The Management of Bell's Palsy

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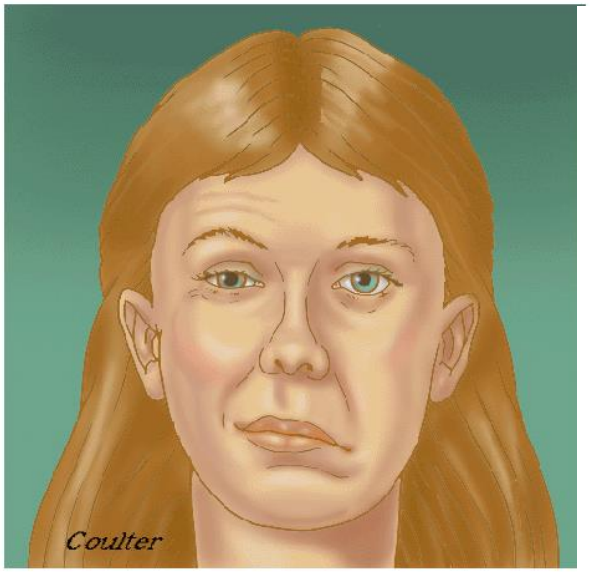
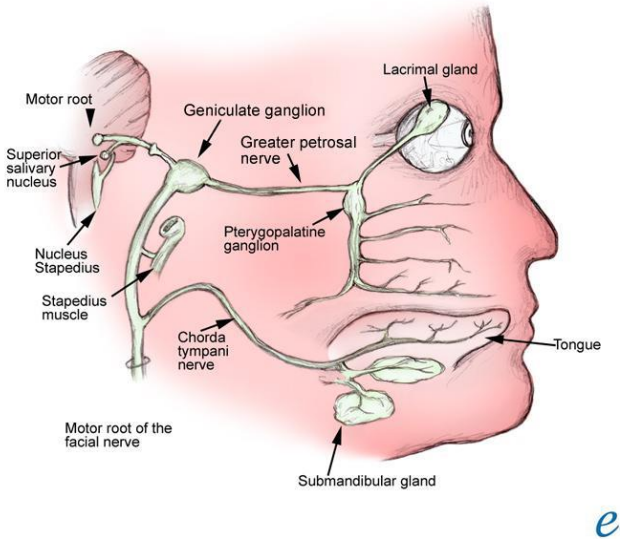
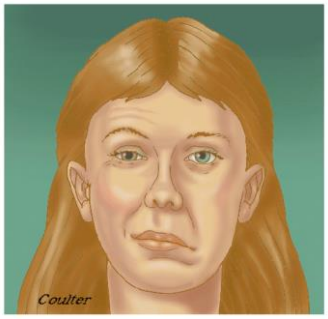
Bell's Palsy





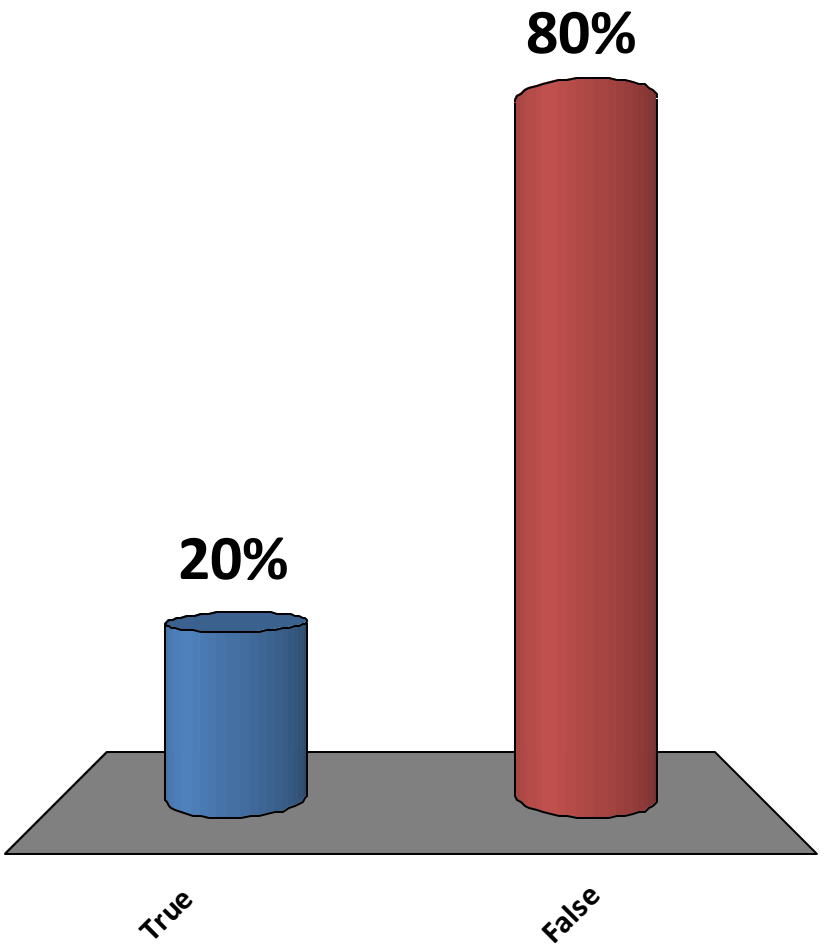
1) Idiopathic
2) Most common cause of unilateral facial palsy
3) The precise pathophysiology of Bell palsy remains an area of debate

