**6. Bell’s Palsy**

This quick reference guideline is based on the NICE Clinical Knowledge Summary Bell’s Palsy - <http://cks.nice.org.uk/bells-palsy#!topicsummary>



Acute onset LMN

7th nerve palsy – and nothing else



YES – see notes overleaf

NO

**RED FLAGS**

* Gradual onset (over >72hrs)
* Other cranial nerve abnormalities
* Other neurological symptoms or signs
* Ipsilateral hearing loss
* Ipsilateral ear discharge
* Recent head trauma

Check the following:

* FBC, glucose, ESR
* Is eye care needed?

**TREATMENT**

1. Prednisolone 60mg/day for 6 days, then 40mg, 20mg, 10mg, 5mg, and stop after 10 days
2. Consider PPI for older people and those with risk factors for GI bleeding
3. Eye patch and eye clinic follow-up if the eye cannot close
4. Give 400mg oral acyclovir 5 x day **only** in people with acute auricular herpes zoster.

Urgent imaging of brain +/- temporal bones and specialist review is indicated.

**FOLLOW UP**

* 80-90% of cases resolve over time (6 weeks – 3 months). The quicker the recovery the more likely it is to be complete.
* Bell’s Palsy is thought to have a recurrence rate of around 7%.
* If little recovery has occurred by 4 weeks then the patient should be referred to neurology outpatients for assessment +/- imaging – **inform the patient and GP.**

**Bell’s Palsy - notes**

1. Bell’s Palsy is an **idiopathic** lower motor neurone (LMN) 7th nerve palsy of acute onset. There are other causes of a LMN 7th nerve palsy which need to be excluded with a careful history and examination.
2. **Warning!** While many clinicians are able to differentiate a LMN from a UMN 7th nerve palsy, it is important to remember that some conditions can mimic Bell’s palsy because they **also cause a LMN 7th nerve palsy**. Examples include: Lyme Disease (in endemic areas), trauma, tumours, demyelination, and Guillain-Barre syndrome. Therefore, a careful history and examination of all cranial nerves is important in the diagnosis of Bell’s palsy.
3. Typical symptoms and signs of Bell’s Palsy are:
	* Acute, but not sudden, onset to a max within 72 hrs
	* Unilateral LMN 7th n palsy: affecting wrinkling of the brow, eye closure and blinking
	* Recovery begins within 4 weeks
	* Mild to moderate post-auricular pain in ~50% of people
	* Altered taste in ~50%
	* Hyperacusis on the affected side in ~5%

**Any other neurological symptoms or signs should prompt an urgent specialist review.**

1. The following should prompt the clinician to think about alternative diagnoses:
* Vestibular or hearing abnormalities (apart from hyperacusis)
* Severe pain
* Systemically unwell
* Prior history of cancer
* Potential Lyme Disease exposure
* Rash on external ear or external auditory meatus (Ramsay-Hunt syndrome)
1. Ramsay-Hunt syndrome is a result of herpes zoster infection of the facial nerve, producing herpetic lesions in the ipsilateral ear, or anterior 2/3 of the tongue, or hard palate. It is usually associated with severe ear or retro-orbital pain, nausea, hearing loss (~50%), and ~30% of people experience vertigo. The facial weakness tends to be more severe than in Bell’s palsy and the chances of full recovery worse. Treatment is with oral aciclovir or valaciclovir as well as steroids.
2. All patients with an acute LMN 7th nerve palsy should be screened for diabetes. An FBC and ESR is also recommended. Syphilis serology and HIV testing is indicated in some patients. If the patient reports a rash or recent tick bite then testing for Lyme Disease is indicated.
3. There is good evidence that steroid therapy reduces the duration and severity of the facial palsy, however treatment is most effective when started within 72 hours (3 days) of symptom onset. There is no good evidence for empirical treatment with anti-viral tablets, apart from in patients with evidence of acute auricular herpes zoster.
4. A poor outcome is associated with older age (>60 years), total paralysis, and when taste is also affected. Patients should be re-assessed by a neurologist and undergo brain imaging if they experience little or no recovery at 4 weeks. Patients and the GP should be given this information in writing.