A CASE OF FACIAL DIPLEGIA

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Introduction

The most common disease of facial nerve is Bell's Palsy, incidence being 23/100,000 annually [1]. Bells Palsy is almost always unilateral, being bilateral very rarely. Even in bilateral Bell's Palsy, simultaneous involvement of both sides (Facial Diplegia) is extremely rare. We present one such case, who recovered fully after treatment.

Case Report

26 year old young soldier on waking up in morning noticed inability to close both the eyes. This was associated with inability to hold liquid or food particles in mouth and loss of sensation over front part of the tongue. There was no associated tinnitus or hyperacusis. He had no preceding history of fever, exposure to cold air, pain throat/ear/mastoid region, injury, diabetes mellitus, hypertension, tuberculosis, leprosy or headache. Clinical examination showed absence of wrinkling over the forehead, loss of nasolabial folds, inability to close both eyes with widened palpebral fissure. Bilateral Bell's phenomenon was present (Figs. 1,2). He had other features of bilateral Bell's Palsy in form of inability to blow air, hold water in the mouth and loss of taste over the anterior 2/3 of tongue. No other neurological deficit was noticed. General exam was non-contributory. Investigation revealed Hb 12-7 gm%, TLC 6900/cmm, DLC-P64%, L30%, M2%, E4%, Urine RE-NAD, Biochemical profile -normal, CSF appearance clear, protein-40 mg%, sugar 60mg%, globulins not raised, WBC 2/cmm, lymphocytes predominant. X-ray chest (PA), Xray mastoid region and CT Scan head were within normal limits. ENT examination was normal.

He was managed with steroids in tapering doses for four weeks along with physiotherapy. Patient recovered in 6 weeks with no residual palsy.

Discussion

Bell's Palsy is named after Sir Charles Bell. Leibowitz had suggested that in view of Bell's Palsy occurring in small epidemics, infective pathology was most likely. Mc Cormick suggested Herpes simplex Virus (HSV) as a cause. While Korezyn had suggested that it is most likely to be due to ischaemia, Abramsky advanced immunological evidence to suggest lymphocyte mediated hypersensitivity, which probably causes Gullian Barre' Syndrome [2]. This controversy has not subsided yet. Murakami et al [3] using PCR technique, identified HSV type -I in the endoneurial fluid of VII

nerve in 11 out of 14 cases of Bell's Palsy.

Bell's Palsy may sometimes be bilateral, but rarely is the involvement on both sides simultaneous. Facial diplegia is more often a manifestation of Gullian Barre' Syndrome, besides lyme disease. Other infrequent causes are sarcoidosis (Heerfordth Syndrome), where paralysis on each side tends to be separated by weeks or longer. Even less common is Melkersson-Rosenthal Syndrome consisting of the triad of recurrent facial paralysis, facial (particularly labial) oedema and less constantly plication of the tongue. The syndrome begins in childhood and may be familial. Bi-

Fig 1 : Bilateral Bell's palsy : note absence of wrinkling over forehead

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Fig 2 : Bilateral Bell's palsy : note inability to close both eyes.

opsy of lip may reveal granulomatous inflammation. Facial diplegia may also be part of Mobius Syndrome (Congenital facial diplegia with convergent strabis-

mus).

Unlike idiopathic trigeminal neuritis, the facial nerve in Bell's Palsy is often visualised on gadolinium enhanced MRI. Correspondingly there is a mild increase of lymphocytes and mononuclear cells in CSF of a few cases.

In view of the findings of viral genome in endoneurial fluid surrounding the seventh nerve, the role of acyclovir in the management of Bell's Palsy is under active study.

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