Quick Reference Guideline: Bell’s Palsy

For management of Bell’s Palsy in ED or EAU only. This quick reference guide has been adapted for local use and 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

NO

YES – see notes overleaf*

RED FLAGS
• Gradual onset (over several days)
• 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?

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

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.

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 and have an MRI brain – inform the patient and GP.
Quick Reference Guideline: Bell’s Palsy - notes

1. Bell’s Palsy is an idopathic lower motor neurone (LMN) 7th nerve palsy of acute onset. There are other causes of cranial nerve palsies – Bell’s Palsy is a diagnosis of exclusion. A careful history and examination should be performed to exclude other possible causes. If the patient has an acute onset LMN 7th nerve palsy and nothing else then Bell’s Palsy is the most likely diagnosis – it is the most common cause of facial palsy.

2. Typical symptoms and signs of Bell’s Palsy are:
   a. Acute onset (maximum facial weakness within 2 days)
   b. **Lower motor neurone weakness:** affecting wrinkling of the brow, eye closure and blinking
   c. Earache or pain behind the ear (60%)
   d. Loss of taste anterior two thirds of the tongue on the same side (50%)
   e. Hyperacusis (30%)
   f. Tingling of the cheek can also occur

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

3. Bell’s Palsy is categorised by severity as follows:

<table>
<thead>
<tr>
<th>Grade</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Normal facial function</td>
</tr>
<tr>
<td>2</td>
<td>Slight weakness on close inspection</td>
</tr>
<tr>
<td>3</td>
<td>An obvious but not disfiguring difference is noticeable</td>
</tr>
<tr>
<td>4</td>
<td>Mod-severe dysfunction</td>
</tr>
<tr>
<td>5</td>
<td>Severe dysfunction</td>
</tr>
<tr>
<td>6</td>
<td>Total paralysis</td>
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</tbody>
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4. All patients with an acute LMN 7th nerve palsy should be screened for diabetes. A 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.

5. 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.

6. 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.

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Signed off by the Salford Healthcare Divisional Governance Committee on: [date]