Methods of Complex Treatment of Neuritis of The Facial Nerve

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Introduction. Sensitive and secretory (parasympathetic) fibers form the intermediate nerve (n. intermedius) - the VIII pair of cranial nerves - a significant part pass along with the facial nerve. Lesions of the facial nerve are polyetiological (idiopathic, ischemic, otogenic, traumatic, etc.). In most cases, there is a unilateral lesion of the facial nerve. The frequency of bilateral neuropathy of the facial nerve (diplegia facialis) is about 6.2%.

Materials and methods. When you try to wrinkle your forehead, skin folds on this side are not formed. The patient fails to close the eye: when trying to close the eye, the eyeball on the side of the lesion turns upward (Bell's symptom) and the sclera is visible through the gaping palpebral fissure under the upward iris ("hare's eye", lagophthalmos). If there is not paralysis, but paresis of the circular muscle of the eye, then when you try to close your eyes tightly, the eyelids do not close tightly, while on the side of the lesion the eyelashes do not sink into the skin folds (eyelash symptom).

The patient usually has difficulty eating, as it falls under the paretic cheek. Liquid food and saliva may flow from an insufficiently covered corner of the mouth on the side of the lesion. In patients in the recovery period or in the stage of residual effects, lacrimation may occur during meals on the side of the paresis (symptom of "crocodile tears"). The defeat of the VII nerve after the departure of the large stony nerve, but before the discharge of the stapedial nerve and the tympanic string, is accompanied by similar symptoms, with the exception of one - instead of dryness of the eye, lacrimation is noted. At the level of damage to the VII nerve in the distal part of the facial canal (after the departure of the large stony nerve and the stapedial nerve, but before the discharge of the tympanic string), peripheral prosoparesis, lacrimation, ageusia of the anterior 2/3 of the tongue, dry mouth and mild sensitivity disorders in the ear area are determined. In case of damage to the trunk of the facial nerve below the discharge of the tympanic string, only peripheral prosoparesis and lacrimation will appear in the clinical picture.

Results. In most neuropathies of the facial nerve, the clinical prognosis is favorable. Complete recovery occurs in about 75% of patients. A more favorable prognosis is in cases where the nerve is affected after exiting the stylomastoid foramen, but only in the absence of otogenic factors, chronic inflammatory processes in the parotid salivary gland, and inflammation of the lymph nodes located in this area. The course of recurrent neuropathies of the facial nerve is relatively favorable, but each subsequent relapse is more difficult than the previous one, the restoration of functions is delayed and becomes incomplete. After 2–3 months, in any form, except for poliomyelitis, contracture of the mimic muscles of the face may develop. At the same time, the palpebral fissure is narrowed, myoclonic twitches are possible in the affected muscles.

Treatment of neuropathy of the facial nerve. The purpose of therapeutic measures for neuropathy of the facial nerve is to increase blood and lymph circulation in the face, improve the conduction of the facial nerve, restore the function of facial muscles, and prevent the development of muscle contracture.

From the first days of the disease, PTL is recommended: infrared rays in a low-thermal dosage on the affected half of the face (treatment course 8–10 days); ultra-high-frequency electric field in a low-thermal dosage (output power 15–20 W) on the area of the large "crow's foot" (projection zone of the

branching of the trunk of the facial nerve in front of the tragus of the ear) and the mastoid process of the affected side; laser therapy on the projection of the exit of the affected trunk and branches of the facial nerve; phonophoresis of hydrocortisone (with preclinical contracture) or Trilon B (with severe clinical contracture) on the affected half of the face and the projection area of the stylomastoid foramen; paraffin (50–52°C), mud (38–40°C) applications on the affected half of the face and collar area (duration of exposure 15–20 minutes every other day). Acupuncture.

Discussion. From physiotherapeutic procedures, electrical stimulation of the affected muscles, massage of mimic muscles are recommended. To prevent atrophy of facial muscles, their training is necessary, which is carried out daily (until complete recovery), several times a day (many times). We recommend performing the technique of facial exercises according to V.A. Kuzmin (see Table 1) A.K. Popov proposes to add the following tasks to the complex of the above exercises: alternate closing of the eyes, as well as the pronunciation of letters and words, in the formation of which the facial muscles take part (vowels - A, U, I, O, consonants - B, C, F). In case of irreversible paralysis of mimic muscles, surgical treatment is indicated: static and kinetic suspension of pubescent tissues, myoplasty, canthoplasty - plastic surgery for the narrowing of the palpebral fissure, i.e. its elongation and expansion.

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