

Physiotherapy Management of Bell's Palsy: A Case Report

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Abstract

Background: Bell's palsy is an acute peripheral facial nerve disorder that can impair facial movement, symmetry, oral function, daily activities, and psychological well-being. Comprehensive assessment may help describe changes across different clinical domains during rehabilitation.

Objective: To describe the physiotherapy assessment, multimodal intervention, and observed clinical changes in a patient with left peripheral Bell's palsy.

Methods: A descriptive single case report was conducted in a 59-year-old woman with left peripheral Bell's palsy who received physiotherapy at RSUD Haji Provinsi Sulawesi Selatan. The intervention comprised infrared radiation, massage, tapping, stretching, facial expression and vowel exercises, and functional facial exercises. Outcomes were assessed before treatment and after three documented sessions using Manual Muscle Testing (MMT), the Ugo Fisch Facial Grading Scale, and the Hamilton Anxiety Rating Scale (HAM A). Data were analyzed descriptively.

Results: Facial MMT remained unchanged at 3 after three sessions. The Ugo Fisch score increased from 54 to 70, representing an observed increase of 16 points. The HAM A score decreased from 6 to 4, representing an observed reduction of 2 points. Eating and drinking difficulties identified at baseline were not reassessed using a standardized post intervention measure.

Conclusion: During the three-session observation period, facial function and recorded anxiety scores changed, whereas facial muscle performance measured by MMT remained unchanged. These observations cannot establish a causal effect of physiotherapy because of the single case design, short observation period, potential spontaneous recovery, multimodal intervention, and incomplete information regarding concurrent medical management.

Keywords

Bell Palsy; Physical Therapy Modalities; Facial Muscles; Facial Expression; Anxiety

Introduction

Bell's palsy is an acute peripheral facial nerve disorder characterized by unilateral facial weakness or paralysis resulting from dysfunction of the facial nerve. The condition may affect voluntary facial movement, facial symmetry, eye closure, speech articulation, oral competence, and facial expression. Impairment of lip closure and cheek control may interfere with eating and drinking by allowing food or fluid to escape from the oral cavity. Beyond physical impairment, facial palsy may also influence social interaction, self-perception, and psychological well-being because facial appearance and facial expression are important components of interpersonal communication.¹⁻³

The clinical course of Bell's palsy varies among individuals, with some patients experiencing substantial recovery and others developing persistent facial weakness, asymmetry, or functional limitations.² This variability highlights the importance of comprehensive clinical assessment during rehabilitation. Assessment should extend beyond isolated evaluation of muscle performance and consider facial movement, symmetry, activity related limitations, and patient related consequences. A multidimensional assessment can provide a broader description of the clinical presentation and identify changes that may occur across different domains during rehabilitation. Evidence also suggests that the psychosocial consequences of facial palsy may not correspond directly with the degree of observable facial impairment, supporting the consideration of psychological factors alongside physical findings.³

Physiotherapy is used in the rehabilitation of patients with facial palsy, particularly through facial exercise therapy and neuromuscular retraining. An updated systematic review reported evidence supporting facial exercise therapy in patients with facial palsy during both early recovery and chronic stages, although substantial heterogeneity remains in intervention protocols, patient characteristics, timing of treatment, and outcome measures.⁴ Such heterogeneity is clinically relevant because rehabilitation programs may incorporate several treatment components simultaneously, making it difficult to determine the contribution of an individual modality. Therefore, evidence supporting facial exercise therapy should not automatically be interpreted as evidence of equivalent effectiveness for every component included in a multimodal physiotherapy program.

Assessment of rehabilitation outcomes also requires consideration of the specific clinical domain represented by each measurement. Facial muscle performance, facial movement, symmetry, functional activity, and psychological status are related but distinct constructs. Consequently, a change in one domain may occur without an equivalent change in another domain. The use of complementary outcome measures may provide a more comprehensive description of the clinical course, particularly in a case report where the primary purpose is to document individual clinical findings and observed changes rather than determine treatment effectiveness or establish a causal relationship.

