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**Literature search results**

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**Search details**

Recurrent sixth nerve palsy. Incidence and case studies. Studies comparing sixth and third nerve palsies.

**Resources searched**

NHS Evidence; TRIP Database; Cochrane Library; BNI; CINAHL; EMBASE; MEDLINE; Google Scholar

*Database search terms*: “sixth nerve palsy”; “VI nerve palsy”; “sixth nerve” adj2 pals*; “6th nerve” adj2 pals*; “VI nerve” adj2 pal*; “sixth nerve paresis”; “6th nerve” paresis*; “VI nerve paresis”; recurrence*; “abducens nerve pals*”; sixth cranial nerve pals*; third nerve pals*; “3rd nerve pals*”; “third nerve” adj2 pals*; “3rd nerve” adj2 pals*; “III nerve pals*”; “third nerve” adj2 pal*; “oculomotor nerve pals*”; ABDUCENS NERVE PARALYSIS

*Google search string*: (“sixth nerve” OR “VI nerve” OR “6th nerve”) (paresis OR palsy OR palsies) recurrence OR recurrent

(“sixth nerve” OR “VI nerve” OR “6th nerve”) (”third nerve” OR “3rd nerve” OR “III nerve”) (paresis OR palsy OR palsies) recurrence OR recurrent

**Summary**

There is a fair amount of research into recurrent sixth and third nerve palsies. However I could find little research that compared both. In terms of incidence, please see research studies 14 and 29. There are a lot more case studies on this topic.

**Guidelines**

None found
Evidence-based reviews
None found

Published research

1. A case of corticotroph carcinoma that caused multiple cranial nerve palsies, destructive petrosal bone invasion, and liver metastasis.

Author(s): Ono M, Miki N, Amano K, Hayashi M, Kawamata T, Seki T, Takano K, Katagiri S, Yamamoto M, Nishikawa T, Kubo O, Sano T, Hori T, Okada Y

Citation: Endocrine Pathology, March 2011, vol./is. 22/1(10-7), 1046-3976;1559-0097 (2011 Mar)

Publication Date: March 2011

Abstract: A 52-year-old woman experienced sudden onset of double vision due to a right abducens nerve palsy and was diagnosed as having a pituitary macroadenoma that invaded into the right cavernous sinus. Otherwise, she was asymptomatic despite marked elevation of ACTH (293pg/ml) and cortisol (24.6g/dl) levels. The patient underwent transsphenoidal surgery followed by -knife radiosurgery (GKR), which healed the diplopia and ameliorated the hypercortisolemia. The excised tumor was diffusely stained for ACTH with a high (15%) Ki-67 labeling index. Early tumor recurrence occurred twice thereafter, producing right lower cranial nerve palsies with petrosal bone destruction at 8months and an ipsilateral oculomotor nerve palsy at 12months after GKR; all palsies resolved completely with the second and third GKRs. Hypercortisolemia worsened rapidly soon after the third GKR, and the patient developed marked weight gain, hypokalemia, and hypertension. Multiple liver lesions were incidentally detected with computer tomography and identified as metastatic pituitary tumor on immunohistochemistry. An ACTH-producing adenoma should be followed carefully for early recurrence and/or metastatic spread when the tumor is an invasive macroadenoma with a high proliferation marker level. The unique aggressive behavior and high potential for malignant transformation of this case are discussed.

Source: MEDLINE

2. Cluster headache associated with a sixth nerve palsy: a case report.

Author(s): Grosberg BM, Vollbracht S, Robbins MS, Lipton RB

Citation: Cephalalgia, January 2011, vol./is. 31/1(122-5), 0333-1024;1468-2982 (2011 Jan)

Publication Date: January 2011

Abstract: BACKGROUND: Cluster headache is a rare primary headache disorder characterized by recurrent, stereotyped short-lasting attacks of severe, unilateral head pain accompanied by autonomic symptoms.METHODS/RESULTS: Ophthalmic features such as conjunctival injection, lacrimation, ptosis and miosis occur in the vast majority of patients with cluster headache, whereas co-existent ocular movement disorders are rare.CONCLUSIONS: To the best of our knowledge, only two documented cases of cluster headache with external ocular movement disorders have been reported. We describe herein an additional case with this unusual finding and discuss the putative pathophysiology of cluster headache associated with ophthalmoparesis.

Source: MEDLINE

3. Recurrent contralateral abducens nerve palsy in acute unilateral sphenoiditis.

Author(s): Gupta N, Michel MA, Poetker DM

Citation: American Journal of Otolaryngology, 01 September 2010, vol./is. 31/5(372-375), 01960709

Publication Date: 01 September 2010
4. Abducens ocular neuromyotonia in a patient with nasopharyngeal carcinoma following concurrent chemoradiotherapy

Author(s): Kau H.-C., Tsai C.-C.

