



Embargoed for Release: 2 PM (ET), November 4, 2013

AAO-HNSF Clinical Practice Guideline: Bell's Palsy

“While patients with Bell’s palsy enter the health care system with facial paralysis as a primary complaint, not all patients with facial paralysis have Bell’s palsy. It is a concern that patients with alternative underlying etiologies may be misdiagnosed or have unnecessary delay in diagnosis. All of these quality concerns provide an important opportunity for improvement in the diagnosis and management of patients with Bell’s palsy.”

— Reginald F. Baugh, MD, Chair of the Bell’s palsy Guideline Panel
Assistant Chairs Gregory J. Basura, MD, PhD, and Lisa E. Ishii, MD, MHS

What is Bell’s palsy?

- Bell’s palsy is an uncommon condition, but it is the most common facial nerve disorder.
- Bell’s palsy affects both men and women across a wide range of ages.
- Bell’s palsy is a condition that causes the facial nerve not to work properly causing paralysis and distortions of the face. The distortions can appear as facial drooping or immobility. A late complication of Bell’s palsy can be unintentional facial movement.
- Bell’s palsy occurs when the facial nerve is damaged by swelling and pressure. The exact cause is not known.
- The facial nerves control the muscles of the face, the ears, the saliva glands in the mouth and tears in the eyes, and provide some of the sense of taste on the tongue.
- A person’s facial paralysis or weakness may range from mild to severe.
- It is important that a health care provider rule out other, non-Bell’s conditions which may be causing the facial paralysis.
- The recovery time and the severity of symptoms vary among individuals. However, most people affected by Bell’s palsy will recover facial nerve function over a period of time.
- The psychological burden of facial paralysis can be significant because of the change in facial appearance and impaired ability to form expressions and display emotions normally.

Why is the Bell’s palsy guideline important?

- Bell’s palsy is the most common acute mono-neuropathy, or disorder affecting a single nerve, and is the most common diagnosis associated with facial nerve weakness/paralysis.
- The guideline was created by a multidisciplinary panel, including otolaryngology—head and neck surgery, neurology, facial plastic and reconstructive surgery, neurotology, emergency medicine, primary care, otology, nursing, physician assistants, and consumer advocates.
- The guideline was developed using a planned protocol to ensure valid, actionable, and trustworthy recommendations.

What is the purpose of the guideline?

- To improve the accuracy of diagnosis for Bell’s palsy.
- To improve the quality of care and outcomes for Bell’s palsy patients.
- To decrease harmful variations in the evaluation and management of Bell’s palsy.

What are significant points made in the guideline?

1. Clinicians should assess the patient using history and physical examination to exclude identifiable causes of facial paresis or paralysis in patients presenting with acute onset unilateral facial paresis or paralysis.
2. Clinicians should not obtain routine laboratory testing in patients with new onset Bell’s palsy.
3. Clinicians should not routinely perform diagnostic imaging for patients with new onset Bell’s palsy.
4. Clinicians should prescribe oral steroids within 72 hours of symptom onset for Bell’s palsy patients 16 years and older.
5. A. Clinicians should not prescribe oral antiviral therapy alone for patients with new onset Bell’s palsy.
5. B. Clinicians may offer oral antiviral therapy in addition to oral steroids within 72 hours of symptom onset for patients with Bell’s palsy.
6. Clinicians should implement eye protection for Bell’s palsy patients with impaired eye closure.
7. A. Clinicians should not perform electrodiagnostic testing in Bell’s palsy patients with incomplete facial paralysis.
7. B. Clinicians may offer electrodiagnostic testing to Bell’s palsy patients with complete facial paralysis.
8. No recommendation can be made regarding surgical decompression of the facial nerve for Bell’s palsy patients.
9. No recommendation can be made regarding the effect of acupuncture in Bell’s palsy patients.
10. No recommendation can be made regarding the effect of physical therapy in Bell’s palsy patients.
11. Clinicians should reassess or refer to a facial nerve specialist those Bell’s palsy patients with (1) new or worsening neurologic findings at any point, (2) ocular symptoms developing at any point, or (3) incomplete facial recovery 3 months after initial symptom onset.

About the AAO-HNS

The American Academy of Otolaryngology—Head and Neck Surgery (www.entnet.org), one of the oldest medical associations in the nation, represents about 12,000 physicians and allied health professionals who specialize in the diagnosis and treatment of disorders of the ears, nose, throat, and related structures of the head and neck. The Academy serves its members by facilitating the advancement of the science and art of medicine related to otolaryngology and by representing the specialty in governmental and socioeconomic issues. The organization’s vision: “Empowering otolaryngologist-head and neck surgeons.”