Psychological factors are relevant to the broader clinical consequences of facial palsy. Patients may experience anxiety, depressive symptoms, appearance related concerns, impaired social functioning, and reduced quality of life.³ These concerns are clinically relevant because facial movement and appearance contribute to communication and social interaction. Assessment of

psychological status may therefore complement physical and functional assessment when describing the rehabilitation needs of an individual patient. However, psychological changes observed during a short rehabilitation period should be interpreted cautiously because they may be influenced by multiple clinical, social, and individual factors.

A reporting gap remains in the integrated description of these domains within individual physiotherapy cases. Previous literature has addressed facial exercise therapy and the psychosocial consequences of facial palsy, but these aspects are frequently considered separately. In clinical case reporting, documentation of baseline impairments, activity limitations, intervention components, and changes across several outcome domains may provide useful contextual information for understanding the rehabilitation process. A case report integrating facial motor performance, facial function, activity related problems, and anxiety can therefore contribute a clinically detailed description without implying that observed changes are attributable to a particular intervention component.

The present case involved a 59-year-old woman with left peripheral Bell's palsy who presented approximately one week after symptom onset with facial weakness and asymmetry, impaired lip and cheek control, difficulties during eating and drinking, and recorded anxiety. The physiotherapy program comprised infrared radiation, massage, tapping, stretching exercises, facial expression exercises, vowel exercises, and functional facial exercises. The diagnosis had been established by the medical team at RSUD Haji Kota Makassar, after which the patient was referred to the physiotherapy service. No concurrent medical treatment was reported in the available case information. The focus of this report is not to propose a novel physiotherapy intervention, but to describe the assessment and clinical management of multiple impairments and activity related problems within the available treatment period.

The present case report aimed to describe the physiotherapy assessment, multimodal intervention, and observed clinical changes in a patient with left peripheral Bell's palsy presenting with facial weakness and asymmetry, eating and drinking difficulties, and anxiety. Specifically, the report documents change in facial muscle performance, facial function, and anxiety during three documented physiotherapy sessions. The findings are presented descriptively and are not intended to establish the effectiveness of physiotherapy or a causal relationship between the intervention and the observed clinical changes.

Methods

This study used a descriptive single case report design to document the physiotherapy assessment, intervention, and observed clinical changes in a patient with left peripheral Bell's palsy. The case was managed in the physiotherapy service of RSUD Haji Provinsi Sulawesi Selatan. The report describes the patient's clinical presentation, identified impairments and activity limitations, documented physiotherapy interventions, and changes in the available outcome measures. Because this was a single case without a comparison group, the analysis was descriptive and no causal inference regarding the effects of physiotherapy was planned.

The patient was a 59-year-old woman with a documented diagnosis of left peripheral Bell's palsy. The diagnosis had been established by the medical team at RSUD Haji Kota Makassar, after which the patient was referred to the physiotherapy service. The patient reported sudden onset of weakness on the left side of the face, first noticed in the morning while at home, with approximately one week between symptom onset and the initial physiotherapy assessment. Her family subsequently noticed a visible change in facial appearance. The available records documented a history of hypertension and diabetes. At the initial assessment, blood pressure was 110/70 mmHg, pulse rate was 75 beats/min, respiratory rate was 18 breaths/min, and body temperature was 36°C. The patient presented with left facial weakness and asymmetry, impaired lip and cheek control, difficulty maintaining food within the mouth, and leakage of fluid during drinking. Detailed information regarding the medical diagnostic works up, investigations performed to exclude alternative causes of facial palsy, and changes in medical treatment was not available in the case records. The authors confirmed that no concurrent medical therapy was reported in the available case information.

