key points

SELECTED BY
Dr Peter Saul
GP, Wrexham and Associate GP Dean for North Wales

Hemifacial weakness, or palsy, results from disruption of communication between cortical motor centres and the facial musculature along the course of the facial nerve. Bell's palsy has a typical presentation of sudden onset, mild otalgia, altered facial sensation and/or taste, with no obvious prodrome. It represents over half of hemifacial weakness cases in primary care. However, as a diagnosis of exclusion, there are a number of key clinical features of more sinister diagnoses that must be considered.

Acute hemifacial weakness secondary to isolated facial nerve palsy must be differentiated from acute cerebrovascular accident. The latter results in sparing of the brow musculature due to the bilateral innervation of the frontalis. Altered facial sensation and mild otalgia are common in Bell's palsy, however severe pain is suggestive of Ramsay Hunt syndrome. Recent facial or head trauma and surgery should also be excluded in causation.

Facial palsy secondary to tumours of the head and neck is generally of slow, progressive onset and is almost always preceded by other symptoms. Middle and external ear infections do not cause facial palsy in isolation. Facial palsy is seen in persistent acute otitis media however it is a rare complication. It may also be associated with systemic disease such as sarcoidosis or HIV.

Acute Bell's palsy can be managed with the expeditious use of steroids (e.g. 50 mg prednisolone once daily within 72 hours of onset for ten days), however there is no clear added benefit from the use of antiviral therapy (as there is in Ramsay Hunt syndrome.)

Patients with the following conditions should be referred: lagophthalmos if the weakness persists beyond a few days or ocular damage is suspected; Ramsay Hunt syndrome (immunocompromised patients, those with significant pain, and where intraoral vesicles prohibit oral intake); and palsy secondary to trauma or surgery. A parotid mass with facial palsy implies malignant change and must be referred within the two-week wait pathway. A history of progressive hearing loss and tinnitus with palsy also requires urgent referral to neuro-otology for assessment of cerebellopontine angle tumours. All cases of facial palsy associated with infective otological symptoms should be discussed with ENT.

Bell's palsy results in full recovery in around 70% of patients, partial paralysis is prognostically favourable. Recovery is usually rapid (within three weeks) but can take up to 12 months. There is recurrence in around 10% of cases. The longer the duration of paralysis in Bell's palsy the poorer the recovery. Recovery in Ramsay Hunt syndrome is less complete with only 60% returning to House-Brackmann grade I or II.

Facial palsy is commonly associated with symptoms of anxiety and/or depression, often poorly correlated with the degree of weakness, and frequently overlooked. Facial therapists formulate strategies to aid symptom optimisation, including neuromuscular training and physiotherapy that may aid those patients with chronic symptoms.