
THE "A FRIGORE" FACIAL PARALYSIS TREATED BY MEANS
OF THE COLD AND OTHER FORMS OF RELIEF OF THE HEAD

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When an anatomical formation is wrapped up in an inextensible bony canal, its compression by congestion in the blood vessels or lymph ducts is of great etiopathogenic importance: the more delicate is this formation in its anatomy and physiopathology, the more frequent and imporant will be the compression.

This conception carried us to propose the sanguineous and lymphatic derivation of the cephalic extremity in the treatment of Menière's syndrome and certain forms of deafness and tinnitus. In this way we have valued the etiopathogenic effect that the slight overpressure might perform on such delicate and complex formation as it is the membranous labyrinth. This overpressure of the labyrinthical fluids might be by its turn the consequence of a local congestive state; the membranous labyrinth thus being enclosed in the inextensible bony labyrinth, the hypertension of the labyrinthical fluids will infallibly injure the membranous labyrinth.

The results that we have gathered in such cases as Menière's syndrome and certain types of deafness and tinnitus since about 15 years were of such kind, that we considered that the same etiopathogenic factor could take place on other anatomical formations which would be in the same conditions. In this way we considered the facial nerve, which traverses in a great part of its extension across the cranium, in a bony and therefore inextensible canal. Being the Fallopian aqueduct not only very narrow, so that the facial nerve fills it up completely, but also full of irregularities of its walls, one can easily understand that the least congestive or oedematous state might slightly, or at times even profoundly, injure the facial nerve.

It is also to take into consideration that the facial nerve suffers in its course in the Fallopian aqueduct two very accentuated angles, in one of which is laid like a coil by the geniculate ganglion which is, as Terracol and Guerrier say, "one of the most vascular parts of the nerve as it literally is sunk in a vascular environment: an arterial and venous net involves it, giving a characteristic violaceous colour to it".

However, it is not only on this place where the vascular factor may be of importance, for in about pretty all the extension of the facial nerve its irrigation is not only abundant, but forms vascular handles around the facial nerve; this factor accentuates the strangulation of the nerve when there would be either hyperhaemia or damming up of the blood.

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Therefore we think that for the treatment of the "a frigore" facial paralysis, we might try to employ the sanguineous and lymphatic derivation of the cephalic extremity. In this way we have employed on 4 patients the same method as we had employed in cases of Menière's syndrome and deafness, that is the diathermy, applicating a solenoid electrode upon the abdomen and along the lower limbs. Other 4 patients, however, have been treated more paradoxically by simple application of ice (which is also efficient in the cases of Menière's syndrome) upon the ear on the side of the paralysis.

All patients we have treated by this method had recovered whenever the facial paralysis did not date from a long time ago. We are presently rearching if we may — by previous electric study of the facial nerve — foresee the cases in which it is still legitimate to expect good results from this treatment.