Bell's Palsy
Affects both genders equally



✓1. True

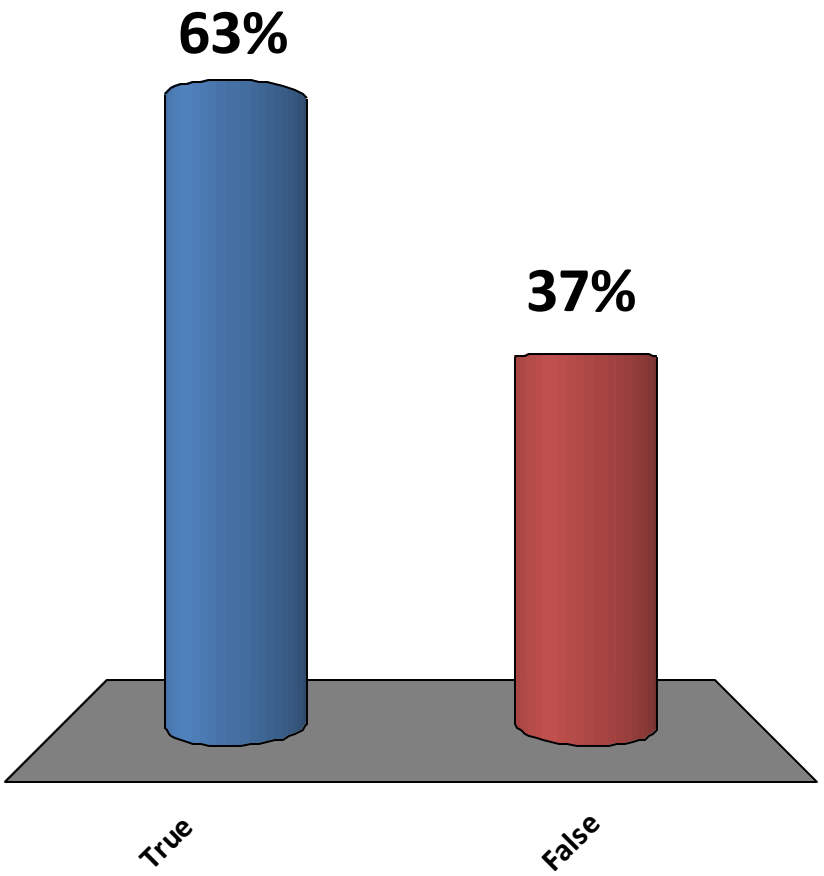
2. False

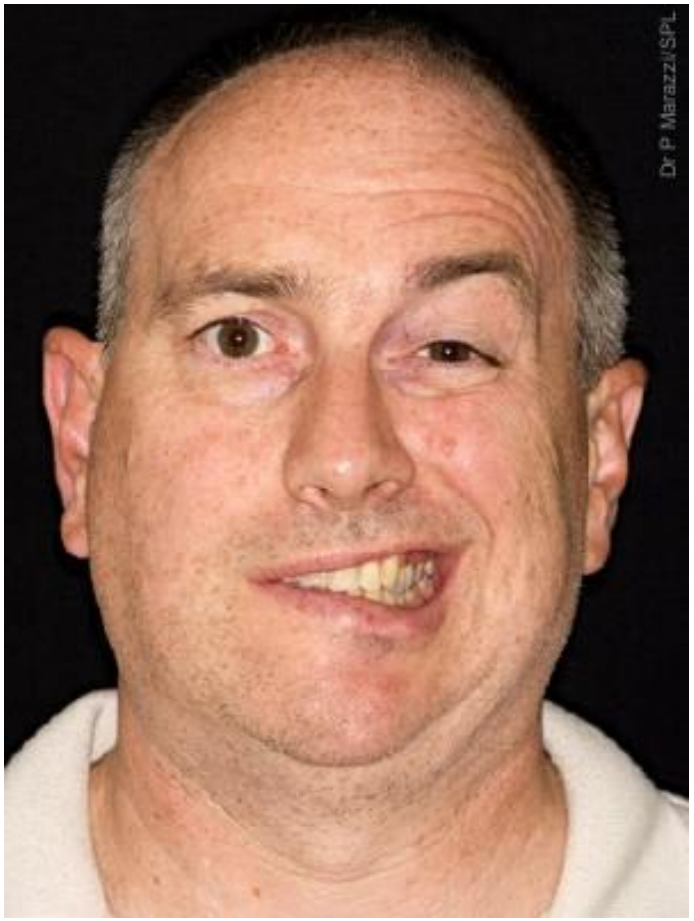


Pregnant women have a higher risk of being affected by Bell palsy than do non-pregnant women