Citation: Journal of Neuro-Ophthalmology, September 2010, vol./is. 30/3(266-267), 1070-8022 (September 2010)

Publication Date: September 2010

Abstract: We describe a case of ocular neuromyotonia (ONM) following concurrent chemoradiotherapy for nasopharyngeal carcinoma (NPC). During an episode of neuromyotonia, the patient developed involuntary contraction of the left lateral rectus muscle and globe retraction with down-shoot movement in the left eye. In the quiescent period, ocular motor examination revealed a partial left sixth nerve palsy. While diplopic complaints in patients with NPC raise suspicion of tumor recurrence or radiation-related cranial neuropathy, ONM must also be kept in the differential diagnosis. 2010 by North American Neuro-Ophthalmology Society.

Source: EMBASE

5. Recurrent abducens nerve palsy associated with neurovascular compression.

Author(s): Kato H, Nakajima M, Ohnaka Y, Ishihara K, Kawamura M

Citation: Journal of the Neurological Sciences, August 2010, vol./is. 295/1-2(135-6), 0022-510X;1878-5883 (2010 Aug 15)

Publication Date: August 2010

Abstract: We report a 50-year-old man who suffered from 5 transient diplopia episodes in 16 months. His diplopia lasted between 2 weeks and 3 months and examination revealed isolated left abducens palsy during the attacks of diplopia. Magnetic resonance (MR) angiography and MR imaging with constructive interference in the steady state sequence showed neurovascular compression of the left abducens nerve at the point of exit from the brain stem. Together with a lack of the preceding headache or febrile illness, we propose that neurovascular compression is a possible etiology of recurrent, isolated abducens nerve palsy. Copyright (c) 2010 Elsevier B.V. All rights reserved.

Source: MEDLINE

6. Delayed cranial nerve palsy after coiling of carotid cavernous sinus aneurysms: Case report

Author(s): Xu D.S., Hurley M.C., Batjer H.H., Bendok B.R.

Citation: Neurosurgery, June 2010, vol./is. 66/6(E1215-E1216), 0148-396X (June 2010)

Publication Date: June 2010

Abstract: Objective: Detachable endovascular coils have become a common treatment strategy for carotid cavernous sinus aneurysms (CCAs), but previously unrecognized postprocedure complications may emerge as longer follow-up data are accumulated. In this report, the authors document the first known cases of delayed cranial neuropathy following CCA coiling in 3 patients, all of whom present at least a year postprocedure without aneurysm regrowth. The potential mechanisms underlying this syndrome are discussed as well as their implications on the selection and optimal endovascular management of CCA patients. Clinical Presentation: Three previously healthy females aged 50, 60, and 62 underwent CCA coiling at our institution and subsequently developed ipsilateral cranial nerve palsies at 56, 28, and 14 months, respectively, post-procedure. At presentation, all 3 patients had a new, recurrent area of flow in their CCA without changes in aneurysm size. Intervention: One patient declined further treatment. In the other 2 patients, a stent was placed across the aneurysm neck, and one patient underwent additional coiling. Unfortunately, all 3 patients remained symptomatic at their latest follow-up. Conclusion: Because of the intimate anatomic environment of the cavernous sinus, neural elements within it may be particularly susceptible to persistent mass or dynamic effects exacerbated by remnant or recurrent flow across the neck of a coiled aneurysm. These 3 cases
prompted the authors to advocate for more aggressive efforts to achieve and maintain CCA occlusion. Furthermore, when such efforts are unsuccessful, consideration of traditional carotid occlusion strategies with or without bypass is warranted. Copyright 2010 by the Congress of Neurological Surgeons.

Source: EMBASE

7. Vertical rectus muscle transposition for correcting abduction deficiency in Duane's syndrome type 1 and sixth nerve palsy

Author(s): Yazdian Z., Rajabi M.T., Yazdian M.A., Rajabi M.B., Akbari M.R.

Citation: Journal of Pediatric Ophthalmology and Strabismus, March 2010, vol./is. 47/2(96-100), 0191-3913 (March-April 2010)

Publication Date: March 2010

Abstract: Purpose: To report the clinical outcome and complications of the Scott Foster procedure for treating abduction deficiency in patients with Duane's syndrome type 1 and sixth nerve palsy. Methods: A retrospective, interventional case series included 62 consecutive patients (62 eyes: 38 eyes with Duane's syndrome and 24 eyes with sixth nerve palsy) who underwent the Scott Foster procedure for treatment of abduction deficiency. The main outcome measures were deviation, face turn, and abduction deficiency. Results: In patients with sixth nerve palsy, mean distance deviation improved from 44.7 +/- 7.2 prism diopters (PD) before surgery to 12.5 +/- 4.0 PD after surgery (P < .05), and in patients with Duane's syndrome type 1, mean distance deviation improved from 31.5 +/- 4.3 PD preoperatively to 9.2 +/- 3.1 PD. Mean near deviation improved from 27.1 +/- 4.5 PD to 6.2 +/- 2.5 PD in patients with Duane's syndrome and from 40.3 +/- 6.2 PD to 13.7 +/- 3.4 PD in patients with sixth nerve palsy. Mean abduction deficiency improved from -4 to -2 (P < .05) in both groups. Face turn improved significantly after surgery. No patient had an overcorrection. No recurrence was detected. Conclusion: The Scott Foster procedure is effective for improving deviation, abduction deficiency, and face turn in patients with Duane's syndrome type 1 and especially in those with sixth nerve palsy. Copyright SLACK Incorporated.

