RecurrentPeripheral Facial ParalysisRevealingBehçet'sDisease: A Case Report

Abstract

We report the case of a 21-year-old female patient presentingwithrecurrentperipheral facial paralysisassociatedwithoropharyngealaphthosis and diffuse arthralgia. Immunologicaltestingrevealed HLA-B51 positivity, suggestingBehçet'sdisease. The patient's condition improvedwith a combination of corticosteroidtherapy, colchicine, functionalrehabilitation, and symptomaticmeasures.

Key Words

Behçet'sdisease – Recurrent facial paralysis – Neuro-Behçet – HLA-B51

Introduction

Behçet'sdisease (BD) is a chronic, relapsing, multisysteminflammatorydisordercharacterized by recurrent oral and genitalulcers, ocularinvolvement, and variable systemic manifestations. It isclassifiedamong the variable vesselvasculitides, as itcan affect botharteries and veins of all calibers. Although the exact etiologyremainsunclear, an interactionbetweengeneticpredispositionparticularly HLA-B51 positivityand environmental or infectious triggers issuspected. Neurologicalinvolvement, termed*neuro-Behçet'sdisease*, occurs in approximately 5–10% of cases and represents one of the mostsevere complications. It canmanifest as parenchymallesionsinvolving the brainstem or as vascular complications such as cerebralvenousthrombosis. Peripheralnervous system involvement, however, remainsexceptional.

Peripheral facial paralysisis a commonneurologicaldisorder, mostoftenidiopathic or post-viral in origin. Itsrecurrenceshould prompt investigation for an underlyingsystemicdisease. We report here an unusualpresentation of Behçet'sdiseaserevealed by recurrentperipheral facial paralysis in a youngwoman, emphasizing the importance of multidisciplinaryevaluation and early recognition of atypicalforms.

Case Report

Ms. M. M., a 21-year-old womanwith no significantmedicalhistory, experienced a right-sidedperipheral facial paralysisthreemonthsearlier, whichhad been attributed to idiopathic (cold-induced) Bell'spalsy. Her condition hadimprovedundercorticosteroidtherapy and physicalrehabilitation.

Threemonthslater, shepresentedagainwith a recurrence of the same facial deficit. Clinicalexaminationrevealed a complete right-sidedperipheral facial paralysis (House-Brackmann grade IV), with no involvement of othercranial nerves. ENT examinationidentified a single aphthousulcerlocated on the right tonsillarfossa. The patient

alsoreportedmigratorypolyarthralgia, mainlyaffecting the knees and wrists, withoutswelling or local inflammatorysigns.

Laboratoryworkupshowed: normal CBC, erythrocytesedimentation rate (ESR) of 28 mm in the first hour, nearly normal C-reactiveprotein (CRP), and positive HLA-B51. Brain MRI wasstrictly normal, showing no brainsteminvolvement or inflammatorylesions. Ophthalmologicexaminationrevealed no uveitis or retinalinvolvement.

Discussion

Peripheral facial paralysisis one of the mostcommonreasons for ENT consultations. It isusuallyidiopathic or post-viral. However, recurrence of such an episodewithina short period in a young patient should prompt consideration of a systemicetiology. In this case, the presence of oropharyngealaphthosis, polyarthralgia, and HLA-B51 positivityled to the diagnosis of Behçet'sdisease. This chronicsystemicvasculitispredominantly affects youngadults and isclassicallycharacterized by the triad of oral aphthosis, genitalaphthosis, and uveitis. Neurologicalinvolvement in Behçet'sdiseaseis rare but severe, occurring in approximately 5–10% of cases, and maybeeitherparenchymal or vascular. In our observation, the absence of brain MRI lesionsruled out central nervous system involvement but suggestedinflammatoryperipheral damage to the facial nerve. This case highlights the importance of acomprehensiveapproach and multidisciplinaryfollow-up in patients presentingwithrecurrent facial paralysis.

The patient wastreatedwith colchicine (1 mg/day) to control systemic inflammation, low-dose oral corticosteroids to reduce facial nerve edema, vitamin B12 to support nerve regeneration, and artificialtears for ocular protection. Functionalrehabilitation sessions wereprescribed to accelerateрecovery of facial motility. Clinicalevolutionwas favorable aftertwoweeks, with progressive recovery of facial movement and disappearance of joint pain. No recurrencewasobservedafterthreemonths of follow-up.

Conclusion

Behçet'sdiseaseshouldbeconsidered in any case of recurrent facial paralysisassociatedwith oral aphthosis. Early recognition of thisetiologyallows for targeted management and prevention of severeneurological or ocular complications. This case underscores the importance of aholisticclinicalapproach and close collaboration between ENT specialists, internists, and ophthalmologists in the management of suchatypicalpresentations.

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