✓1. True

2. False





You are in clinic.

60 year old gentleman walks into your consultation room.

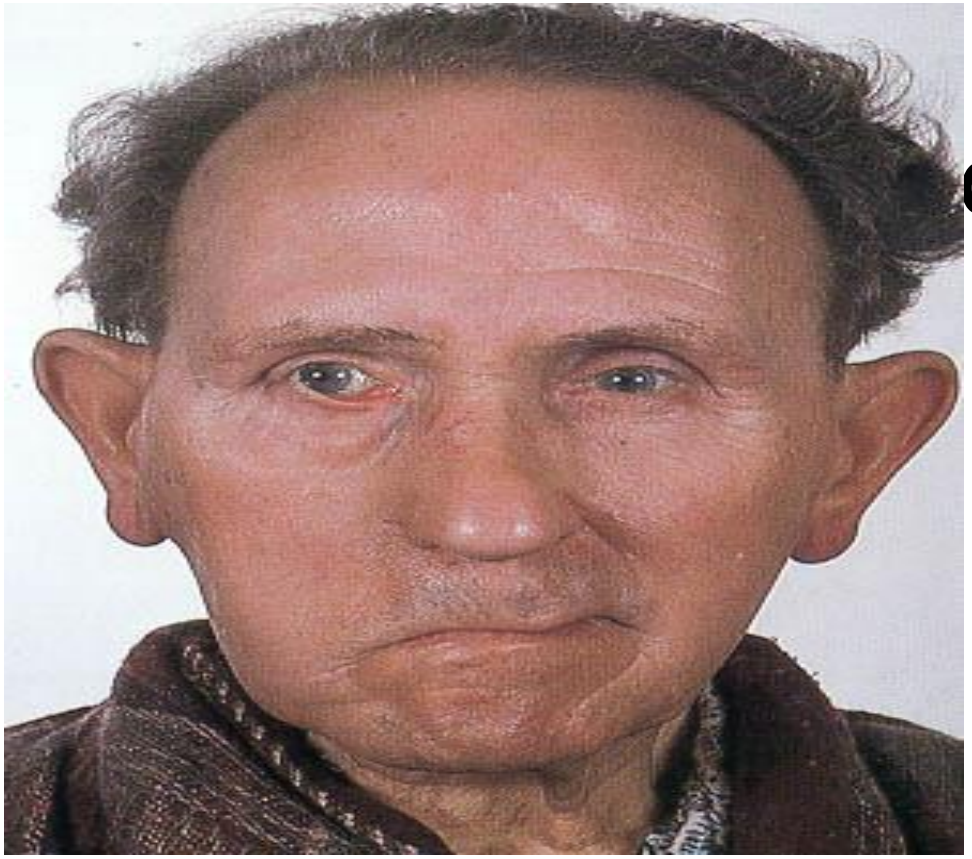
“Doctor I woke up this morning and my face felt tingly, I looked in the mirror and my face looks weird…….”

