



Your Questions Answered

BELL'S PALSY

Q What if anything can be done to regain facial nerve function years after having Bell's palsy? Can facial exercises or surgery reactivate facial nerves?



**DR. STEVEN
L. LEWIS
RESPONDS:**

A Although the cause of Bell's palsy is unknown, it's suspected to be related to a viral infection, which causes inflammation and swelling of the nerve that controls facial muscles. Patients with Bell's palsy have weakness affecting their ability to raise the eyebrow, close the eye, and smile on one side of the face. During periods of severe weakness, the main medical concern is keeping the eye protected from being scratched or irritated, since it's not protected by blinking.

Treatment typically involves a short course of corticosteroids (usually prednisone) started as soon as possible, since there is some evidence that this may improve the chances of recovery. Antiviral medications are sometimes prescribed, although there is no clear evidence that these are helpful

for Bell's palsy.

Most patients improve considerably whether or not they receive steroids, with most fully or almost fully recovering within a few weeks to months. However, even patients who almost completely recover may experience mild though bothersome problems related to unusual patterns of nerve regrowth. These problems can include subtle involuntary closure of the eye when smiling or tearing of the eye when eating (crocodile tears).

I often tell my patients with Bell's palsy that massaging their face makes sense in helping the outcome, although this is unproven. I doubt this would be beneficial years after the onset of Bell's palsy, and no medications or surgical procedures are known to be effective for patients with incomplete recoveries. However, if a patient has severe persisting cosmetic problems or continued inability to protect their eye long after any further improvement would be expected, a referral to a facial plastic surgeon may be appropriate.

Steven L. Lewis, M.D., is professor and associate chairman of the department of neurological sciences at Rush University Medical Center, Chicago, IL.

CHIARI MALFORMATION

Q A recent MRI showed I have Chiari Malformation Type I, but I don't have any symptoms. Should I see a doctor?



**DR. LANGSTON
HOLLY
RESPONDS:**

A Chiari Malformation Type 1 (CIM) occurs when the cerebellum—the lowest part of the brain, which controls balance and coordination—descends through the opening in the bottom of the skull. As a result, the cerebellum is forced into the area between the brain and spinal canal (called the foramen magnum), which is filled with cerebrospinal fluid. This may cause a blockage in the normal flow of the cerebrospinal fluid between the brain and the spinal canal resulting in headaches, neck pain, and vision and hearing problems.

It had been estimated that CIMs occur in one in every 1,000 births. However, the increased use of diag-

nostic imaging suggests CIMs may be more common, according to the National Institute of Neurological Disorders and Stroke Web site (ninds.nih.gov).

If a patient has a relatively mild CIM without symptoms that is discovered incidentally, I would recommend observation of the CIM but not surgery. If the patient has a large CIM as well as a syrinx—when the cerebrospinal fluid enters the spinal cord because of an obstruction in its normal flow—I recommend surgery. A CIM and syrinx left untreated can injure the spinal cord tissue and cause neurologic problems, such as weakness in the arms or legs, bowel or bladder problems, and pain. Even in the absence of these symptoms, I recommend surgery if the patient has both a large CIM and syrinx to prevent any long-term neurologic complications.

Langston Holly, M.D., is associate professor and co-vice chief of clinical affairs for the department of neurosurgery at the University of California Health System, and a member of the Comprehensive Spine Center in Santa Monica, CA.

SHINGLES

Q I have shingles. What can I do to reduce the incidence of postherpetic neuralgia pain at home? Is there anything beside medication that can help ease the pain?



**DR. KENNETH
L. TYLER
RESPONDS:**

A Shingles (herpes zoster) is caused by the same virus as chickenpox, the varicella-zoster virus. The reactivation of this virus can cause a painful, blistering rash that's sometimes accompanied by numbness or itching. It has been estimated that nearly 20 percent of individuals will be affected by shingles during their lifetime, and that close to a million cases occur annually in the U.S.

Almost all people with shingles will experience some pain, but a portion of those affected will experience significant pain for an extended period of time. This is called post-herpetic neuralgia (PHN) and is most commonly defined as pain occurring for at least one month (sometimes beyond three months) after the shingles rash has healed. The risk of PHN increases with age and is uncommon in people under 50.

In 2006 the FDA approved live zoster vaccine for the prevention of shingles and PHN. During clinical trials it reduced the risk of shingles by more than 50 percent and of PHN by nearly two thirds. The Centers for Disease Control and Prevention Advisory Committee on Immunization Practices recommends that people over 60 without an impaired immune system receive the vaccine.

If PHN has already developed, the treatment generally parallels those used for neuropathic pain. The most commonly used treatments include tricyclic antidepressants (amitriptyline, nortriptyline, desipramine); anti-epileptics (gabapentin and pregabalin); and analgesics (tramadol and opioids). Some topical medications have also shown benefit, including the xylocaine patch and capsaicin cream. Patients who fail to respond to these treatments may be candidates for more aggressive pain management strategies that include epidural steroid or anesthetic injections.

Some non-medicinal approaches to treatment of PHN include acupuncture and transcutaneous electrical nerve stimulation (the stimulation of nerves by an electrical current for therapeutic reasons). Unfortunately there are few clinical trials that demonstrate the effectiveness of these treatments either alone or in conjunction with medicinal treatments.

Kenneth L. Tyler, M.D., is the Reuler-Lewin Family Professor and chairman of the department of neurology at the University of Colorado Denver.

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