Bilateral Facial Palsy: Diagnostic Workup and Differential Diagnosis

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Case Report

A 52 year old gentleman presented with 2 day history of headache followed by left facial droop, associated with slurred speech. He was discharged with prednisolone and acyclovir after diagnosing Bell’s palsy. He presented with right sided facial symptoms a week later with no other on-going symptoms. Rest of neurology was unremarkable apart from a bilateral LMN facial palsy.

Routine blood tests were all normal. Diagnosis centred investigations for Lyme disease, sarcoidosis, viral serology and vasculitis were negative. Imaging studies drew a blank as was CSF evaluation which only showed a mild nonspecific raise in protein level. He was diagnosed as idiopathic bilateral simultaneous facial palsy.

Discussion

Bilateral facial paralysis is extremely rare with an incidence of only 0.3%–2%(1). The most common causes are Lyme disease, Guillain-Barre syndrome, idiopathic (Bell’s) palsy(2), leukaemia, sarcoidosis, bacterial meningitis, leprosy, infectious mononucleosis, skull fracture and viral infections.

Lyme disease is caused by Borrelia Burgdorferi. In our patient, the Lyme serology was negative. HIV, Herpes viruses and infectious mononucleosis may also affect the facial nerve but the viral screen and CSF-PCR for viruses were negative.

Guillain-Barre syndrome(4) was excluded by absence of associated neurology and non diagnostic CSF analysis. Normal MRI brain imaging made CNS leukaemia, lymphoma and benign intracranial hypertension unlikely.

Sarcoidosis(3), SLE and PAN are also noted to cause facial diplegia, but with normal ESR, CXR, serum ACE and auto antibody screen, these possibilities were excluded.

Our patient was finally diagnosed to have idiopathic bilateral simultaneous facial palsy.

References