CASE 3

ID/CC A 45-year-old female presents with new-onset right-sided **facial weakness** and **drooping of the right side of the mouth**.

HPI She complains of a sore right eye (due to drying of the cornea). She also becomes irritated upon hearing even minor noises, complaining that they are "too loud" (HYPERACUSIS).

PE Alert and oriented ×3; funduscopy normal; right-sided **paralysis of upper and lower face** such that eye cannot be closed tightly (or can easily be opened by physician); eyeball turns up on attempted closure (BELL'S PHENOMENON); patient is **unable to raise right eyebrow** (LOWER MOTOR NEURON RIGHT FACIAL PALSY); corner of mouth droops and **nasolabial fold** is **decreased**; voluntary and involuntary movements of mouth are paralyzed on right side (lips are drawn to opposite side); examination of right ear normal (to rule out herpetic Ramsay Hunt syndrome); no other cranial nerve palsy found; no other neurologic deficit.

Imaging MR, brain (with gadolinium): no intracranial lesions; shows facial nerve enhancement. CT, head: no intracranial lesions or hemorrhage.

Pathogenesis Bell's palsy is by definition **idiopathic**, but evidence suggests that it may have a viral etiology. Approximately 80% of patients recover fully.

Epidemiology The **most common form of facial paralysis**.

Management The current standard of care for all patients diagnosed with Bell's palsy includes glucocorticoids (therapy may improve symptoms and shorten the disease course) and antiviral therapy. Since HSV is the most widely accepted cause of Bell's palsy, patients may be treated with acyclovir. Artificial tears and taping the eye shut at night.

Complications Chronic paralysis in a minority of cases.