History taking

- Timing of onset
- Otalgia
- Changes in hearing
- Recent infections
- Eye symptoms (pain/blurred vision)
- Eye lid closure

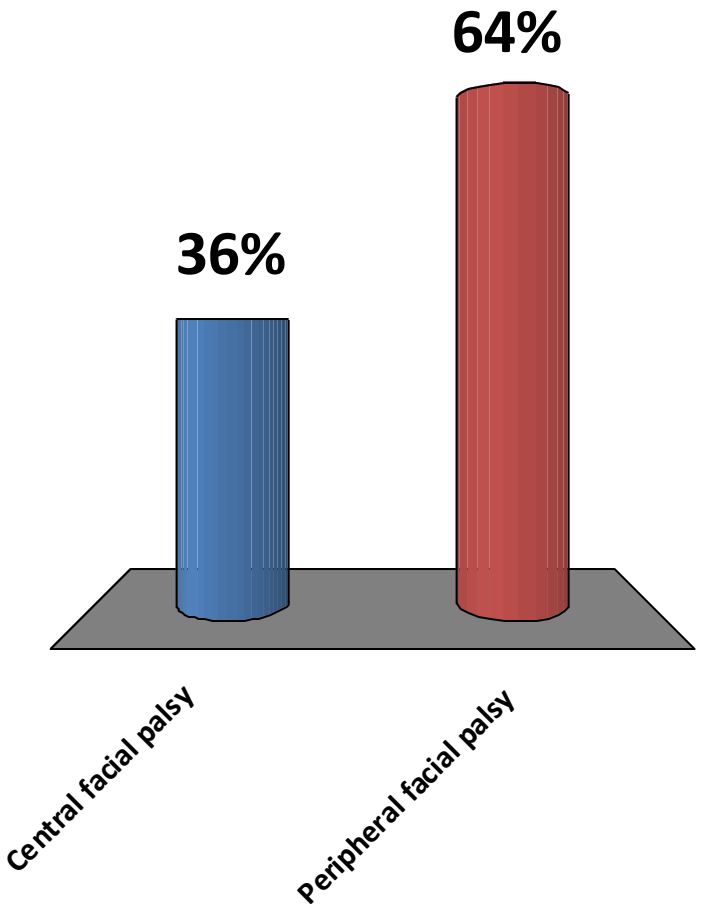
Examination

Determining whether facial nerve paralysis is peripheral or central is a key step in the diagnosis

