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Title
Atypical Guillain–Barré Syndrome with Prominent Dysautonomia and Hyperreflexia: A Case Report

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Case Diagnosis
Atypical Guillain–Barré syndrome (GBS) variant

Case Description
A 36-year-old unhoused man, with diabetes (controlled), Bell's palsy (treated), remote alcohol abuse, and prior tick exposure, presented to the emergency department with 1-day of acute lower back and bilateral leg pain, progressive sensory loss in the legs, urinary retention, constipation, and inability to stand. Examination demonstrated decreased sensation from the perineum to the feet, right hip/knee weakness, and bilateral lower extremity hyperreflexia.

Setting
Physiatry oversaw rehabilitation across acute hospitalization, inpatient rehabilitation, and the outpatient settings.

Results
Neuroimaging revealed no intracranial or spinal cord abnormalities. Extensive toxic, metabolic, infectious, and autoimmune evaluations were unremarkable. Despite atypical features (asymmetric proximal weakness, hyperreflexia, and predominant sensory loss), the presence of albuminocytologic dissociation in cerebrospinal fluid (CSF) and sensory axonal polyneuropathy with electrodiagnostics supported GBS. The patient demonstrated early signs of dysautonomia, including neurogenic bowel/bladder, which progressed to recurrent fevers, tachycardia, and dyspnea. This prompted additional infectious and cardiopulmonary evaluation, which were negative. Following treatment with intravenous immunoglobulin and 1 month of inpatient rehabilitation, the patient regained independent ambulation and was discharged to a shelter. At outpatient follow-up, dysautonomia and hyperreflexia had resolved; the patient regained continence with full strength and residual paresthesias.

Discussion
This case illustrates that GBS may present atypically with features mimicking a central neurologic process. This together with the patient's history of diabetes, alcoholism,

and prior tick exposure complicated the diagnosis. However, the presence of CSF albuminocytologic dissociation remains a pivotal diagnostic for GBS, which allowed for prompt intervention. Physiatry played a central role in coordinating multidisciplinary management, monitoring dysautonomia, confirming the diagnosis, and guiding rehabilitation while considering the patient's limited post-discharge resources.

Conclusions

GBS may present atypically with asymmetric weakness, hyperreflexia, and predominant sensory impairment, requiring careful evaluation. Physiatrists are essential in managing dysautonomia, restoring function, and coordinating care for neurologic presentations across the rehabilitation continuum.