The documented clinical chronology included symptom onset approximately one week before the initial physiotherapy assessment, followed by three treatment sessions and a post treatment evaluation. The treatment sessions occurred on 14 October 2025, 16 October 2025, and 22 October 2025, with the final evaluation conducted on 22 October 2025. No additional follow up assessment was documented. The available records did not provide a precise calendar date for symptom onset or the baseline assessment. The clinical sequence was therefore reported using the available dates without reconstructing undocumented intervals. The physiotherapy assessment included history taking, vital signs measurement, static and dynamic facial inspection, palpation, assessment of basic facial movements, sensory examination, facial muscle performance assessment, facial function assessment, and anxiety assessment. Static inspection evaluated facial symmetry and resting appearance, whereas dynamic inspection was performed while the patient spoke, smiled, blew, and inflated the cheeks. Basic facial movements included forehead wrinkling, eyebrow elevation, eye closure, lip elevation, smiling, whistling, cheek inflation, and lip pursing. Palpation assessed edema, local temperature changes, skin contour changes, and tenderness. Sensory examination used sharp and dull stimuli for pain sensation and light and coarse stimuli for tactile sensation. These procedures documented the physiotherapy findings available in the clinical record and did not replace the medical diagnostic process.

Facial muscle performance was assessed using Manual Muscle Testing (MMT) according to the patient's ability to produce voluntary facial movement during the examined tasks. The affected side had a baseline MMT score of 3. MMT was used as a descriptive indicator of facial muscle performance and was interpreted together with the facial function assessment. The available record also documented weakness involving the orbicularis oris, procerus, zygomaticus, risorius, buccinator, depressor labii inferioris, and depressor anguli oris. The limitations of facial MMT as a comprehensive assessment of facial symmetry, coordination, and activity related performance were considered when interpreting the findings.⁵

Facial function was assessed using the Ugo Fisch Facial Grading Scale.⁵ The documented assessment included facial appearance at rest and voluntary facial movements, including forehead wrinkling, eye closure, smiling, and whistling. The baseline score was 54. The same available scoring procedure was applied during the post treatment assessment, which yielded a score of 70. No recalculation or retrospective modification of the recorded scores was performed. A verified methodological reference describing the original Ugo Fisch scale, its scoring procedure, and relevant measurement properties should be added to the final reference list.

Anxiety was assessed using the Hamilton Anxiety Rating Scale (HAM A).⁶ The baseline score was 6 and the post treatment score was 4. HAM A was used to document the recorded level of anxiety during the observation period. A standard methodological reference for the instrument and an appropriate source supporting its scoring and interpretation should be included in the final reference list.

The documented physiotherapy intervention consisted of infrared radiation, massage, tapping, stretching exercises, facial expression exercises, vowel exercises, and functional facial exercises. The treatment sequence was infrared radiation, manual techniques, stretching, facial exercises, and functional exercises. Infrared radiation was applied to the face while the patient used an

eye covering for approximately 10 minutes at an approximate distance of 45 cm from the skin surface. The available record did not specify the device model, output characteristics, irradiance, treatment area boundaries, or skin temperature monitoring. These parameters were therefore not reconstructed.

Manual therapy consisted of massage using gentle friction and releasing up techniques for approximately 5 minutes. The original treatment record described the applied pressure as approximately 30%, but the method used to quantify this percentage was not documented. The pressure is therefore reported only as gentle manual pressure as documented. The authors confirmed that massage was performed in the direction of the facial muscle fibers, with pressure also applied in the tragus area. Facial tapping was documented as 10 to 15 taps over approximately 5 minutes. The precise anatomical sequence and tap frequency were not documented and were therefore not reconstructed. Stretching exercises were performed for 10 to 15 counts with three repetitions over approximately 5 minutes. The exact target muscles, duration of each stretch, and sequence were not available in the clinical record.

Facial expression and vowel exercises were performed for approximately 5 minutes during each documented session, with the patient instructed to perform the movements with attention and visual focus. Functional facial exercises included blowing, cheek inflation, smiling, and other task oriented facial movements. These exercises were performed for eight counts with three repetitions over approximately 5 minutes at each treatment session. A home program consisted of facial expression exercises performed in front of a mirror two to three times daily for 10 to 15 repetitions. The exercises included raising both eyebrows, wrinkling the forehead, slowly closing the eyes, smiling, inflating the cheeks, and pursing the lips as if blowing. The patient was also instructed to perform light facial massage one to two times daily for approximately 5 to 10 minutes.

