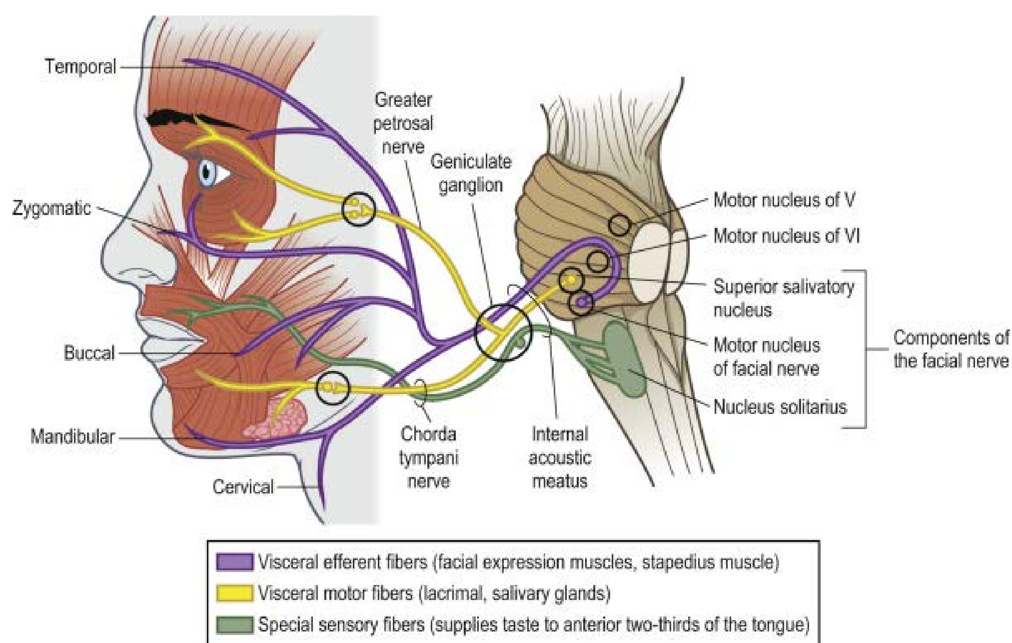
Recognition and management of Bell's Palsy in the Emergency Department

What is it?

Bell's Palsy describes an **acute** onset, **idiopathic** palsy of the **facial nerve**

- Acute onset = over hours, sometimes preceded by ear pain
- Aetiology is thought to be viral, but is unknown
- The facial nerve supplies the **muscles of facial expression** and the **stapedius** muscle, as well as receiving **taste sensation** from the anterior 2/3 of the tongue



How does it present?

With:

- Unilateral weakness of the muscles of facial expression **including the forehead**
- Possible dry eye/mouth
- Possible alteration/loss in taste sensation on ipsilateral side.
- Possible hyperacusis in ipsilateral ear

Red flags!

Look for, ask about, and **exclude** other signs and symptoms, which may indicate **serious pathology**, including:

- An **upper motor neuron lesion**, suggested by **forehead sparing** facial paralysis (? Stroke or SOL)
- Involvement of **other cranial nerves**
- **Bilateral** facial paralysis
- Other **neurological signs**
- Facial **rash**, including **external auditory meatus** and **soft palate** (? Ramsay Hunt Syndrome)
- **Trauma** (? # temporal bone)

Manage according to SIGN guidelines:

- Consider **prednisolone** (50mg OD for 10 days, or 60mg OD for 5 days, then reduced by 10mg daily) if onset <72 hours at presentation
- Consider **antiviral medication** with prednisolone- seek expert advice
- **Eye protection** is vital! Prescribe lubricating eye drops and give advice on taping eye closed at night if required
- Advise GP/ENT follow-up (depending on local policy).

References: Oxford Handbook of Emergency Medicine, Davidson's Principles and Practice of Medicine, Gpnotebook, RCEM Learning.