Source: EMBASE

Full Text: Available in fulltext at EBSCO Host

8. Recurrent orbital myositis mimicking sixth nerve palsy: Diagnosis with MR imaging

Author(s): Fischer M., Kempkes U., Haage P., Isenmann S.

Citation: American Journal of Neuroradiology, February 2010, vol./is. 31/2(275-276), 0195-6108 (February 2010)

Publication Date: February 2010

Abstract: We present a case with recurrent orbital myositis sequentially affecting both lateral rectus muscles separately. In the first episode, the absence of the required symptoms for the diagnosis of orbital myositis led to the erroneous diagnosis of sixth nerve palsy. Eventually, the correct diagnosis was established with cerebral MR imaging. Orbital myositis should be included in the differential diagnosis of what appears clinically to be abducens palsy, and MR imaging with a focus on the orbita is mandatory in such patients.

Source: EMBASE

Full Text: Available in fulltext at Highwire Press


Author(s): Sturm V, Schoffler C

Citation: Eye, January 2010, vol./is. 24/1(74-8), 0950-222X;1476-5454 (2010 Jan)

Publication Date: January 2010
Abstract: PURPOSE: Benign abducens nerve palsy is rare in childhood. Diagnosis is made by exclusion, and the severe underlying pathologies have to be ruled out. The aim of our study was to present the largest single-center series of patients with the longest period of follow-up to confirm the benign nature of this entity. PATIENTS AND METHODS: We carried out a retrospective study of 12 consecutive children with benign abducens nerve palsy. All children underwent a careful orthoptic and ophthalmic examination during acute presentation and follow-up. RESULTS: Painless palsies were associated with a preceding infection or immunization in five patients. The left eye was affected in nine children and no bilateral case was found. No sex differences were seen. Recovery was observed within 6 months in all cases, and ipsilateral recurrences occurred in three children. Three children required strabismus surgery. None of the patients developed long-term recurrences or neurological abnormalities during a mean follow-up of more than 9 years. CONCLUSIONS: Our data support earlier findings, such as painless and predominantly left-sided occurrence, spontaneous recovery within 6 months, and ipsilateral recurrence. In contrast to much of the literature, we did not find a female preponderance. Exclusion of severe causes and close follow-up is mandatory for these patients. As none of the patients developed long-term recurrences or neurological sequelae, this entity can be regarded as a benign condition without malignant associations or complications.

Source: MEDLINE

Full Text: Available in fulltext at EBSCO Host

10. Partial third nerve palsy after Measles Mumps Rubella vaccination.

Author(s): Manzotti F, Menozzi C, Porta MR, Orsoni JG

Citation: Italian Journal of Pediatrics, 2010, vol./is. 36/1(59), 1720-8424;1824-7288 (2010)

Publication Date: 2010

Abstract: BACKGROUND: Measles Mumps Rubella (MMR) vaccination is known to cause some serious adverse events, such as fever, rash, gland inflammation and neurologic disorders. These include third and sixth cranial nerve palsies. RESULTS: The case reported describes a partial recurrent oculomotor palsy associated with systemic symptoms following MMR vaccination in a healthy young child. The oculomotor palsy did not recover completely during the follow-up. CONCLUSIONS: Most of the times, measles, mumps and rubella cause mild illness and discomfort; but can also have serious or fatal sequelae. MMR vaccination has been proved to be safe and to reduce significantly the number of reported infections due to these viruses. However, significant adverse events can occur and paediatricians and public health operators should be aware of this aspect.

Source: MEDLINE

Full Text: Available in fulltext at BioMedCentral

Available in fulltext at National Library of Medicine

11. Ophthalmoplegic migraine [Turkish] Oftalmoplejik migren

Author(s): Dogan M., Yilmaz C., Caksen H., Guven A.S.

Citation: Nobel Medicus, January 2010, vol./is. 6/1(86-88), 1305-2381 (January-April 2010)

Publication Date: January 2010

Abstract: Ophthalmoplegic migraine is characterized with recurrent 3rd, 4th and/or 6th nerve palsy during or following ipsilateral periorbital or temporal headache. In this study, we report four years old child with ophthalmoplegic migraine because of a rare occasion. The patient was brought to our hospital for the first time due to ptosis following headache, which continued for 4 days. From the history, it was learned that one year ago, ptosis which lasted for one week following headache, had occurred too. Neurological examination was normal except the complete third nerve palsy. Cranial magnetic resonance imaging and electroencephalography examinations were normal. One year later, the patient was brought to us again with the same complaint. Since the attacks were so few we didn't give him
migraine prophylaxis and we advice him to use analgesic during the attacks. The patient still comes to our hospital for periodic controls.

