BILATERAL FACIAL PARALYSIS FOLLOWING HERPES SIMPLEX

Report of a Case

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I am prompted to record my notes on this case by its obvious rarity. The patient was a married woman, aged 41 years, in full-time employment as a tailoress. I was called to see her because she had developed an eruption of herpes simplex on the right half of the upper and lower lip and a severe herpetic stomatitis. Inside the mouth the vesicles were discrete and distributed over the surface of the tongue and on the inside of both cheeks. The palate was not affected. On general examination a few discrete vesicles were found on the back between the shoulder blades. There was nothing of significance in the patient's previous history, there having been no previous attacks of herpes. It is rather unusual for a woman of this age to present with this infection without any previous history of the disease. The patient was otherwise well, and no precipitating factor could be ascertained. The skin lesions were treated by dabbing with surgical spirit. and careful toilet of the mouth was maintained. Aqueous solution of 1% gentian violet, was painted on the buccal mucosa. Both skin and mucous membrane cleared rapidly, and indeed by the 10th day resolution was quite complete. On the 8th day, however, the patient was seen to have developed bilateral facial paralysis of the infra-nuclear type. The left side of the face was more severely paralysed than the right, on which side the upper part of the face was less affected. From the 12th day it was possible to start physiotherapy. Ten days later the right side showed marked improvement, and during the next two weeks voluntary movement returned quite rapidly on both sides. Seven weeks after starting physiotherapy the patient returned to work, with minimal residual weakness on the left side.

Differential Diagnosis and Discussion

This was the patient's first attack of herpes, and it was interesting to note that the facial paralysis was less marked on the right side although this was the side of the face on which the skin lesions occurred.

The eruption was distinguished from that of herpes zoster by the absence of any pre-eruptive pain, and of the typical distribution which is seen when it results from affection of the gasserian ganglion. It should be noted, however, that some cases of Bell's paralysis have been shown by complement fixation to be due to the zoster virus (Aitken and Brain), 1933, without the appearance of the typical skin lesions.

Facial paralysis also occurs in auricular zoster, but here it is usually accompanied by vertigo, deafness, and tinnitus. This is the Ramsay Hunt syndrome. In such cases vesicles are found on the tympanic membrane, in the external auditory canal and on the skin behind the pinna. In the case seen there were no lesions in the ears and only facial paralysis was present.

Bilateral facial paralysis is rare and should be regarded as the result of some serious condition until proved otherwise. One such condition is a basal meningitis (Fieling, 1950). Herpes simplex has been suggested as the cause of some cases of meningitis of acute onset, short duration, and good prognosis (Armstrong, 1943, and Abiteoul, 1936). The patient, however, was afebrile and exhibited no signs pointing to a possible meningitis. It is also difficult to believe that a local basal meningitis could affect both facial nerves without also affecting other structures, for example, the accoustic and abducent nerves.

Meningo-encephalitis has also been recorded in herpes zoster (Brain, 1931). In such cases lower motor neurone lesions, including oculomotor and facial paralysis, have been recorded.

Summary

A case of bilateral facial paralysis following herpes simplex is described. The differential diagnosis and possible causes of the paralysis are discussed.

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