Medical

ASSIGN BUSTER

New Health Center Martinsville, Virginia History and Physical Examination Patient ABC Patient Number: 7654-12 Birth 04/23/86 02/08/11 Room number: 12 History: Twenty four years old female, Ms. ABC presented to the clinic with complaints of sudden onset of facial weakness since this morning. The patient reported that she was in her usual state of health until last night. However, this morning when she woke up she felt that the right side of her face felt numb, which she thought was due to sleeping in the wrong position. However, while brushing her teeth, she noticed weakness of her facial muscles manifesting as inability to close her right eye properly and drooping of the right lower lip. She also reported difficultly in speaking resulting in slightly slurred speech. Her sister also commented on her facial appearance saying that her face seemed disfigured. While having breakfast she also noticed having excessive tearing in the right eye (Crocodile tears). These symptoms progressively worsened over the course of the next 8 hours and thus she decided to undergo evaluation for these complaints. She does not have any other existing comorbid conditions and has not had any similar complaints in the past. Her past medical history revealed that she had recently recovered from an episode of common cold and her family history was positive for diabetes, however, she herself is not a known diabetic. Social history was unremarkable. Physical Examination: On inspection of the face, it was observed that the nasolabial folds on the left side of the face were flattened and the patient was unable to completely close her left eye. When the patient was asked to forcefully close her right eye, inward and upward rolling of the eyeball was noted, i. e. demonstration of the Bell’s phenomenon (Monnell & Zachariah, 2009). When she was asked to raise her eyebrows and smile, weakness of the right facial muscles was noted. Rest of

the neurological examination and HEENT examination was unremarkable. No vesicles or any other signs of infection were noted in the ear or the mouth. Laboratory: The clinical findings were suggestive of Bell’s Palsy. However, in order to reach a definitive diagnosis and to rule out other possible differential diagnoses, the patient was advised to get Electromyography (EMG), Nerve conduction velocity (NCV), MRI and CT Scan done. EMG and NCV revealed a 55% difference in amplitude between the right and the left side, which was highly suggestive of right facial nerve dysfunction. Moreover, in order to rule out pre-existing diabetes, fasting and random blood sugar levels were also obtained which were within normal limits. The MRI revealed enhancement of the facial nerve near the geniculate ganglion. The cerebellopontine angle appeared to be normal without any masses, which ruled out the possibility of a CP angle tumor. CT scan was found to be normal and no evidence of any pathology of the temporal and petrosal bone was found. Impression: This patient is suffering from Bell ’s palsy which results in the paralysis of the 7th nerve, i. e. the facial nerve, most often due to ischemia resulting from herpes simplex infection. Treatment Plan: The patient should be started on a combination of antiviral agents such as acyclovir and steroids (e. g. prednisone or dexamethasone). The current treatment guidelines recommend the use of prednisone at a dose of 1 mg/kg or 60 mg/d for 6 days, followed by a taper, for a total of 10 days combined with acyclovir 400 mg PO 5 times per day (Monnell & Zachariah, 2009). Moreover, the patient should be counseled regarding proper eye care in order to avoid damage due to exposure and dryness. References Monnell, K., & Zachariah, S. B. (2009, October 26). Bell Palsy. Retrieved February 9,

2011, from eMedicine: http://emedicine. medscape. com/article/1146903-overview