Source: EMBASE

12. Recurrent isolated sixth nerve palsy after consecutive annual influenza vaccination in a child.

Author(s): Khan AO

Citation: Journal of Aapos: American Association for Pediatric Ophthalmology & Strabismus, December 2009, vol./is. 13/6(623), 1091-8531;1528-3933 (2009 Dec)

Publication Date: December 2009

Source: MEDLINE

13. Recurrent isolated sixth nerve palsy after consecutive annual influenza vaccinations in a child

Author(s): Leiderman Y.I., Lessell S., Cestari D.M.

Citation: Journal of AAPOS, June 2009, vol./is. 13/3(317-318), 1091-8531 (June 2009)

Publication Date: June 2009

Abstract: Recurrent sixth nerve palsy in children in the absence of structural or other neurological abnormality is a rare occurrence. We report the case of recurrent isolated sixth (abducens) nerve palsy after consecutive annual influenza vaccinations in an otherwise healthy 2-year-old boy. Investigations including magnetic resonance imaging of the brain and orbits after each episode failed to reveal any abnormality. The temporal relation to the immunizations supports but does not prove that the influenza immunization regimen was responsible. 2009 American Association for Pediatric Ophthalmology and Strabismus.

Source: EMBASE

14. Benign recurrent sixth abducens nerve palsies in children

Author(s): Mahoney N.R., Liu G.T.

Citation: Archives of Disease in Childhood, May 2009, vol./is. 94/5(394-396), 0003-9888;1468-2044 (May 2009)

Publication Date: May 2009

Abstract: Sixth nerve palsy can occur as a result of elevated intracranial pressure, neoplasm or trauma. Reports from tertiary centres indicate that between 5% and 16% of referred cases have no ascribed aetiology and are classified as benign. Rarely, these benign palsies can recur. A retrospective chart review of a cohort of 253 paediatric patients with sixth nerve palsies was analysed and uncovered 30 cases of benign sixth nerve palsy, nine of which recurred. Our data and review of other studies on the subject imply that a new onset sixth nerve palsy presenting in children can be benign in approximately 13% of cases, so a thorough history and physical examination to evaluate for any other neurological symptoms or signs followed by MRI of the brain with and without contrast is recommended.

Source: EMBASE

Full Text:
Available in fulltext at Highwire Press

15. Ophthalmoplegic migraine with recurrent sixth nerve palsy: A rare presentation of headache in a young lady

Author(s): Chowdhury M.H., Nur Z., Begum H.A., Mahbub Md.S., Ahasan H.N.

Citation: Journal of Medicine, 2009, vol./is. 10/2(139-141), 1997-9797 (2009)

Publication Date: 2009

Abstract: Migraine is a common presentation of headache but migraine with
opthalmoplegia with third nerve palsy is rare and with fourth or sixth nerve palsy is very rare. Although it represents a benign course, duration and severity are variable among the patients. We demonstrated a young lady presenting with right hemicranial headache for 12 days with several episodes of vomiting. She also complained of double vision for 7 days. The headache started from the inner canthus of right eye and gradually spread throughout the right half of head over 2 hours and was throbbing in nature. She also complained of double vision from 5th day after onset of headache. Interestingly, she informed similar types of attack for two episodes in last 1 year which persisted for around 22-25 days each time. On examination, she appeared ill looking with convergent squint on right lateral gaze. Cranial nerves examinations showed all the cranial nerves were intact except right sixth cranial nerve palsy. Laboratory investigations and neuroimaging were normal. Our case fulfilled the International Classification of Headache Disorders (ICHD II) criteria for ophthalmoplegic migraine with recurrent six nerve palsy which responded dramatically with prednisolone therapy 1mg/kg/day which also prevented recurrence within 6 months.

Source: EMBASE

16. Benign recurrent abducens (sixth) nerve palsy.

Author(s): Okutan V, Yavuz ST, Mutlu FM, Akin R

Citation: Journal of Pediatric Ophthalmology & Strabismus, January 2009, vol./is. 46/1(47-9), 0191-3913; 0191-3913 (2009 Jan-Feb)

Publication Date: January 2009

Abstract: Benign recurrent abducens nerve palsy is rare. Twenty-three cases in children have been reported in the literature and many of these cases followed immunization or were associated with viral illness. Most of the reported patients share the following features: spontaneous recovery within 6 months, ipsilateral recurrence, and painless palsy. The authors describe a Turkish child with recurrent abducens nerve palsy with no obvious etiology.

Source: MEDLINE

Full Text:
Available in fulltext at EBSCO Host

17. Occurrence of abducens palsy after renal cancer surgery

Author(s): Miyamoto K.

