Lower Motor Neuron Facial Nerve Palsy

**Routine Care**
- History, Examination & BP
- FBC, U&E & Lyme Serology
- **Eye care** is the priority in all cases – use Hypromellose/Eye-lube + tape at night if incomplete eye closure
- Antibiotics – Oral Amoxicillin 15-20mg/kg (max 500mg) tds for 14 days.
  - If penicillin allergies:
    - < 12 years – Azithromycin 10mg/kg (max 500mg) od 3 days/week for 2 weeks
    - > 12 years – 150mg bd for 2 weeks
- Steroids – If symptomatic for > 72 hours prescribe Prednisolone 1mg/kg (max 40mg) for 10 days

**Consider**
- Imaging – CT or MRI if red flags
- Probably not indicated
- Activitats – Cochrane review showed no significant benefit

**Follow-up**
- Arrange review in 1-2 weeks.
- Stop antibiotics if Lyme serology negative.
- If progression of symptoms consider underlying diagnosis and need for referral.
- Arrange further review in 3-6 weeks.
- If persistent symptoms reconsider underlying diagnosis and need for referral.
- Long term prognosis is good with 85% resolution within 3 weeks. Complete resolution should occur within 3-5 months.

**Red Flags**
- Guillain-Barré syndrome or other abnormal neurological findings
- Acute otitis media, effusion, hearing loss, vertigo, ear discharge, vestibular
- Parotid mass
- Bilateral palsy
- Severe pain
- Bruising or organomegaly
- Hypertension

**Consider Referral**
- Ophthalmology – essential if eye closure is impaired
- ENT – Refer any child < 3 years with ear symptoms and if there are red flags in all age groups
- Neurology – if focal or evolving neurological signs
- Speech/Language therapy – if concerns about communication or swallowing
- Physiotherapy – if no recovery at 6 weeks. See guidelines for details.

**Complex or atypical cases should be referred to:**
**The Wessex Facial Nerve Centre**

---

**INTRODUCTION:**
The management of paediatric facial nerve palsy can prove challenging for children, caregivers and clinicians. The incidence of paediatric facial nerve palsy varies between 6.1-25 children per 100,000 per year. It may be classified as upper motor neurone (UMN) or lower motor neurone (LMN), unilateral or bilateral. Although 50% of cases are of unknown aetiology there are numerous identifiable potential causes that must be excluded to optimise recovery and exclude significant underlying disease. Although presentations are infrequent, it is essential that a thorough management approach is employed to achieve these goals.

**Methods:**
5-year service evaluation at our tertiary unit, accompanied by a non-systematic literature review. This informed the multi-disciplinary development of a flow chart for the management of these cases, which has been adopted across our region.

---

**Results:**
In our region, Lyme disease accounted for 50% of lower motor neurone paediatric facial nerve palsy and so routine therapy now includes antibiotic treatment. In order to facilitate effective and comprehensive management we emphasise the importance of a multi-disciplinary approach with a focus on effective communication between specialties.