**Short report**

**Concurrent Bell’s palsy and diabetes mellitus: a diabetic mononeuropathy?**

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**SUMMARY** In a series of 126 patients with Bell’s palsy, chemical or overt diabetes mellitus was found in 39% of the cases. A high frequency of disturbances of taste was found in the patients who had no diabetes (83%), as compared to only 14% of diabetic patients whose taste was affected ($p < 0.001$). Thus, the usual site of facial nerve lesion in diabetics appears to be distal to the chorda tympani, while in patients whose glucose tolerance is normal, no such selectivity exists. This may only be explained by a diabetes-related pathogenesis and a vascular rather than a generalised “metabolic” impairment is postulated, leading to a localised facial nerve ischaemia in the distal part of the Fallopian canal. Thus, some cases of Bell’s palsy may in fact be a diabetic mononeuropathy.

Since Korczyn first reported a high frequency of diabetes mellitus in patients presenting with Bell’s palsy, this association has been confirmed by others, so that screening for diabetes mellitus was recommended for patients presenting with this neurological deficit. Conversely, the risk of Bell’s palsy is increased in diabetes. It was also noted that diabetic patients with Bell’s palsy were much more prone to develop a more severe nerve injury and had a less favourable outcome. A suggestion was made that Bell’s palsy resulted from ischaemia of the facial nerve, due in many cases to diabetic small vessel disease, but no convincing evidence for a causal relation was presented so far. Bell’s palsy is prominent among the causes of taste impairment, but the reported frequency of taste involvement in Bell’s palsy varies. Taste has not yet been studied in concurrent diabetes mellitus and Bell’s palsy, and may perhaps be used to clarify the dilemma of this relationship.

**Patients and methods**

One hundred and eighty-four consecutive patients were referred for treatment of Bell’s palsy, during a period of five years. Fifty-eight cases had to be excluded from the study, either because more than five days had elapsed between the onset of the symptoms and presentation, or because investigations had not been completed. The remaining 126 patients had a fasting blood-glucose determination and levels above 130 mg/dl on two separate occasions were considered to be diabetic. In each of the other patients, an oral glucose tolerance test was performed, and interpreted according to Fajans and Conn. When whole blood glucose level had not fallen below 120 mg/dl, two hours after the oral glucose load—the diagnosis of chemical diabetes was made. (In patients over 50 years old, 10 mg/dl per decade were added to the post-glucose values.) Taste impairment was detected by inquiring for a loss or alteration of sensation, and by testing with salt and sugar solutions on each side of the tongue. In doubtful cases (taste disturbances established by only one of the methods), electrogustometry was performed; only those with an abnormal result (> 10 μA threshold difference) were considered to be suffering from an impairment of taste. All evaluations of taste were performed by the same observer (PP) when the patient first presented. Glucose determination and glucose tolerance tests were performed later, but within 24 hours of presentation and prior to the initiation of prednisone treatment.

**Results**

Out of the 126 patients examined, 13 were known diabetics and only two further cases were diagnosed on presentation as having overt diabetes mellitus. In another 34 cases, an abnormal glucose tolerance test...
result was found, thus the overall frequency of diabetes in this series of Bell's palsy was 39% (table). Chemical diabetes mellitus is evidently more prevalent than overt diabetes among the patients with Bell's palsy, in a ratio of 2:2:1. Of the patients with overt diabetes mellitus, seven patients had diabetes of less than one year duration, and of these none required insulin treatment. No other clinical evidence of diabetic neuropathy was found in these patients on presentation. However, five patients (out of 49) were again referred to us owing to the development of other neurological symptoms, and the diagnosis of diabetic mononeuropathy (three ocular motor palsies, one trochlear nerve, one femoral nerve) was established, more than a year following the Bell's palsy. Taste disturbances were detected in 71 patients (56-3%). Their incidence in patients with Bell's palsy and diabetes mellitus was lower than in the patients whose glucose tolerance test was normal (table). Of the 77 patients with normal glucose tolerance, 64 (83%) had impairment of taste, while the incidence in the diabetes group was only 14% (p < 0-001). No differences of age or sex were found between the groups presented in the table.

