The Shrewsbury and Telford Hospital NHS Trust

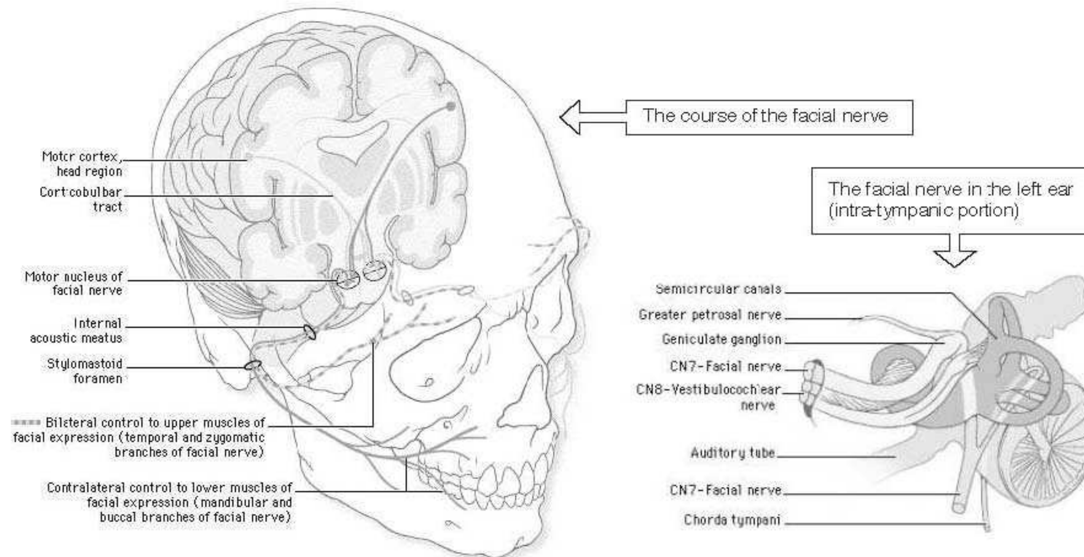
MANAGEMENT OF FACIAL PALSY

Ref No: 0180

Lead Clinician	:	Mr. C. Hari, Consultant ENT Surgeon
Care Group	:	Scheduled Care (Head & Neck and Ophthalmology)
Implemented	:	
Last updated	:	February 2020
Last reviewed	:	February 2020
Planned review	:	February 2023
Keywords	:	facial palsy, facial weakness, Bell's palsy
Comments	:	Mr Duncan Bowyer

DIAGNOSIS

- Bell's palsy is only diagnosed when there is no underlying cause found.
- Look for any causes of pathology throughout the course of the facial nerve
- **Any traumatic facial palsy must be referred immediately to an ENT senior.**



- Absence of trauma should be documented.

- **Assess for forehead sparing**, which indicates an upper motor neurone lesion
- **Examine other cranial nerves,** as their dysfunction may relate to the location of a mass lesion.
- **Perform an audiogram.** An ipsilateral sensory neural hearing deficit may indicate a cerebellopontine angle tumour.
- **Examine the ear** Exclude otitis media, severe (malignant) otitis externa and varicella zoster virus infection causing Ramsay-Hunt syndrome (vesicles in/on the ear and/or on the tongue)
- **Examine the neck,** particularly the parotid gland to exclude a parotid body tumour compressing the facial nerve.

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- **Check the mouth** as part of the parotid and cranial nerve examinations, also in excluding Ramsey-Hunt syndrome.

GRADING

- Accurate grading is important for subsequent comparative assessment
- The House-Brackmann grading system is commonly used.

MANAGEMENT

I	Normal symmetrical function in all areas.
II	Slight weakness noticeable only on close inspection. Complete eye closure with minimal effort
III	Obvious weakness, but not disfiguring. **Complete eye closure**. Strong but asymmetrical mouth movement with maximal effort.
IV	Obvious disfiguring weakness. **Incomplete eye closure** and asymmetry of mouth with maximal effort.
V	Motion barely perceptible Incomplete eye closure, slight movement corner mouth.
VI	No movement, loss of tone.

- Where assessment has revealed potential cause, refer to an ENT senior.

- Commence treatment promptly for Bell's palsy or Ramsey-Hunt syndrome, unless contraindicated.

    - **Prednisolone 50**mg OD for 10 days (1mg/kg/day if less than 50kg). See precautions:
        - Consider PPI for patients with high risk of GI side effects.
        - To advice patient to take whole dose in the morning with food
        - Consider tapering dose esp for patients with infection, trauma, recent surgery
        - Advise patients on Warfarin to increase INR monitoring while on steroid
        - Advise patients with Diabetes to increase BM monitoring.
        - No live vaccines within 3 months of stopping high dose steroids.
    - Acyclovir 400mg 5 times daily for 7 days in suspected cases of Ramsey-Hunt syndrome (vesicles, hearing loss)
    - Also consider **Lansoprazole 30mg od** for gastric protection from steroids

- Reassure the patient that most Bell's palsies recover.

- **Refer to ophthalmology** to reduce the likelihood of complications of incomplete eye closure and educed tearing. Use artificial tears (e.g viscotears) 1-2 hourly during the day and consider taping the eyelid shut at night and/or lacrilube if incomplete eye closure.

- **ENT follow-up** In consultant clinic is essential to confirm diagnosis, monitor recovery and further treatment if necessary – 6 week follow up.

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