the nurse should carefully observe the child's condition for possible difficulty in swallowing and respiratory involvement. The child's respiratory function is closely monitored, and oxygen source, appropriate-sized insufflation bag and mask, endotracheal intubation and suctioning equipment, tracheotomy tray, and vasoconstrictor drugs are kept available. Vital signs are monitored frequently, as well as neurologic signs and level of consciousness. For children who develop respiratory impairment, the care is the same as that for any child with respiratory distress requiring mechanical ventilation.

Respiratory care, if intubation is required, requires close monitoring of oxygenation status (usually by pulse oximetry and sometimes arterial blood gases), maintenance of an open airway with suctioning, and postural changes to prevent pneumonia. Consideration should be given to preventing opportunistic infections such as VAP; meticulous oral care and hypopharynx suctioning, elevation of the head of bed 30 degrees, and strict asepsis with suctioning equipment (including catheters, a Yankauer device, or both) should be implemented to prevent VAP. Children with oral and pharyngeal involvement may be fed via a nasogastric