Discussion

Thirty-nine per cent of the 126 patients with Bell's palsy evaluated by us had diabetes mellitus, a high frequency which is in agreement with previously published data.1-6 An overall frequency of 56-3% of taste disturbances was found in our series, while other authors, using various assessment methods, report a similar frequency of about 60%.7-9 However, in the sub-group of diabetic patients, a considerably lower frequency of taste impairment was found. Only 14% of diabetics had taste involvement as compared to 83% of patients with a normal glucose tolerance. This difference is suggestive of a pathogenesis which is directly related to the diabetes, in most of the cases of concurrent diabetes mellitus and Bell's palsy. The sparing of taste in most of these cases is analogous to the sparing of pupillary fibres in third nerve lesions due to diabetes but not to other causes,11-13 and likewise may have an anatomical explanation. The chorda tympani carrying taste fibres from the anterior two thirds of the tongue, joins the facial nerve in its bony canal 5-6 mm above the stylomastoid foramen.14 To spare taste, nerve lesion in diabetes with Bell's palsy would have to be located distal to the bifurcation of the chorda tympani. In the rest of the cases where another aetiology, possibly viral, is involved,15,16 we found no evidence of such a localised lesion and the facial nerve seems to be affected throughout or mainly proximal to the chorda tympani, involving taste as well as motor function. Pathological studies of diabetes with a recent Bell's palsy are unavailable, so the nature of the facial nerve lesion and the reasons for the special vulnerability of the distal part of the facial nerve in diabetes, cannot be ascertained. However, it seems that no generalised metabolic abnormality in the Schwann cell and myelin sheath of diabetics17,18 can account for such a selective lesion, while a vascular pathogenesis is more probable.

The relationship of small vessel disease in diabetes to neuropathy19-20 and mononeuropathy in particular21-23 has been reported and related to nerve ischaemia in infarcts. This was confirmed by several pathological studies24-26 and by the similarity to the mononeuropathy of polyarteritis nodosa, in which nerve infarcts have also been demonstrated.27 The blood supply of the facial nerve in the petrous bone comes from two main sources:28-31 the stylomastoid artery (originating from the occipital or posterior-auricular arteries and ascending through

<table>
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<th>Table</th>
<th>Type and duration of diabetes and frequency of taste impairment among patients with Bell's palsy</th>
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<tr>
<td>Diagnosis</td>
<td>No of patients</td>
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<tr>
<td>Overt</td>
<td>15</td>
</tr>
<tr>
<td>Chemical</td>
<td>34</td>
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<tr>
<td>No diabetes</td>
<td>77</td>
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<td>Total</td>
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<table>
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<tr>
<th>Diagnosis</th>
<th>Taste impairment*</th>
<th>Taste unaffected</th>
<th>Total</th>
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<tr>
<td>No diabetes</td>
<td>64 (83%)</td>
<td>13 (17%)</td>
<td>77</td>
</tr>
<tr>
<td>Diabetes</td>
<td>7 (14%)</td>
<td>42 (86%)</td>
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<tr>
<td>Total</td>
<td>71 pts</td>
<td>55 pts</td>
<td>126</td>
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*A χ2 test for independence in 2 × 2 contingency table was performed. The χ2 statistic = 57-67, is highly significant in 0-001 level (p < 0-001).
the stylomastoid foramen), and the branches of the petrosal artery (originating from the middle meningeal artery, entering the hiatus Fallopii and descending in the bony canal). Ample anastomosis exist between them, however, this does not preclude the possibility of diabetic small vessel disease affecting the blood supply of the distal part of the facial nerve, possibly at the loop formed by the stylomastoid artery on entering the skull, or at its bifurcation at an acute angle to form the chorda tympani branch. Indeed, embolisation of both arteries was followed by a clinical picture very similar to Bell's palsy. It may be argued that a highly susceptible area of the microcirculation often occurs distal to the chorda tympani, hence diabetic small vessel disease may cause localised facial nerve ischaemia (infarction?) and oedema, which would further compromise the nerve's blood supply due to the rigid Fallopian canal at that area. In that respect, the facial nerve shows marked similarity to the other nerves commonly affected by diabetic mononeuropathy: all traverse an enclosed space which makes them especially vulnerable to the effects of ischaemia. The clinical profile of Bell's palsy, with sudden, painful asymmetrical onset and the pattern of gradual recovery, also is suggestive of nerve ischaemia and similar to a diabetic mononeuropathy, although most of the cases have a different aetiology, and nerve oedema and ischaemia are probably secondary phenomena.

Our findings as to the severity and duration of diabetes mellitus in our patients (table) are in agreement with the known data that diabetic mononeuropathies tend to occur in mild diabetes of short duration and to be independent of other types of diabetic neuropathy. Subclinical involvement of the contralateral side and other cranial nerves in Bell's palsy cannot be interpreted as indicative only of an infective aetiology, as it is also found in diabetes mellitus, even with newly diagnosed disease. The reported occurrence of Bell's palsy with other diabetic cranial neuropathies further supports a possible causal association between diabetes mellitus and Bell's palsy. In one report, 25% of patients with diabetic ophthalmoplegia had a past history of Bell's palsy. We therefore propose that the sparing of taste fibres in cases with concurrent diabetes mellitus and Bell's palsy may be related to diabetic small vessel disease, and that these cases of Bell's palsy may in fact be regarded as a diabetic mononeuropathy.

References

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34 Richards RL. Ischaemic lesions of peripheral nerves: a review. J Neurol Neurosurg Psychiatry 1951;14:76-80.