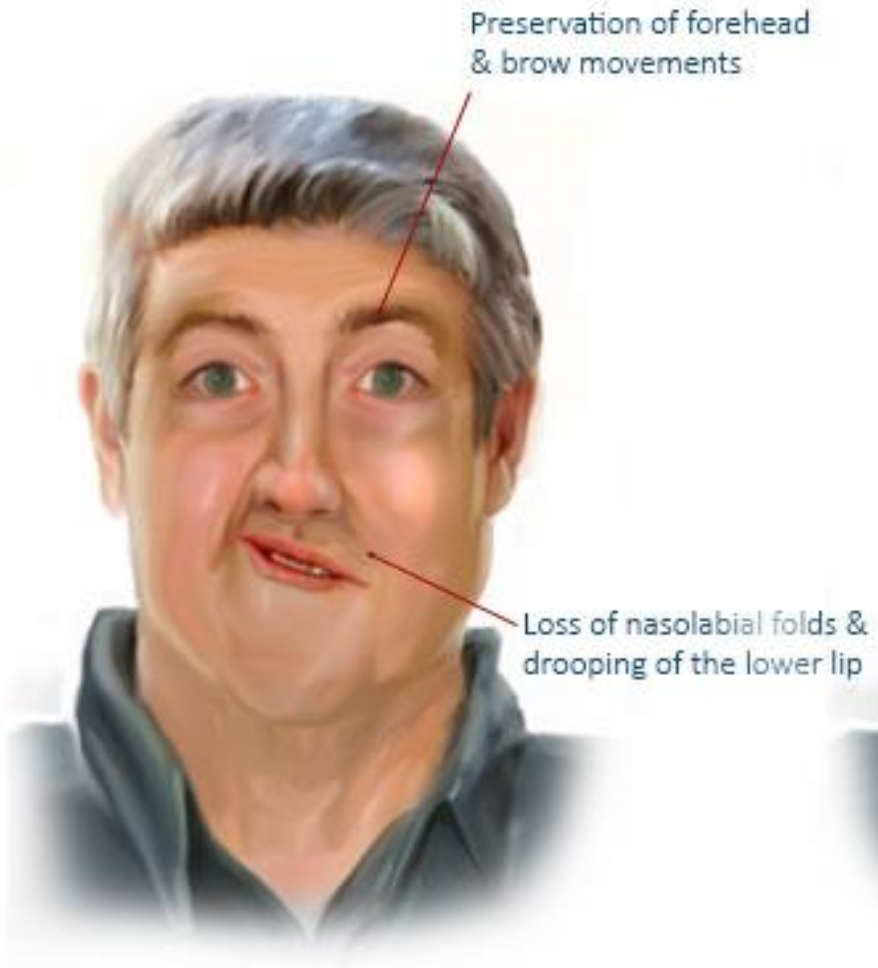


on Text

1. Central facial palsy
2. Peripheral facial palsy ✓



Central facial palsy



Peripheral facial palsy

Examination

1. Otologic examination: Otoscopy and tuning fork examination
   - Vesicles
2. Ocular examination
   - Degree of eye lid closure
3. Oral examination
   - Taste and salivation often affected
   - Vesicles
4. Neurologic examination: All cranial nerves, sensory and motor testing, cerebellar testing
5. Neck/parotid examination

Differential diagnoses

In most cases, the diagnosis of Bell palsy is straightforward

Need to be able to recognise structural, infectious, or vascular lesions leading to facial nerve palsies

(eg, stroke, Guillain-Barré syndrome, basilar meningitis, cerebellar pontine angle tumour)

Management

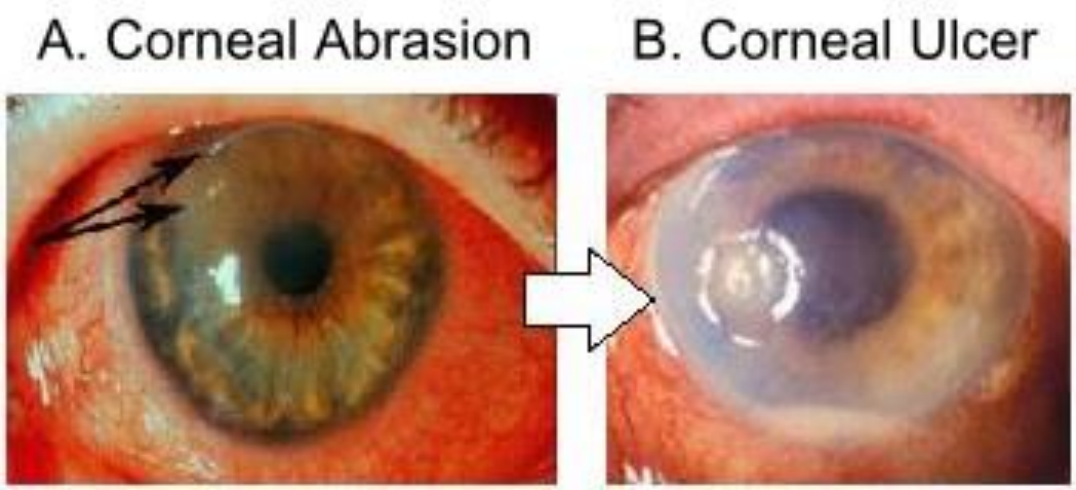
Goals of treatment:

1. Improve facial nerve function
2. Reduce neuronal damage
3. Prevent complications from corneal exposure

Management

Treatment includes the following:

1. Corticosteroid therapy (prednisone 1mg/kg)
2. Antiviral agents
3. Eye care: Topical ocular lubrication is usually sufficient [illegible] eal drying, a



Referral to ophthalmology

Consider an urgent referral to ophthalmology if:

1. Eyelid closure is incomplete and the cornea remains visible on attempting to close the eye
2. The eye remains at risk despite the use of eye drops/ointments and taping shut at night
3. The eye becomes red or painful.

When to refer to ENT?

1. When the diagnosis is in doubt
2. Ear symptoms especially ear discharge
3. A parotid or neck mass
4. Neurological symptoms other than facial nerve especially audiovestibular symptoms such as hearing loss or imbalance
5. Facial palsy progressing over one month
6. Partial palsy showing no signs of recovery after six weeks
7. Recurrence of facial weakness or bilateral facial weakness.

Thank you! Any questions?