Paraplegie amyotrophique lentement ascendante, d'abord spasmodique, puis flasque, s'accompagnant de dissociation albuminocytologique. *Revue Neurol (Paris)* 1926;33 (2):1-42.

² Aminoff MJ. *Spinal Angiomas*, Oxford: Blackwell, 1976:82-85.

³ Antoni N. Spinal vascular malformations (angiomas) and myelomalacia. *Neurology (Minneapolis)* 1962;12:895-904.

⁴ Greenfield JG, Turner JWA. Acute and subacute necrotic myelitis. *Brain* 1939; 62:227-52.

⁵ Hughes JT. *Pathology of the Spinal Cord*, 2nd Edition, London: Lloyd-Luke, 1978:81-83.

⁶ Jellinger K. Pathology of spinal vascular malformations and vascular tumours. In: Pia HW, Djindjian R, eds. *Spinal Angiomas. Advances in Diagnosis & Therapy*. Berlin: Springer-Verlag (1978):18-44.

three days after admission, being asymptomatic three months later. A further EMG study after 33 days evolution showed a clear reduction in spontaneous activity and a normal blink reflex.

Facial palsy in the course of cephalic tetanus usually appears when there is already evidence of trismus^{3,5,8} or simultaneously with it.^{4,6,9-11} Thus the interest in our case lies in the fact that facial paralysis was the only clinical sign for the first eight days of evolution, being diagnosed understandably as Bell's palsy. Although mistaken diagnoses of facial paralysis at the onset of cephalic tetanus have been mentioned occasionally,^{2,12} the pattern of evolution described here has only been reported in one case.¹⁰ This was a 14-year-old patient who developed left facial paralysis 3 days after suffering an eye injury on the same side; trismus and dysphagia were present the following day. Our EMG findings are consistent with those previously described.^{2,3,5,11} Consequently, when Bell's palsy and craniofacial injury are found together, the possibility of cephalic tetanus should be considered.

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References

- ¹ Boudouresques J, Khalil R, Vigouroux RA, Daniel F, Goset A. Infectious diseases of nerves. In: Vinken PJ, Bruyn GW, eds. *Handbook of Clinical Neurology*. Vol 7. Amsterdam: North Holland Publishing Company, 1970:473-494.
- ² Vakil BJ, Singhal BS, Pandya SS, Irani PF. Cephalic tetanus. *Neurology (Minneapolis)* 1973;23:1091-1096.
- ³ Dastur FC, Shanani MT, Dastoor DH, et al. Cephalic tetanus: demonstration of a dual lesion. *J Neurol Neurosurg Psychiatry* 1977;40:782-6.
- ⁴ Farquharson RG. Cephalic tetanus. *Proc R Soc Med* 1972;65:875-6.
- ⁵ García Mullin R, Daroff RB. Electrophysiological investigations of cephalic tetanus. *J Neurol Neurosurg Psychiatry* 1973;36:296-301.
- ⁶ Abde VW, Dekate MP. Cephalic tetanus (clinical analyses of 9 cases). *J Indian Med Assoc* 1980;74:111-3.
- ⁷ Mishra M, Sinha BN. Facial palsy in tetanus. *Br Med J* 1972;3:475-6.
- ⁸ Ahuja GK, Kamala G. Cephalic tetanus. *Neurol India* 1978;26:10-13.
- ⁹ Bagratuni L. Cephalic tetanus with report of a case. *Br Med J* 1952;1:461-3.
- ¹⁰ Park DM. Cranial nerve palsies in tetanus and cephalic tetanus. *J Neurol Neurosurg Psychiatry* 1970;33:212-5.
- ¹¹ Mamoli B, Ludin HP. Electrophysiological investigations in a case of cephalic tetanus. *Neurol* 1977;214:251-5.
- ¹² Struppler A, Struppler E, Adams RD. Local tetanus in man. *Arch Neurol* 1963;8:102-78.

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Cephalic tetanus presenting with Bell's palsy

Sir: Cephalic tetanus is a clinical variant characterised by paralysis of the cranial nerves.¹⁻⁵ Weakness of the muscles innervated by the seventh nerve is the most frequently reported symptom. However, cephalic tetanus commencing with facial paralysis, as in the case described here, is unusual.

A 53-year-old man suffered a wound on the right side of his chin, caused by a stick. Two days later, there was inflammation at the site of the injury and weakness of the right orbicularis oris muscle. Later the paralysis increased, with weakness of the ipsilateral orbicularis oculi, but without facial stiffness. On the fifth day, the patient was seen by his general practitioner who diagnosed right-sided Bell's palsy and prescribed prednisone 15 mg daily. Five days later, the patient had difficulty in swallowing and in opening his mouth, and was referred to our hospital. Examination revealed severe lockjaw and left facial hemispasm, combined with right facial paralysis, predominantly affecting the lower portion (fig). Taste was not affected. The wound was infected. Treatment included debridement of the wound, tracheotomy, penicillin, antitetanic gamma globulin, tetanus toxoid and diazepam. At rest, the electromyogram showed bilateral continuous abnormal activity in the masseters, orbicularis oris and orbicularis oculi muscles; electrical silence was not obtained. The patient began to improve

Fig Patient 20 days after onset of symptoms. Note the healed wound on the right side of the chin, right peripheral facial palsy and spasm of the left orbicularis oris and orbicularis oculi muscles.