The documented treatment was provided by a professional physiotherapist at the hospital. The available records did not specify the therapist's formal qualification beyond the professional role, years of clinical experience, or additional certification. No documented progression algorithm, predefined criteria for treatment modification, or formal tailoring protocol was available. The authors confirmed that no modification of the intervention was documented across the three treatment sessions. Treatment fidelity was not formally monitored, and adherence to the prescribed home program was not assessed using a structured method. These details were therefore reported as unavailable rather than inferred.

Outcome assessment was conducted before the treatment period and after the third documented physiotherapy session. The repeated outcomes were facial muscle performance measured by MMT, facial function measured by the Ugo Fisch Facial Grading Scale, and anxiety measured by HAM A. Eating and drinking difficulties were identified at baseline as clinically relevant activity limitations, but no standardized post treatment assessment of food or fluid leakage, eating ability, or drinking ability was documented. Consequently, these activities were not included as quantitative before and after outcomes.

Data analysis was descriptive. Baseline and post treatment values were compared using the recorded numerical scores and absolute changes. No inferential statistical test, p value, confidence interval, or inferential effect size was calculated because the report involved a single patient and no comparison condition. The analysis was limited to the documented observations and did not attempt to estimate treatment effects.

For publication ethics, the authors confirmed that the patient had provided informed consent for publication of the case report. No ethical approval, ethical exemption, institutional ethics policy, committee name, or approval number was available from the authors' documentation. Accordingly, no institutional approval or exemption is claimed in this report. Direct patient identifiers were omitted from the manuscript. A patient perspective was not collected or documented during the case and therefore could not be reported.

Results

At the initial physiotherapy assessment, the patient was a 59-year-old woman with a documented diagnosis of left peripheral Bell's palsy. The diagnosis had been established by the medical team at RSUD Haji Kota Makassar, after which the patient was referred to the physiotherapy service. Approximately one week had elapsed between symptom onset and the initial physiotherapy assessment. At baseline, blood pressure was 110/70 mmHg, pulse rate was 75 beats/min, respiratory rate was 18 breaths/min, and body temperature was 36°C. The patient presented with left sided facial weakness and facial asymmetry, with slight deviation toward the right side.

During dynamic facial examination, asymmetry of the lips was observed while the patient spoke, smiled, and blew. The patient was unable to maintain air optimally in the left cheek during cheek inflation, whereas nostril expansion remained symmetrical. The patient was able to wrinkle the forehead and raise the eyebrows, and eye closure was nearly complete. Lip elevation was limited, with deviation toward the right during smiling and whistling. These findings were accompanied by impaired control of the left cheek and lips. Palpation revealed no edema, local temperature change, skin contour abnormality, or tenderness. Sensory examination showed normal pain and tactile sensation according to the documented assessment.

Eating and drinking difficulties were also documented at baseline. Food could escape through the corner of the mouth, and fluid leakage occurred during drinking. These findings represented the recorded activity related problems at the initial assessment. No standardized quantitative assessment of eating or drinking performance was documented at baseline beyond these clinical observations.

Facial muscle performance was assessed using MMT. The affected left side received a score of 3 at baseline. The clinical record documented weakness involving several facial muscles, including the orbicularis oris, procerus, zygomaticus, risorius, buccinator, depressor labii inferioris, and depressor anguli oris. The baseline Ugo Fisch Facial Grading Scale score was 54. The documented movement assessment showed greater limitation in lip related movements, particularly smiling and whistling, compared with forehead movement and eye closure. The baseline HAM A score was 6 and was recorded in the case documentation as mild anxiety.

To consolidate the principal baseline findings, Table 1 presents the main clinical characteristics and outcome measurements documented before physiotherapy. The table focuses on the findings most directly related to facial motor performance, facial function, anxiety, and the patient's activity related complaints.

