Bell’s palsy

Bell's palsy and facial nerve palsy are terms that are often used interchangeably, but they refer to slightly different conditions:

Facial Nerve Palsy:

Definition: Facial nerve palsy is a condition characterized by weakness or paralysis of the muscles on one side of the face. It can affect any part of the facial nerve pathway, leading to partial or complete inability to move the facial muscles.

Causes: It can be caused by a variety of conditions including:

Infections (like Lyme disease or herpes zoster)

Neurological disorders (such as stroke or brain tumors)

Trauma to the nerve

Congenital conditions

Systemic diseases (like diabetes)

Diagnosis: Diagnosis may involve a thorough medical history, physical examination, blood tests, imaging studies like MRI or CT scans, and possibly a nerve conduction study to assess the extent of nerve damage.

Treatment: Treatment depends on the underlying cause but may include medications (like corticosteroids or antiviral drugs), physical therapy, or surgery.

Bell's Palsy:

Definition: Bell's palsy is a specific type of facial nerve palsy where there is sudden, temporary weakness or paralysis of the facial muscles on one side of the face. It is idiopathic, meaning the exact cause is unknown.

Causes: While the exact cause is not clear, it is often associated with viral infections that may cause inflammation and swelling of the facial nerve.

Diagnosis: Bell's palsy is typically diagnosed based on clinical examination and the exclusion of other possible causes of facial paralysis. No specific tests definitively diagnose Bell's palsy, but tests like MRI or EMG might be used to rule out other conditions.

Treatment: Treatment usually involves corticosteroids to reduce inflammation and, in some cases, antiviral medications if a viral infection is suspected. Most patients recover fully within weeks to months, although some may have residual facial weakness.

In summary, while Bell's palsy is a type of facial nerve palsy characterized by its idiopathic nature and typically good recovery prognosis, facial nerve palsy itself is a broader term that includes any form of paralysis affecting the facial muscles due to various causes.

Management

General measures

Eye protection: protection of the eye is critical. Artificial tears during the day, eye ointment at night, avoid bright light (using dark glasses during the day).

Presentation

A viral prodrome is frequent: URI, myalgia, hypesthesia or dysesthesia of the trigeminal nerve, N/V, diarrhea… Paralysis may be incomplete and remain so (Type I); it is complete at onset in 50% (Type II), the remainder progress to completion in 1 week. Usually exhibits distal to proximal progression: motor branches, then chorda tympani (loss of taste and decreased salivation), then stapedial branch (hyperacusis), then geniculate ganglion (decreased tearing). Associated symptoms are shown in, and are usually, but not always, ipsilateral. Herpes zoster vesicles develop in 4% of patients 2–4 days after onset of paralysis and in 30% of patients 4–8 days after onset. During the recovery phase, excessive lacrimation may occur (aberrant nerve regeneration).

Evaluation

Patients with PFP should be examined at an early stage to optimize outcomes.

Electrodiagnostics: EMG may detect re-innervation potentials, aids prognostication. Nerve conduction study: electrostimulation of the facial nerve near the stylomastoid foramen while record- ing EMG in facial muscles (a facial nerve may continue to conduct for up to ≈ 1 week even after complete transsection).

Medical management

Steroids: prednisolone 25mg p.o. BID×10 days, started within 72 hours of onset of symptoms, improves the chances of complete recovery at 3 & 9 months. Acyclovir: does not help (alone or in combination with prednisolone) [1].

1)
Sullivan FM, Swan IR, Donnan PT, et al. Early treat- ment with prednisolone or acyclovir in Bell's palsy. N Engl J Med. 2007; 357:1598–1607