Citation: Neuro-Ophthalmology Japan, 2009, vol./is. 26/1(89-93), 0289-7024 (2009)

Publication Date: 2009

Abstract: Here, I present a case where abducens palsy developed after renal cancer treatment, and describe a rare side effect that was caused by interferon (IFN) therapy. A 65-year-old man underwent surgery for renal cell carcinoma 5 years previous. Subsequently, the patient developed right pulmonary metastasis 2 years later and since that time has been managed with IFNa therapy for recurrence. After 4 years of IFN therapy, this conventional IFN treatment was changed to a longer-acting IFN, i.e, pegylated IFN (PEG-IFN) for better curative effect. On the day after starting the PEG-IFN therapy, he developed diplopia, and was diagnosed as having right abducens palsy. A further examination revealed that he did not have diabetes mellitus, hypertension, or inflammatory disease. Magnetic resonance imaging (MRI) of the head indicated there was no evidence of metastasis or intracranial hypertension, although he did exhibit enhancement of the right abducens nerve. At one month after the onset of the diplopia, he developed painful swelling of the right parotid gland, dry eye and dry mouth sensations. Laboratory data resulted in a diagnosis of primary Sjogren's syndrome. Considering the poor prognosis for the carcinoma and the lack of any alternative treatments, he was returned to conventional IFN therapy. His diplopia gradually improved and resolved within 5 months. IFNs have complex immunomodulating effects and can frequently induce or exacerbate autoimmune disease. In the current case, IFN activated the patient's immune system and induced acute inflammation in the abducens nerve, which caused the enhancement of the abducens nerve in MRI and the ensuing abducens palsy. When administering IFN therapy, close attention needs be paid to the potential development of autoimmune disease and if it does
occur, cessation of IFN or a change in the type of IFN needs to be considered.

Source: EMBASE

18. Ocular complications of HIV infection in sub-Saharan Africa.

Author(s): Nkomazana O, Tshitshwana D

Citation: Current HIV/AIDS Reports, August 2008, vol./is. 5/3(120-5), 1548-3568;1548-3576 (2008 Aug)

Publication Date: August 2008

Abstract: This article reviews the magnitude and spectrum of ocular complications of HIV infection in sub-Saharan Africa. A literature search was done using PubMed, Google, and UpToDate and by talking to ophthalmologists and HIV experts working in the region. Ocular complications of HIV infection, mostly retinal, are seen in 29% to 71% of patients. Cytomegalovirus retinitis affects 0% to 16.5% of HIV-infected patients and is treated successfully with intravitreal ganciclovir in South Africa and Botswana. Ocular surface squamous neoplasia is seen in 4% to 7.8% of persons with HIV (a 5%-6% increase in Uganda and Tanzania), and recurrence after surgery occurs in 3.2% to 31.2%. In Zimbabwe, 45% of meningitis in adults is cryptococcal, and cryptococcal meningitis is the third leading cause of death in HIV patients in rural Uganda. In Rwanda, 9% of patients with cryptococcal meningitis developed visual loss and sixth nerve palsy. Thus, HIV infection leads to significant ocular morbidity in sub-Saharan Africa.

Source: MEDLINE

19. Ophthalmoplegic migraine: a case with recurrent palsy of the abducens nerve.

Author(s): Vasconcelos LP, Stancioli FG, Leal JC, da Silva A, Gomez RS, Teixeira AL

Citation: Headache: The Journal of Head & Face Pain, 01 June 2008, vol./is. 48/6(961-964), 00178748

Publication Date: 01 June 2008

Abstract: Ophthalmoplegic migraine (OM) is a rare disorder characterized by recurrent episodes of migraine-like headaches associated with extrinsic ocular musculature palsy. In this article, we report a patient with OM that presented recurrent palsy of the abducens nerve and other atypical features. Case reports of OM with abducens nerve palsy were also reviewed.

Source: CINAHL

Full Text:
Available in fulltext at EBSCO Host

20. Periodic abducens nerve palsy in adults caused by neurovascular compression.

Author(s): Sandvand KA, Ringstad G, Kerty E

Citation: Journal of Neurology, Neurosurgery & Psychiatry, January 2008, vol./is. 79/1(100-2), 0022-3050;1468-330X (2008 Jan)

Publication Date: January 2008

Abstract: Unilateral abducens nerve palsy with periodic recurrences is a well-recognised finding in children, but is rare in adults. The underlying pathophysiological mechanism is unknown. Vascular compression of the nerve is suspected but never demonstrated. We describe an adult patient with, altogether, 11 periods of unilateral right-sided abducens palsy and arterial contact at the root exit zone of the symptomatic side.

Source: MEDLINE

Full Text:
21. An unusual presentation of adenoid cystic carcinoma of the minor salivary glands with cranial nerve palsy: A case study

Author(s): Abdul-Hussein A., Morris P.A., Markova T.

