Botulism is neuromuscular paralysis secondary to a neurotoxin secreted from Clostridium Botulinum bacteria. It is a rare syndrome as a result of food poisoning with the spore-forming clostridium bacteria. The ingested food is contaminated with the pre-secreted botulinum toxin. Infant botulism occurs with the ingestion of the clostridial spores that later germinate and colonize the intestine and secrete the neurotoxin. Other forms of botulism include; wound botulism where the toxin is secreted in infected wounds, inhalational botulism in biological wars and iatrogenic botulism rarely in people using botulinum toxin for cosmetic purposes.

Introduction

Infant botulism is the most common form of botulism worldwide. It is more common between 2 and 8 months. The introduction of milk formula and solid foods increase infant’s vulnerability to the bacteria. Sources of food poisoning with botulism include; canned food especially with home canning and honey ingestion in infant botulism. Honey is a source of bacterial spores that germinate in the infant’s alimentary tract and start producing the neurotoxin in vivo. Infants can also get the spores through ingestion of environmental dust contaminated with bacterial spores.
Wound botulism is common among the military. Inoculation of the spores deep in the tissues presents a good environment for germination and toxin secretion. polymicrobial bacterial infection can be present in wound botulism. Wound debridement, antitoxin therapy, antibiotics and tetanus toxoid are recommended for management.

Microbiology of Botulism

Clostridium Botulinum is a group of gram-positive anaerobic bacilli which are able to form spores during unfavorable environmental conditions. The spores are heat resistant for up to 100 ºC for hours and hence they can be easily transmitted via food. With low acidity, oxygen and appropriate temperature; the spores germinate into the toxin-producing bacteria.

The bacteria is commonly isolated from the soil and can be found on the surfaces of vegetables and fruits. The toxin produced by Clostridium botulinum is the most potent known toxin with the least known minimal lethal dose. It is a heat labile protein that can be easily denatured by temperatures above 80 ºC however it can resist the gastric acidity and proteolytic enzymes of the gut. It is easily absorbed through the stomach or the intestinal mucosa to the blood stream.

Botulinum toxin affects the presynaptic cholinergic transmission of sensory, motor and autonomic nerve fibers leading to neuromuscular paralysis. The toxin reaches the central nervous system through systemic spread or axonal transport and can inhibit the release of dopamine, serotonin, somatostatin gamma-aminobutyric acid and noradrenaline from presynaptic neurons.

Clinical Picture of Botulism

Patients present with symmetric descending weakness with bilateral cranial neuropathies without fever or mental dysfunction. The weakness of muscles supplied by cranial nerves followed by weakness of the limbs and diaphragm are characteristic.

Some cases have gastrointestinal symptoms as the most predominant symptoms. In infants less than 12 months old, colonization of the intestine with Clostridium botulinum bacteria present early with constipation followed by progressive hypotonia and loss of deep tendon reflexes. Cranial neuropathies present with a weak cry, poor sucking and feeding, drooling, ptosis and pupillary paralysis. Autonomic dysfunction may be present with dry mouth, dry eye, fluctuating heart rate and blood pressure.

Ingestion of the preformed toxin in foodborne botulism presents first after few hours with nausea, vomiting, diarrhea, dry mouth and pain. The symmetric descending weakness of the trunk and limbs. Blurring of vision, diplopia and ptosis are neurological manifestations due to the involvement of the cranial nerves III, IV and VI. Other cranial nerve involvement leads to dysarthria, dysphagia and facial palsy. Diaphragmatic paralysis is common and patients eventually need intubation and mechanical ventilation. Urine retention is also common and results from smooth muscle paralysis.

Differential Diagnosis of Botulism

Other forms of neuromuscular paralysis include; Guillain-Barré syndrome, tick paralysis, myasthenia gravis, poliomyelitis, antibiotic-associated paralysis and Lambert-Eaton myasthenic syndrome.
Infant botulism should be differentiated from metabolic encephalopathy, brainstem encephalitis, sepsis, spinal muscular atrophy type 1, neonatal myasthenia gravis and dehydration.

**Diagnosis of Botulism**

Clinical suspicion is important as early administration of antitoxin therapy is lifesaving while waiting for culture results and confirmatory tests. Detection of the botulinum toxin in the serum of suspected individuals is diagnostic. The toxin can also be isolated in the stool, vomitus or food remnants of the suspected individuals. Repetitive nerve stimulation and electromyography can be used to differentiate between myasthenia gravis, LEMS and botulism specially wound botulism. CSF is usually normal.

Infant botulism: the spores and the toxin can be isolated from the stool of infected infants but not in the serum. The diagnosis usually takes few days until the results of the culture are positive or detection of the toxin in stool samples.

**Management of Botulism**

Patients with suspected botulism should be monitored closely in the hospital or even the ICU to ensure adequate respiration and oxygenation. Many patients will need intubation and mechanical ventilation to prevent respiratory failure and airway compromise. Adequate feeding should be continued for prolonged respiratory support with a nasogastric tube or even parenteral nutrition.

Antitoxin therapy: should be administered to all patients based on clinical suspicion of botulism without waiting for confirmatory tests. It is proven to decrease mortality rates for patients diagnosed with botulism even with a long period of symptoms. Patients presenting with a febrile descending paralysis and cranial neuropathies should be evaluated for botulism.

There are two types of antitoxin therapy; equine serum heptavalent botulism antitoxin and human-derived botulism immunoglobulin. The equine serum heptavalent botulism antitoxin includes antibodies against 7 types of botulin toxins. It is mainly administered for adults and children older than one year. Hypersensitivity reaction with anaphylaxis and serum sickness can result from the equine serum antitoxin thus skin test, desensitization and proper dosing is important prior to therapy. Other adverse effects include; rash, nausea, fever, headache, and chills.

Human-derived botulinum immunoglobulin is used for infants less than 12 months old with infant botulism.

Antibiotics can be given for patients with wound botulism due to infection but they are contraindicated in patients with infant botulism or foodborne botulism. Antibiotic-mediated lysis of the Clostridium bacteria can increase the toxin amount and absorption to the circulation.

**Prevention of Botulism**

Prevention of foodborne botulism depends mainly on proper canning of food. Boiling of food before consumption is sufficient to denature the heat labile toxin. For infant botulism, prevention is mainly achieved with avoidance of honey in infants less than one-year-old. Early treatment is mandatory in infants with no history of honey consumption.