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Letter to the Editor

The Occurrence of Synkinesis Following Bell's Palsy in Childhood can only be Reliably Assessed through Objective Measurements

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Letter to the Editor

We have read the article by Stapperfend *et al.* on a controlled cross-sectional study on the use of corticosteroids, their long-term effects, and the long-term psychological impact of idiopathic (n=14) or Borrelia-associated (n=12) facial palsy in children with interest ^[1]. Data were collected via telephone interviews and questionnaires ^[1]. All Borrelia-associated facial palsies and 11 of the 14 idiopathic facial palsies resolved completely; however, four patients with idiopathic facial palsy developed synkinesis ^[1]. Seven patients with idiopathic and two with Borrelia-associated facial palsy reported psychological impairment at the final follow-up ^[1]. The study is groundbreaking, but some points warrant discussion.

First, it is unclear why only 4 of the 14 patients with idiopathic facial palsy received glucocorticoids ^[1]. Corticosteroids are considered the gold standard in the treatment of idiopathic facial palsy ^[2]. Why were so few patients with an indication for glucocorticoids actually receiving them? Were they diabetic or were there other absolute contraindications for the use of steroids?

The second point is that teleconsultation cannot differentiate between clinical and electrophysiological recovery. There is clinical recovery, which can be assessed during an in-person examination or via video call, but there is also electrophysiological recovery of facial paralysis. Even with complete clinical recovery, persistent facial nerve damage may remain visible in electrophysiological studies. Therefore, it is recommended that these patients also undergo nerve conduction studies.

The third point is that the assessment scales used (Facial Clinimetric Evaluation Scale (FCES), Facial Disability Index (FDI), Synkinesis Assessment Questionnaire (SAQ)) and the mental health questionnaire have limitations. The FCES underestimates the social impact, is insensitive to individual changes, relies solely on subjective reports, and does not always correlate with objective, clinically evaluated motor assessments such as the Sunnybrook Facial Grading System (SFGS) ^[3]. Disadvantages of the FDI include its subjectivity and the fact that it is based on self-reports, its limited scope, and the lack of detailed assessment of synkinesis and resting symmetry ^[4]. The SAQ is also based exclusively on patient reports, correlates only weakly with clinically used scales such as the House-Brackmann scale or the Sunnybrook scale, does not capture the underlying paresis or resting asymmetry, and is not objective ^[5].

The fourth point is that the latency period between the facial palsy and the follow-up examination was approximately eight years, suggesting that other causes besides the preceding facial palsy could be responsible for the synkinesis. How could a disease of the central or peripheral nervous system that occurred after the facial palsy be ruled out as the cause of the supposedly remaining symptoms?

Before concluding that one-fifth of children with Bell's palsy develop synkinesis eight years after the facial palsy, objective measurement methods must be applied and alternative must be excluded.

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