

# Fatigue examined

FATIGUE is a common symptom in patients with GBS and CIDP. The mechanisms of fatigue are still not completely understood but fatigue can be one of the most disabling symptoms for GBS/CIDP patients.

There are at least three ways in which fatigue can manifest itself. The first is a lack of energy and the feeling of being "all in" most of the time. This symptom is most pronounced in the morning and gets somewhat better as the day goes on.

The second symptom is mental exhaustion, similar to the experience of taking a rigorous written examination or speaking in a foreign language without recent practice.

The third is reduced muscular endurance and the inability to perform tasks that previously presented little or no challenge. Someone who can now do only one push-up where previously they could easily perform 40 has clearly developed muscular fatigue.

This symptom is the most relevant for people with Guillain-Barré Syndrome. In GBS, muscular fatigue is dramatic in the acute phase of the illness due to the

## FATIGUE IN GUILLAIN-BARRÉ SYNDROME

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demyelination occurring within the nerves.

Nerve segments that contain demyelinated segments cannot conduct trains of impulses. The same is true in patients with CIDP where muscle-fatigue and weakness go hand in hand.

Thus, fatigue may be a major issue for patients with GBS and CIDP. When persistent muscular weakness affects patients with GBS long after the acute onset, there is no medical therapy that will reverse the treatment.

Plasma exchange or intravenous immunoglobulin or other medical therapies are not effective for people who have failed to completely recover from GBS. Rehabilitation strategies, including muscular strengthening and aerobic exercise, may be appropriate under the supervision of a trained physician.

For patients with CIDP who have persistent weakness, there may be a

benefit from immune suppressive therapies to help improve strength.

For patients who have completely recovered their strength after GBS, or those with CIDP who have no persistent weakness, muscle-strengthening exercises and cardiovascular aerobic exercise is usually helpful.

Deconditioning after GBS and CIDP is extremely common and leads to a substantial feeling of fatigue that is both generalised and muscular.

A reconditioning programme, under the supervision of a rehabilitation expert, is often extremely helpful.

In one study, 40 per cent of patients with GBS still reported significant fatigue two years after onset. Of those patients reporting fatigue, 59 per cent displayed, at most, only minor motor impairment. Thus, fatigue in GBS long after the acute event, might be due to a change in lifestyle rather than persistent

demyelination (Bernstein et al 2001). In another study (Merkies et al 1999), 80 per cent of patients with some persistent weakness three to six years after GBS onset experienced persistent fatigue, and a majority of patients who have regained normal strength also reported severe fatigue.

Treatable causes of extreme fatigue in GBS/CIDP include a non-nourishing sleep pattern that can often be improved with intervention by a trained physician.

Depression can also be a major cause of persistent fatigue and is often responsive to appropriate medical therapy with antidepressant medication. Persistent pain, which can occasionally occur in patients with CIDP and GBS, may also rob one of energy. Appropriate treatment for the pain can be helpful in reducing fatigue.

Finally, gaining weight and getting out of shape are both common contributors to fatigue in GBS/CIDP. Reconditioning exercises and weight loss may be of great help.

More studies are needed to understand completely the mechanisms of fatigue but there is no need for anyone to wait for these studies to seek treatment.

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