Citation: BMC Cancer, August 2007, vol./is. 7/, 1471-2407 (13 Aug 2007)

Abstract: Background: Adenoid Cystic Carcinoma (ACC) is a rare tumor entity and comprises about 1% of all malignant tumor of the oral and maxillofacial region. It is slow growing but a highly invasive cancer with a high recurrence rate. Intracranial ACC is even more infrequent and could be primary or secondary occurring either by direct invasion, hematogenous spread, or perineural spread. We report the first case of the 5th and 6th nerve palsy due to cavernous sinus invasion by adenoid cystic carcinoma. Case presentation: A 49-year-old African American female presented to the emergency room complaining of severe right-sided headache, photophobia, dizziness and nausea, with diplopia. The patient had a 14 year history migraine headaches, hypertension, and mild intermittent asthma. Physical examination revealed right lateral rectus muscle palsy with esotropia. There was numbness in all three divisions of the right trigeminal nerve. Motor and sensory examination of extremities was normal. An MRI of the brain/brain stem was obtained which showed a large mass in the clivus extending to involve the nasopharynx, pterygoid plate, sphenoid and right cavernous sinuses. Biopsy showed an ACC tumor with a cribriform pattern of the minor salivary glands. The patient underwent total gross surgical resection and radiation therapy. Conclusion: This is a case of ACC of the minor salivary glands with intracranial invasion. The patient had long history of headaches which changed in character during the past year, and symptoms of acute 5th and 6th cranial nerve involvement. Our unique case demonstrates direct invasion of cavernous sinus and could explain the 5th and 6th cranial nerve involvement as histopathology revealed no perineural invasion.

Source: EMBASE

Full Text:

Available in fulltext at BioMedCentral

22. Multiple cranial nerve paralysis in a patient with recurrent rectal adenocarcinoma: Imminent cerebellar herniation

Author(s): Abali H., Guler N., Engin H., Kocak T., Dagli N., Erman M., Celik I.

Citation: Turkish Journal of Cancer, April 2007, vol./is. 37/2(72-73), 1019-3103 (Apr 2007)

Abstract: Rectal adenocarcinoma may spread to the central nervous system and may result in various symptomatologies. Rectal adenocarcinoma presenting with multiple cranial nerve palsies has not been reported. A case of metastatic rectal adenocarcinoma with audio-visual complaints is presented. The therapeutic approach is discussed briefly. It is concluded that multiple cranial nerve palsies in a case with rectal adenocarcinoma herald brainstem metastasis, high risk of sudden death and need for immediate intervention appropriately.

Source: EMBASE

23. A case report of Wegener’s granulomatosis presenting with multiple cranial nerve palsy and hypertrophic cranial pachymeningitis

Author(s): Sakurazawa M., Katsumata T., Kunugi S., Katsura K.-I., Sakamoto S., Katayama Y.

Citation: Clinical Neurology, February 2007, vol./is. 47/2-3(85-89), 0009-918X (Feb 2007)
Abstract: We report a 41-year-old man whose initial neurological symptoms are atypical of Wegener's granulomatosis. The patient was admitted because he developed left ocular pain, headache, bilateral visual loss and left abducens nerve palsy. He was initially diagnosed with optic neuritis at ophthalmological department and steroid therapy was started. Although steroid therapy led to rapid recovery of visual acuity and eye movement, he was readmitted for seizure. Two weeks later, a second seizure attack occurred, followed by palsy of the left side of cranial nerves II, III, IV, V and VI. Brain MRI showed focal thickening and enhancement of the dura mater over left frontal lobe, leading to a new presumptive diagnosis of idiopathic hypertrophic cranial pachymeningitis. Steroid therapy was resumed and the symptoms improved rapidly. As right hemiparesis developed during the clinical course, another brain MRI was obtained. T2-weighted image showed a high intensity area in the left portion of the pons. 14 months later, recurrent epistaxis suggestive of Wegener's granulomatosis appeared. A subsequent nasopharyngeal mucosa biopsy revealed a necrotizing granulomatous inflammation. A significant elevation of PR-3 ANCA was also noted. A definitive diagnosis of Wegener's granulomatosis was established. The initial presentation of this case was of multiple cranial neuropathies with no superior respiratory tract symptoms, which are typical of early stage Wegener's granulomatosis. In patients with various central nervous system symptoms and MRI evidence of hypertrophic cranial pachymeningitis, a thorough clinical workup of vasculitis syndrome including Wegener's granulomatosis should be considered.

Source: EMBASE

24. Recurrent isolated sixth nerve palsy secondary to an intracavernous carotid artery aneurysm [37]

Author(s): Nguyen D.Q., Perera L., Kyle G.

Citation: Eye, December 2006, vol./is. 20/12(1416-1417), 0950-222X;1476-5454 (Dec 2006)

Publication Date: December 2006

Source: EMBASE

Full Text:
Available in fulltext at EBSCO Host

25. Cerebral venous thrombosis--clinical presentations

Author(s): Mehndiratta M.M., Garg S., Gurnani M.

