

Case description- Bell's Palsy treatment by Fascial Manipulation

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Mrs. S. came to me for Physical therapy after a sudden attack of Bell's Palsy in the left side.

Mrs. S. (52), married with 3 children, a secretary by profession, was under stress when one evening she had a strange feeling on one side of her face. When she woke next morning, she was horrified to discover that the left half of her face was paralyzed. She consulted a physician who diagnosed the symptoms of Bell's palsy and prescribed steroids, p.t and acupuncture. The patient began taking steroids and tried acupuncture. After a useless fortnight she came to me for P.T, at that time I was not yet qualified for Fascial Manipulation.

The examination showed almost total paralysis of the left half of the face with corresponding difficulty in raising the left eyelid (a light wrinkle visible on the forehead), in puffing up the cheeks, closing the left eye completely and mainly in smiling. It is important to note that the paralysis was worse on the lower part of the face (CP2). **See photos below.**

I treated the patient with all techniques familiar to physical therapists- electrical stimulation, facial exercises and manual massage. We had 6 sessions over a fortnight with only one achievement- minimal improvement in the ability to raise the eyelid. After the six sessions I took a course in Fascial Manipulation level 1, and used that technique in the 7th session.

During the interview the patient mentioned a fracture in her right CA 6 years ago with pain that lasted half year later and recurrent headaches that she started to experience one year after the fracture in CP3- RE BILATERAL. On the basis of the interview I chose to focus on three segments, namely CP2, CP3 and CA. On the basis of the movement assessment and palpation assessment findings, I hypothesized that a lack of elasticity in the CA in the Antebrachial fascia, caused by the fracture, could have created an excessive tension along the Antemotion sequence till the Lacertusfibrosus provides the continuity between the Antebrachial and the Brachial fascia. Proximally the brachial fascia continues into that of the PectoralisMajor. The Pectoralis fascia is in continuity with the anterior Cervical fascia and the Facial fascia. This fascial continuity can explain the Ascending compensation that may have caused the Bell's palsy.

Six center of coordination were chosen for the treatment in the sagittal plane:

CP2 AN LT- over the Zygomaticus muscle

CP2 RE LT- centrally between the two Frontalis muscles

CP3 RE RT- below occiput over the initial part of the Erector Spine muscle

CP3 AN LT- over inferior border of body of the Mandible

CA AN RT- between Brachioradialis and Flexor Carpus Radialis, over Flexor PollicisLongus

HU RE RT- posterior to axilla over muscle belly of Teres Major muscle

The patient was photographed prior to the treatment (photo 1). In the course of the treatment she reported pain and a feeling that “the treatment is loosening her face”. After two days she reported improvement eating, drinking, smiling and closing of the eyes (photo 2). After a week she reported a significant improvement in function of all facial muscles, and almost total symmetry could be seen in all muscular functions, especially in smiling. It is important to note that this was achieved in a single F.M session- an improvement not achieved by the conventional P.T techniques used for Bell’s Palsy.

Although the above concern a single case it indicates a significant superiority of F.M over all other conventional P.T techniques, hence the need for further study with a view to assessing the effect of the F.M technique on the Bell’s palsy patient population

Patient photo before and after treatment:

