TRAVEL TREATING TRAUMATIC FACIAL NERVE PARALYSIS: TRUTH OR COINCIDENCE?

Sir,

Time and patience have been the conventional healers of delayed-onset traumatic facial nerve paralysis. Facial nerve stimulation has played a supportive role in speeding up the recovery. It is managed depending on time of onset and completeness of the paralysis. Delayed-onset paralysis is usually managed conservatively as the rate of spontaneous recovery in such cases is very high.

We present a case of a 46-year-old man who developed progressive facial paralysis 5 days following head injury and temporary loss of consciousness. The patient developed all the classical features of lower motor neuron facial paralysis, along with loss of lacrimation and taste perception. He primarily presented complaining of hearing loss in the right ear. On examination, his tympanic membrane was normal, and there was no associated bleeding from the ear or hemotympanum. Tuning fork tests suggested mixed hearing loss. The pure-tone audiogram of the patient showed mixed hearing loss, and an impedance audiogram showed absent stapedial reflex. CT scan showed no fracture of the temporal bone and intact ossicles. The patient was prescribed high-dose steroids, along with vigorous facial nerve stimulation and massages.

After 3 weeks of treatment, the facial nerve stimulation tests were repeated and the readings were compared to those taken prior to treatment. There was negligible improvement. The patient was offered an exploratory mastoidectomy to try to locate the lesion of the facial nerve and decompress or repair the damaged part, which he turned down. He chose to be discharged against medical advice and discontinued all medications.

Three months after the initial trauma, the patient claimed to have suffered another episode of trauma similar to the first episode but less severe and with no loss of consciousness. The patient did not seek any medical advice. He however reported that his facial disfigurement started improving and recovery was complete in 6 to 7 days. There was, however, no reported improvement in lacrimation or taste.

A repeat audiogram showed an increased sensorineural component. Impedance audiometry showed an absent stapedial reflex. We concluded that the motor component of the facial nerve had recovered but the other functions remained depressed.

Facial nerve paralysis can be a disfiguring disorder with profound impact on the patient.[1] Patients suffering from this debilitating condition are unable to express various emotional states.[2] It occurs in 5% of the cases of head injuries,[3] and 25% of facial injuries recover spontaneously.[4]

Early onset/complete palsy indicates disruption of continuity of the nerve. A delayed onset/partial paresis suggests secondary swelling or compression of nerve that is more likely to recover spontaneously. Most patients of peripheral traumatic facial nerve injury recover with time; and occasionally, treatment. The case we present is unique in the sense that a second similar episode of trauma resulted in recovery of facial nerve motor function which is inexplicable. It is possible that the repeat trauma to the facial nerve stimulated the nerve and speeded the recovery process or that the facial nerve recovered spontaneously and the second episode of trauma was coincident.

In the literature, we have not come across any mention of repeat trauma leading to recovery of traumatic facial nerve palsy. This case highlights the fact that the hope of recovery in traumatic facial paralysis (delayed onset) should not be lost, and the patient should be advised electro-physiotherapy for up to 6 months after the initial episode.

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Strands of facial nerve interconnect with cranial nerves V, VIII, IX, X, XI, and XII and with the cervical cutaneous nerves. This free intermingling of fibers of the facial nerve with fibers of other neural structures (particularly the cranial nerve V) has been proposed as the mechanism of spontaneous return of facial nerve function after peripheral injury to the nerve.[4]
REFERENCES


LETTERS TO EDITOR

TELEDERMATOLOGY IN INDIA: PRACTICAL IMPLICATIONS

KALIYADAN FEROZE

ABSTRACT

Teledermatology is considered to be one of the solutions to the problem of inadequate number of dermatologists in remote parts of India. We present a brief account of the technological components involved in teledermatology in India, and an evaluation of the advantages and limitations of the use of teledermatology as a clinical tool.

Key words: Interactive video consultation, ‘store and forward’ technology, teledermatology

INTRODUCTION

“I shall be telling this with a sigh
Somewhere ages and ages hence:
Two roads diverged in a wood,
I took the one less traveled by,
And that has made all the difference.”

(From ‘The Road Not Taken’ by Robert Frost)

Telemedicine is one of the most recent advances in medical technology. The application of the principles of telemedicine to dermatology is generally referred to as ‘teledermatology.’ Dermatologists have for many years conducted long-range consultations by telephone or e-mail, but the unique feature of advanced teledermatology is the two-way electronic network that allows immediate interactive communication between the patient, the primary care physician, and the specialist. The advantages of such an arrangement are immense, especially in a country like India with a large rural population having minimal access to specialist treatment.

BACKGROUND

Telemedicine services in our institution started toward the end of 2002. Since then, the institution has had more than 1000 teleconsultations from all over India. Included in this are more than 100 teledermatology consultations (two-way interactive consultations). In our short experience with teledermatology, we have noted both the obvious advantages and the definite limitations of this wonderful technology. Through this article, we hope to give a brief picture of the pros and cons of teledermatology, as we see it.