Citation: JPMA. The Journal of the Pakistan Medical Association, November 2006, vol./is. 56/11(513-516), 0030-9982 (Nov 2006)

Publication Date: November 2006

Abstract: Cerebral venous thrombosis (CVT) is an under diagnosed condition for acute or slowly progressive neurological deficit. CVT is less frequent than arterial thrombosis. CVT has a wide spectrum of signs and symptoms, which may evolve suddenly or over the weeks. It is clinically challenging and mimics many neurological conditions such as, meningitis, encephalopathy, benign intracranial hypertension, and stroke. With increasing awareness, CVT cases are now being diagnosed more frequently. Newer imaging procedures have led to easier recognition of venous sinus thrombosis, offering the opportunity for early therapeutic measures. It may be difficult to diagnose it on clinical grounds alone. Headache is the most frequent symptom in patients with CVT, present in about 80% of cases. Most common pattern of presentation is with a benign intracranial hypertension-like syndrome. The prognosis of CVT is worse in elderly subjects. The shorter the history the more likely is the presence of focal signs. Sixth cranial nerve palsy usually manifests as false localizing sign. Subarachnoid haemorrhage (SAH) has been described, as the presenting event with CVT. Patients may have seizures that can be recurrent. Cranial nerve syndromes are seen with venous sinus thrombosis. Psychiatric disturbances are sometimes the presenting symptoms. CVT, an important cause of stroke in puerperium, is frequently observed in India. We have seen 6 patients of CVT out of 490 stroke registry. Of these 6, four were females and two were males. The mean age among females was
27.75 years and among males was 41.5 years. Of the 4 females two were postpartum; one was on oral contraceptive and in one Antiphospholipid antibodies (APLA) were positive. Amongst two males one had hyperhomocysteinemia and one had hyperlipidemia.

Source: EMBASE

26. **Hepatocellular carcinoma metastasizing to the skull base involving multiple cranial nerves**

**Author(s):** Kim S.R., Kanda F., Kobessho H., Sugimoto K., Matsuoka T., Kudo M., Hayashi Y.

**Citation:** World Journal of Gastroenterology, November 2006, vol./is. 12/41(6727-6729), 1007-9327 (07 Nov 2006)

**Publication Date:** November 2006

**Abstract:** We describe a rare case of HCV-related recurrent multiple hepatocellular carcinoma (HCC) metastasizing to the skull base involving multiple cranial nerves in a 50-year-old woman. The patient presented with symptoms of ptosis, fixation of the right eyeball, and left abducens palsy, indicating disturbances of the right oculomotor and trochlear nerves and bilateral abducens nerves. Brain contrast-enhanced computed tomography (CT) revealed an ill-defined mass with abnormal enhancement around the sella turcica. Brain magnetic resonance imaging (MRI) disclosed that the mass involved the clivus, cavernous sinus, and petrous apex. On contrast-enhanced MRI with gadolinium-chelated contrast medium, the mass showed inhomogeneous intermediate enhancement. The diagnosis of metastatic HCC to the skull base was made on the basis of neurological findings and imaging studies including CT and MRI, without histological examinations. Further studies may provide insights into various methods for diagnosing HCC metastasizing to the craniospinal area. 2006 The WJG Press. All rights reserved.

Source: EMBASE

27. **Adult-Onset Ophthalmoplegic Migraine with Recurrent Sixth Nerve Palsy: A Case Report.**

**Author(s):** Mucchiut M, Valentinis L, Provenzano A, Cutuli D, Bergonzi P

**Citation:** Headache: The Journal of Head & Face Pain, 01 November 2006, vol./is. 46/10(1589-1590), 00178748

**Publication Date:** 01 November 2006

**Abstract:** We describe a patient with ophthalmoplegic migraine and left sixth nerve palsy, in whom disease’s onset occurred at middle age.

Source: CINAHL

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**Author(s):** Zarnowski T, Nowomiejska K, Zagorski Z

**Citation:** Klinika Oczna, 2006, vol./is. 108/7-9(332-3), 0023-2157;0023-2157 (2006)

**Publication Date:** 2006

**Abstract:** We present a case of isolated unilateral abducens nerve palsy with multiple recurrences in a young woman. First episode occurred at the age of 12 with no apparent reason. The palsy resolved without other associated neurological signs or symptoms, neuro-imaging test were also normal. Since that time she had 6 episodes lasting 6-8 weeks with the average interval of 1 year and 4 months. Each episode was followed by a headache of the right hemisphere. The diagnosis of benign sixth nerve palsy is one of exclusion and may be made after the long period of observation and diagnostic procedures.
29. **Multiple cranial nerve palsies: Analysis of 979 cases**