Table 1. Baseline clinical findings before physiotherapy

Parameter	Baseline finding
Facial muscle performance	MMT score 3 on the left side
Facial function	Ugo Fisch Facial Grading Scale score 54
Anxiety	HAM A score 6, recorded as mild anxiety
Facial symmetry	Asymmetry with deviation toward the right
Lip control	Deviation toward the right during smiling and whistling
Cheek inflation	Air could not be maintained optimally on the left side
Sensory examination	Pain and tactile sensation documented as normal
Eating and drinking	Food escape from the corner of the mouth and fluid leakage during drinking

The baseline findings demonstrated that the principal documented impairments involved left facial motor control and facial symmetry, particularly during movements requiring lip and cheek coordination. The recorded activity related problems were concentrated on oral containment during eating and drinking. Forehead movement, eyebrow elevation, near complete eye closure, and sensory examination were relatively preserved according to the clinical assessment.

The patient subsequently completed three documented physiotherapy sessions on 14 October 2025, 16 October 2025, and 22 October 2025. The intervention during these sessions consisted of infrared radiation, massage, tapping, stretching exercises, facial expression and vowel exercises, and functional facial exercises as described in the Methods section. The final evaluation was conducted on 22 October 2025 after the third documented treatment session. Repeat measurements were available for facial MMT, the Ugo Fisch Facial Grading Scale, and HAM A.

Table 2 presents the available numerical outcome measurements before treatment and after three physiotherapy sessions. This comparison is limited to outcomes for which measurements were documented at both assessment points.

Table 2. Recorded outcome measurements before and after three physiotherapy sessions

Outcome	Before physiotherapy	After three sessions	Observed change
Facial MMT	3	3	0
Ugo Fisch Facial Grading Scale	54	70	+16
HAM A	6	4	-2

Following the three documented treatment sessions, the facial MMT score remained unchanged at 3. The Ugo Fisch Facial Grading Scale score increased from 54 before treatment to 70 after the third session, corresponding to an observed numerical change of 16 points. The HAM A score decreased from 6 to 4, corresponding to an observed numerical change of 2 points. Thus, the three repeated outcome measures showed different numerical patterns between the two assessment points.

The eating and drinking problems documented at baseline did not have a corresponding standardized post treatment measurement. No post treatment score or structured assessment of food escape, fluid leakage, eating ability, or drinking ability was documented. Therefore, no before and after numerical comparison could be made for these activity related problems. Similarly, although sensory examination was documented as normal at baseline, no quantitative comparative sensory assessment was recorded after treatment.

For completeness, Table 3 summarizes the availability of post treatment measurements for the clinical domains documented during the baseline assessment. This distinguishes outcomes that were reassessed from baseline problems for which comparable post treatment data were unavailable.

Table 3. Availability of post treatment outcome data

Clinical domain	Baseline status	Post treatment data
Facial muscle performance	MMT score 3	MMT score 3 available
Facial function	Ugo Fisch score 54	Ugo Fisch score 70 available
Anxiety	HAM A score 6	HAM A score 4 available
Eating and drinking function	Food and fluid leakage documented	No standardized post treatment reassessment documented
Sensory function	Pain and tactile sensation documented as normal	No quantitative comparative reassessment documented

The available post treatment data therefore consisted of three repeated numerical outcomes. Facial muscle performance measured by MMT showed no numerical change, while the Ugo Fisch Facial Grading Scale showed an increase of 16 points and HAM A showed a reduction of 2 points. The activity related problems involving eating and drinking and the baseline sensory findings did not have comparable post treatment measurements in the available documentation. No additional follow up outcome assessment beyond the final evaluation on 22 October 2025 was documented.

Discussion

This case documented different patterns of change across the measured clinical domains after three documented physiotherapy sessions. The Ugo Fisch Facial Grading Scale score increased from 54 to 70, while the HAM A score decreased from 6 to 4. In contrast, facial muscle performance assessed using MMT remained unchanged at 3. The different patterns across these measures indicate that the recorded outcomes did not change uniformly during the observation period. However, these observations should be interpreted within the context of a single case, a short treatment period, and the absence of a comparison condition. The findings therefore describe the clinical course documented in this patient rather than demonstrate the effectiveness of physiotherapy.

