



Visual Diagnosis

An Unusual Cause of Recurrent Facial Nerve Palsy

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This 18-year-old man presented with acute onset right facial weakness. He was diagnosed with left Bell's palsy three weeks earlier and had partially recovered after receiving oral corticosteroids and valacyclovir. He had lower motor neuron pattern right facial nerve palsy with inability to close the right eye completely. He also exhibited nontender rubbery swelling of his upper and lower lips and a furrowed tongue (Figs A and B). Additionally, he had bilateral moderate sensorineural hearing loss and bilateral anterior uveitis. He did not have fever, cough, diarrhea, rashes, joint pain, or previous illnesses. An extensive evaluation for infections, connective tissue disorders, inflammatory conditions, and rheumatological diseases was unremarkable. Magnetic resonance imaging with and without contrast demonstrated bilateral enhancement of the seventh cranial nerve (Figs C and D).

Melkersson-Rosenthal syndrome (MRS) is a rare neuromucocutaneous granulomatous disorder characterized by the classic triad of lip swelling, fissured tongue, and recurrent facial paralysis. Although it occurs primarily during the second to fourth decades of life, presentation in the pediatric age group

has been documented. The facial paralysis associated with MRS is indistinguishable from Bell's palsy. The etiology and

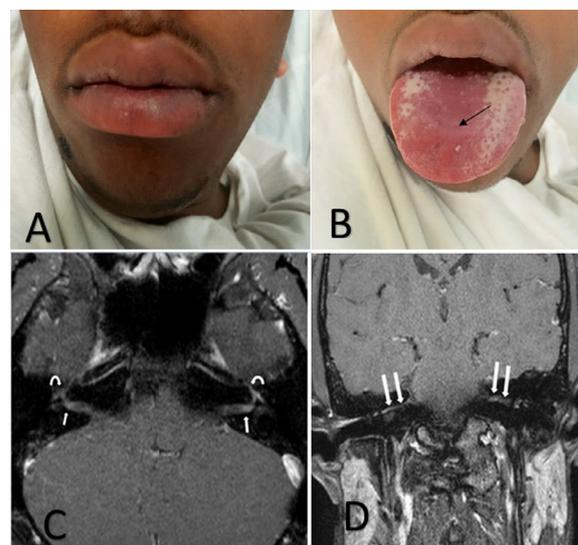


FIGURE. (A) Macrocheilitis, (B) A geographic tongue with a horizontal central groove (arrow) and several small grooves and fissures running anteriorly from the middle third of the tongue, (C) Axial fat saturated T1-weighted image shows bilateral intense enhancement of geniculate ganglion of the facial nerve (curved arrows), the labyrinthine and tympanic segments. Notice the intense enhancement of the facial nerve in the internal auditory canal (arrows). (D) Coronal fat saturated T1-weighted image passing through the internal auditory canal shows bilateral intense enhancement of facial nerves passing along the superior aspect of the internal auditory canals (arrows).

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pathogenesis of MRS are not well understood, and there is not a specific and well-established therapy for this condition. Our young man exhibited the complete triad of signs along with atypical features of bilateral anterior uveitis and sensorineural hearing loss. Bilateral hearing loss and anterior uveitis have not been documented in conjunction with the MRS triad.¹ This report emphasizes the importance of recognizing lip swelling

and furrowed tongue in patients with recurrent facial nerve paralysis.

Reference

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