AAN Summary of Evidence-based Guideline for **CLINICIANS**

UPDATE: STEROIDS AND ANTIVIRALS FOR BELL PALSY

This is a summary of the American Academy of Neurology (AAN) guideline regarding steroidal and antiviral treatment of Bell palsy. This information updates the findings of the 2001 AAN guideline on this topic.

Please refer to the full guideline at* www.aan.com *for more information, including definitions of the classifications of evidence and recommendations.

STEROIDS

For patients with new-onset Bell palsy does treatment with steroids improve facial functional recovery?

Strong evidence	For patients with new-onset Bell palsy, oral steroids should be offered to increase the probability of recovery of facial nerve function (**Level A**).

ANTIVIRALS

For patients with new-onset Bell palsy does treatment with antiviral agents improve facial functional recovery?

Weak evidence	For patients with new-onset Bell palsy, antivirals (in addition to steroids) might be offered to increase the probability of recovery of facial function (**Level C**). Patients offered antivirals should be counseled that a benefit from antivirals has not been established, and, if there is a benefit, it is likely that it is modest at best (risk difference [RD] < 7%).

CLINICAL CONTEXT

Although there is strong evidence that steroid use increases the probability of good facial functional recovery in patients with Bell palsy, it does not necessarily follow that all patients with Bell palsy need to take steroids. For example, it would be reasonable for a clinician to opt not to use steroids in a patient with brittle diabetes mellitus. Other comorbidities potentially requiring further consideration include morbid obesity, osteopenia, and a prior history of steroid intolerance.

We found limited evidence of the efficacy of steroids and antivirals in important Bell palsy subgroups, including those with a lower probability of recovery because of severe palsy at presentation and those with possible zoster sine herpete. Such studies are particularly important relative to the efficacy of the addition of antivirals to steroids given the lack of evidence for moderate efficacy in the "typical" patient with Bell palsy.

Authors of one Class I study performed a preplanned subgroup analysis on patients with severe palsy at presentation defined by a Sunnybrook scale score of 0 to 25. This analysis showed no significant difference in 12-month recovery rates between patients treated with prednisolone alone as compared with patients treated with prednisolone plus valacyclovir (RD 0.2% favoring valacyclovir 95% CI, -18% to 17.6%). However, the analysis lacked the statistical precision to exclude an important beneficial effect (or harm) from the addition of valacyclovir. A Class IV study observed a significant improvement in recovery (RD 26.6%) between patients with severe Bell palsy treated with prednisone alone and patients with severe Bell palsy treated with prednisone plus famciclovir (House-Brackmann Scale score of 5 or 6). This study had a high risk of bias because of pseudo-randomized treatment allocation and unmasked outcome assessment.

Relative to zoster sine herpete, a Class IV study observed no significant difference in recovery after treatment with prednisolone alone as compared with treatment with prednisolone plus valacyclovir in a subgroup of 28 patients with evidence of zoster reactivation (hazard ratio for recovery 1.6 favoring prednisolone plus valacyclovir, 95% CI 0.4 to 6.1). The small sample size and high risk of bias make this observation inconclusive.

These studies in aggregate do not provide strong evidence to identify subgroups of patients that might benefit more or less from treatment.

Because the studies included only patients presenting early after palsy onset, it is difficult to determine the effect of steroid or antiviral treatment in patients presenting later in the course of their illness (e.g., one week after the onset of facial weakness). Likewise, although it seems reasonable to assume that an equivalent dose of alternative steroids would also be effective, decisions regarding alternative steroid dosing regimens necessarily require clinician judgment.

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