The observed increase in the Ugo Fisch score is compatible with evidence indicating that facial exercise therapy and neuromuscular retraining may be associated with improved facial function in patients with facial palsy.^{1,7} An updated systematic review reported supportive findings for facial exercise therapy in both early recovery and chronic facial palsy, although considerable heterogeneity was identified in intervention protocols, patient characteristics, treatment timing, and outcome measures. Earlier Cochrane evidence also reported potential benefits of tailored facial exercises for facial function and some sequelae, while emphasizing limitations related to study quality and heterogeneity.⁷ The present observation is therefore consistent with the direction of findings reported in previous literature, but it cannot establish that the increase in facial function score was caused by the exercise components delivered in this case.

The intervention used in this case was multimodal and included infrared radiation, massage, tapping, stretching exercises, facial expression exercises, vowel exercises, and functional facial exercises. The available evidence should not be interpreted as providing equivalent support for each of these components. Facial exercise therapy and neuromuscular retraining have a more direct evidence base in the rehabilitation literature, whereas the independent contribution of infrared radiation, massage, tapping, and stretching within a combined treatment program cannot be determined from the present case.¹ The multimodal nature of the

intervention also prevents separation of the effects of individual components. Accordingly, the observed change in facial function should be attributed only to the clinical course documented during the treatment period and not to any specific modality.

The unchanged MMT score provides an important contrast with the increase in the Ugo Fisch score. Facial muscle performance and facial function are related but distinct clinical constructs.⁵ MMT provides information about voluntary muscle performance, whereas facial grading systems consider broader patterns of facial movement and function.⁵ A patient may therefore demonstrate changes in movement coordination, symmetry, or task performance without a corresponding change in an ordinal muscle performance score over a short period.⁵ In this case, the difference between the two measures illustrates the value of complementary assessment when documenting facial palsy rehabilitation. Nevertheless, facial MMT should not be interpreted as a comprehensive measure of facial nerve recovery, and standardized facial grading systems remain important for evaluating facial dysfunction.⁵

The short observation period is particularly relevant when interpreting the recorded changes. Bell's palsy has a variable natural history, and spontaneous recovery can occur during the period in which rehabilitation is provided.² Because the patient received treatment during an early stage following symptom onset, spontaneous changes in facial function cannot be separated from changes occurring during physiotherapy. In addition, the available case information did not contain sufficient detail regarding the medical diagnostic work up, investigations used to exclude alternative causes, or changes in medical management. Although the authors reported no concurrent medical therapy in the available case information, the incompleteness of the clinical record limits the extent to which other influences on the observed course can be excluded. Therefore, neither the increase in the Ugo Fisch score nor the unchanged MMT score can be causally attributed to physiotherapy.

The HAM A score decreased from 6 to 4 during the observation period. HAM A is an established clinician rated instrument for assessing anxiety symptoms.⁶ In this single case, the two-point reduction represents an observed numerical change rather than evidence of a clinically meaningful treatment effect. Anxiety may fluctuate in response to multiple factors, including adaptation to the condition, reassurance, therapeutic interaction, personal circumstances, or changes in perception of facial appearance and function.³ Consequently, the recorded reduction should not be interpreted as evidence that physiotherapy directly reduced anxiety. Nevertheless, inclusion of psychological assessment provides additional clinical information because facial palsy can have psychosocial consequences that extend beyond observable motor impairment.

