

## RELAPSING-REMITTING FACIAL PALSY AND BRACHIAL PLEXOPATHY CAUSED BY HSV-1

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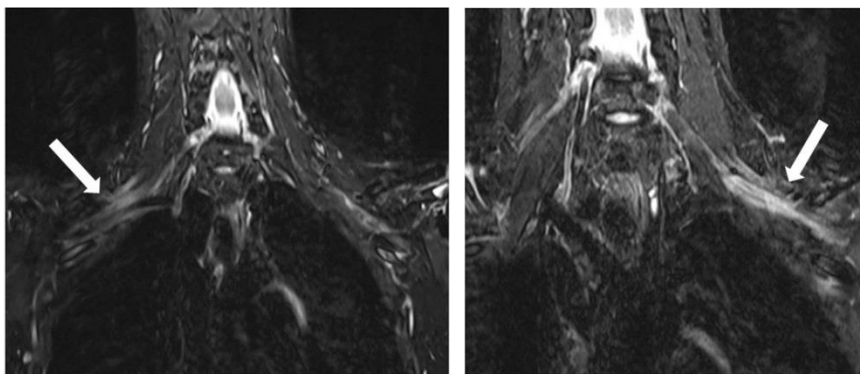
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The etiologies of Bell's palsy and brachial neuritis remain uncertain, and the conditions rarely co-occur or reoccur. Here we present a woman in her twenties who had several relapsing-remitting episodes with left-sided facial palsy and brachial neuropathy. The episodes always started with painful left-sided oral blisters. Repeat PCRs HSV-1 DNA from oral vesicular lesions were positive. Extensive screening did not reveal any other underlying cause. Except a mannose-binding lectin (MBL) deficiency, a congenital complement deficiency that is frequently found in the general Caucasian population, no other immunodeficiency was demonstrated in our patient. In vitro resistance to acyclovir was tested negative ( $IC_{50} \leq 2 \mu\text{g/ml}$ ), but despite prophylactic treatment with the drug in high doses, relapses recurred. However, the stereotype neurological symptoms, confined to the same anatomical areas during each episode, and with short latency of the HSV-1 reactivation, favors a local infectious neuropathy. Findings on MRI T2-weighted brachial plexus STIR images, using a 3.0-Tesla scanner during an episode, were compatible with brachial plexus neuritis. To our knowledge, this is the first ever reported documentation of relapsing-remitting facial and brachial plexus neuritis caused by HSV-1.



**Figure 1.** Bell's phenomenon in a 24-year-old woman with relapsing-remitting facial palsy combined with ipsilateral brachial plexitis.



**Figure 2.** Coronal T2-weighted fat-suppressed images (TR 3700 msec, TI 230 msec, TE 44 msec, Simens Medical System GMBH, Erlangen, Germany): A, Normal right brachial plexus (arrow). B, Increased signal in fascicles of left brachial plexus (arrow) consistent with inflammatory edema. Fat-suppressed T1-weighted images post intravenous contrast revealed no enhancement (not shown).