
**Hepatitis E Infection with Bell’s Palsy**

**Sir,**

Hepatitis E virus has been implicated in epidemics of viral hepatitis in India, South East Asia and Africa. An association of hepatitis E virus with Bell’s palsy has not been documented till date. Their co-existence may be a cause-effect relationship (hepatitis E virus causing Bell’s palsy) or it may represent a chance co-existence. A literature search did not reveal such co-existence between the two.

We had a 32 years young man who presented with yellowness of eyes and urine of 3 weeks duration and concomitant weakness of right side of face of 2 weeks duration. There were symptoms suggestive of viral prodrome three weeks back, which subsided with onset of jaundice. In the last 2 weeks he developed deviation of angle of mouth to left with loss of nasolabial fold and forehead wrinkles on the right side of face. The patient did not report hearing loss or loss of taste or visual blurring. There was no history of trauma or otologic disease.

General examination revealed icterus and confirmed the presence of right-sided facial weakness. Neurological examination revealed right-sided lower motor neuron facial palsy (Bell’s palsy) with a House-Brackmann facial nerve grading scale of 3. Abdominal examination was unremarkable except for a reduced liver span of 9 cm.

Viral hepatitis could be established by elevated liver enzymes (ALT and AST values of 1000 IU) and increased bilirubin levels. IgM antibodies against hepatitis E virus were positive. IgM antibodies against hepatitis A virus was negative. HBsAg, VDRL and HIV tests were negative. Chest radiograph was normal.

He was started on treatment for viral hepatitis with liver supportive measures. Steroids were withheld keeping in mind the possibility of exacerbation of hepatitis. Moreover, he presented to us with Bell’s palsy, which showed features of recovery. He fully recovered from viral hepatitis and Bell’s palsy in 3 weeks.

Bell’s palsy is an acute, unilateral, peripheral, LMN facial-nerve paralysis that gradually resolves over time in 80-90% of cases. Its cause is unknown, though it appears to be a polyneuritis. Possible etiologies include infections (herpetic, Lyme disease, syphilis, Epstein-Barr viral infection, HIV infection), inflammation, and microvascular disease (diabetes mellitus and hypertension). Hepatitis E virus has not yet been implicated as an inciting agent in Bell’s palsy. Researchers have investigated for serologic evidence of cytomegalovirus, rubella virus, and hepatitis A, B, and C viruses in patients with Bell’s palsy. They found an association between hepatitis B and idiopathic facial paralysis. Bell’s palsy in Hepatitis E virus infection has not been documented till date. The association may be a cause-effect relationship or it may represent a chance co-existence. Methods to detect Hepatitis E virus or antibodies within facial nerve are not available. Electrophysiological studies are indicated in patients with a House-Brackmann facial nerve grading scale of 4 or more so as to plan surgical decompression. Management of Bell’s palsy with Hepatitis E virus infection is not different from that of Bell’s palsy alone.

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