The patient's baseline eating and drinking difficulties are also clinically relevant. Food escape through the corner of the mouth and fluid leakage during drinking indicated activity related problems associated with impaired lip and cheek control. Functional facial exercises were included in the intervention, but these activities were not reassessed using a standardized or comparable post treatment measure. An increase in the Ugo Fisch score therefore cannot be assumed to represent improvement in eating or drinking performance. This distinction is important because impairment level and activity level are not interchangeable clinical outcomes. Future rehabilitation assessment should include repeated functional measures that directly correspond to the patient's principal activity limitations.⁵

The home program provided additional facial exercises and light facial massage outside the clinical sessions. However, adherence was not formally assessed, and treatment fidelity was not monitored using a structured procedure. The available records also did not document a progression algorithm, predefined modification criteria, or changes in treatment parameters across the three sessions. These factors limit the reproducibility of the intervention and prevent determination of the actual dose received by the patient. Future case reports should provide clearer documentation of treatment fidelity, adherence, progression, and modification, particularly when multiple treatment modalities are delivered concurrently.

This case has several strengths despite these limitations. It documents facial motor performance, facial function, activity related problems, sensory findings, and anxiety within the same clinical rehabilitation episode. It also demonstrates the importance of distinguishing measured outcomes from clinically relevant problems that were not subsequently reassessed. At the same time, the interpretation is limited by the single case design, absence of a comparison condition, short observation period, potential spontaneous recovery, multimodal intervention, incomplete information regarding the broader medical management, lack of standardized reassessment of eating and drinking, and absence of structured adherence and treatment fidelity data. Patient perspective was also not collected or documented, limiting the ability to describe the patient's subjective experience of treatment or perceived functional change.

Overall, the case provides a descriptive account of an increase in facial function score and a reduction in recorded anxiety score, while facial muscle performance measured by MMT remained unchanged after three documented physiotherapy sessions. The findings are compatible with the possibility of clinical change during rehabilitation but do not establish treatment effectiveness or causality. The case supports the value of multidimensional and repeated assessment while highlighting the need for longer follow up, standardized functional outcome measurement, complete documentation of concurrent management, and more rigorous study designs to clarify the contribution of individual physiotherapy interventions in Bell's palsy.

Conclusion

This case report described the physiotherapy assessment, multimodal intervention, and observed clinical changes in a 59-year-old woman with left peripheral Bell's palsy. After three documented physiotherapy sessions, the Ugo Fisch Facial Grading Scale score increased from 54 to 70, while the HAM A score decreased from 6 to 4. Facial muscle performance measured by MMT remained unchanged at a score of 3. Eating and drinking difficulties were identified at baseline, but no standardized post treatment reassessment was available for these activity related problems.

The observed changes provide a descriptive account of the patient's clinical course during the documented rehabilitation period and should not be interpreted as evidence of physiotherapy effectiveness. The single case design, absence of a comparison condition, short observation period, potential spontaneous recovery, multimodal intervention, and incomplete information regarding the broader clinical course limit causal attribution to physiotherapy or any individual treatment component.

This case also highlights the importance of multidimensional assessment in Bell's palsy rehabilitation.⁵ Facial muscle performance, facial function, activity related limitations, and psychological status represent distinct clinical domains and should be assessed using appropriate and repeatable measures.⁵ Future clinical reports and prospective studies should include longer follow up, standardized reassessment of eating and drinking function, clearer documentation of concurrent medical management, treatment fidelity, intervention progression, and home program adherence. Patient reported perspectives should also be incorporated when feasible to provide a more comprehensive understanding of rehabilitation outcomes.

Author Contribution

Nurul Inayah: Conceptualization, Methodology, Investigation, Data Curation, Clinical Assessment, Intervention, Formal Analysis, Writing Original Draft, and Writing Review and Editing.

Meutiah Mutmainnah Abdullah: Methodology, Supervision, Validation, Interpretation of Clinical Findings, Writing Review and Editing, and Project Administration.

Agung Sahari: Conceptualization, Methodology, Supervision, Validation, Interpretation of Results, Writing Review and Editing, and Final Approval of the Manuscript.

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Conflict of Interest Statement

The authors declare no conflicts of interest related to the preparation or publication of this case report.

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Ethics Statement

The patient provided informed consent for publication of this case report. No ethical approval or ethical exemption was available from the authors' institutional documentation. No institutional ethics committee approval or exemption number is therefore claimed.

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