# CHRONIC INFLAMMATORY DEMYELINATING POLYNEUROPATHY WITH ATYPICAL PRESENTATION – A PARANEOPLASTIC SYNDROME?

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## Background

Chronic Inflammatory Demyelinating Polyneuropathy (CIDP) is an acquired immune-mediated neuropathy, usually presenting with symmetrical, insidious sensorimotor deficits, responsive to immunomodulatory therapy. However, atypical presentations, such as acute onset or severe motor impairment, may resemble other neuropathies and hinder diagnosis. In such cases, paraneoplastic syndromes should be considered. Although rare, the association between CIDP and malignancy is documented and justifies further investigation when clinical presentation or imaging findings raise suspicion.

## Case report

We present the case of a 73-year-old man, previously independent, with a history of poorly controlled type 2 diabetes mellitus, dyslipidemia and atrial flutter. He developed acute-onset tetraplegia, initially suspected to be Guillain-Barré syndrome, for which he received intravenous immunoglobulin without clinical improvement. During hospitalization, motor worsening occurred, with associated dysphagia and facial paresis. Lumbar puncture revealed marked hyperproteinorrachia, and electromyography demonstrated an acquired demyelinating sensory-motor polyneuropathy with signs of secondary axonal damage, consistent with CIDP. He was treated with plasma exchange and high-dose corticosteroids, resulting in partial improvement of upper limb strength, while severe lower limb motor deficits persisted, in correlation with follow-up EMG findings. A PET-FDG scan revealed a suspicious pulmonary lesion, raising the possibility of a paraneoplastic syndrome and prompting lung biopsy. Histological analysis showed resolving atelectasis without evidence of malignancy, and follow-up with a chest CT was recommended in two months. The patient was admitted to an intensive rehabilitation unit, where he remains, showing functional improvement and having started gait training with third-party assistance.

## Conclusion

This case highlights an atypical presentation of CIDP, initially difficult to distinguish from an acute polyradiculoneuropathy, followed by targeted investigation for a possible paraneoplastic syndrome. Despite the absence of confirmed malignancy, this case reinforces the importance of considering paraneoplastic causes in patients with unusual clinical or imaging features. A multidisciplinary approach and broad diagnostic work-up were essential for proper diagnosis and therapeutic management.

**Keywords:** CIDP, Paraneoplastic, Electrodiagnosis, Neurorehabilitation