**Author(s):** Keane J.R.

**Citation:** Archives of Neurology, November 2005, vol./is. 62/11(1714-1717), 0003-9942;1538-3687 (Nov 2005)

**Publication Date:** November 2005

**Abstract:** Background: To my knowledge, no large series of multiple cranial neuropathies is available. Objectives: To examine the seats and causes of multiple cranial neuropathies in a large group of inpatients. Design: Personal case series. Setting: Wards of a large municipal hospital and affiliated rehabilitation hospital. Patients: A consecutive series of 979 unselected inpatients with simultaneous or serial involvement of 2 or more different cranial nerves. Results: Cranial nerves VI (565 cases), VII (466 cases), V (353 cases), and III (339 cases) were most commonly affected. The locations and causes were diverse, with cavernous sinus (252 cases), brainstem (217 cases), and individual nerves (182 cases) being the most frequent sites, and tumor (305 cases), vascular disease (128 cases), trauma (128 cases), infection (102 cases), and the Guillain-Barre and Fisher syndromes (91 cases total) being the most frequent causes. Recurrent cranial neuropathy was uncommon (43 cases, 106 episodes, 136 nerves), with diabetes mellitus (14 cases), self-limited unknown causes (14 cases), and idiopathic cavernous sinusitis (10 cases) being the usual causes. Conclusion: While the locations and causes of multiple cranial neuropathy are highly diverse, the fact that tumor composes more than one quarter of cases places a premium on prompt diagnosis. 2005 American Medical Association. All rights reserved.

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30. **Painful oculomotor palsy: A diagnostic approach [French] Paralysies oculomotrices douloureuses: Une approche diagnostique**

**Author(s):** Vighetto A., Tilikete C.

**Citation:** Revue Neurologique, May 2005, vol./is. 161/5(531-542), 0035-3787 (May 2005)

**Publication Date:** May 2005

**Abstract:** We review the question of diagnosis of painful and relatively isolated ophthalmoplegia due to diseases affecting the ocular motor nerves. For each clinical setting, we provide an overview of the main causes and a practical way to approach the diagnosis. As vascular malformations should always be kept in mind in patients with painful ophthalmoplegia, emergency neuroradiological investigations may be needed. However, the etiological scope is wide and the rationale for choosing the more appropriate examination and its optimal timing depends exclusively on the clinical evaluation. Despite advances in investigation techniques, diagnosis may remain difficult or even unresolved in a certain number of patients. We discuss successively paralysis of the third, sixth and fourth nerve, paralysis of several ocular motor nerves, recurrent ophthalmoplegia and ischaemic ocular motor palsies, which are the most frequent cause.

**Source:** EMBASE

31. **Recurrent headache and sixth nerve palsy associated with lumbar ependymoma.**

**Author(s):** Gormley KM, Gutowski NJ

**Citation:** Journal of Neurology, March 2005, vol./is. 252/3(359-60), 0340-5354;0340-5354 (2005 Mar)

**Publication Date:** March 2005

**Source:** MEDLINE
32. **Benign recurrent abducens (6th) nerve palsy in two children**

**Author(s):** Knapp C.M., Gottlob I.

**Citation:** Strabismus, March 2004, vol./is. 12/1(13-16), 0927-3972 (Mar 2004)

**Publication Date:** March 2004

**Abstract:** Benign recurrent abducens (6th) nerve palsy is rare. We found 23 cases in children reported in the literature; however, many of these cases followed immunization or were associated with viral illness. Here we report two cases of recurrent abducens nerve palsy with no obvious etiology. The diagnosis should be considered in any child who experiences abducens nerve palsy in the absence of any underlying pathology or precipitating factors.

**Source:** EMBASE

33. **Juvenile myasthenia gravis mimicking recurrent VI nerve palsy of childhood**

**Author(s):** Vishwanath M.R., Nischal K.K., Carr L.J.

**Citation:** Archives of Disease in Childhood, January 2004, vol./is. 89/1(90), 0003-9888 (Jan 2004)

**Publication Date:** January 2004

**Source:** EMBASE

34. **Factor XII deficiency and recurrent sixth nerve palsy.**

**Author(s):** Kipioti A, Backhouse OC, Jacobs PM, Howard MR

**Citation:** British Journal of Ophthalmology, March 2003, vol./is. 87/3(369-70), 0007-1161;0007-1161 (2003 Mar)

**Publication Date:** March 2003

**Source:** MEDLINE

35. **Long-term prognosis in patients with vasculopathic sixth nerve palsy.**

**Author(s):** Sanders SK, Kawasaki A, Purvin VA
PURPOSE: To better define the long-term prognosis in patients with a vasculopathic sixth nerve palsy (6NP), specifically addressing the degree of recovery and incidence of recurrent similar episodes.

DESIGN: Observational case series.

METHODS: Retrospective chart review. Setting: An outpatient neuroophthalmic practice. Study population: Patients with one or more vascular risk factors and an acute, isolated 6NP that spontaneously recovered. Observation procedure: Information regarding resolution of the 6NP, subsequent vascular events and recurrent ocular motor nerve palsy was obtained from chart review of follow-up clinic visits, mailed questionnaires and telephone interviews. The duration of follow-up ranged from 2 to 13 years.

Main outcome measures: Resolution of 6NP (complete or incomplete) and incidence of recurrent ocular motor nerve palsy.

RESULTS: Fifty-nine patients were identified with a mean age of 65.3 years +/- 11.6 (range 34-90 years). Fifty-one patients (86%) experienced complete resolution of their first episode of vasculopathic 6NP and eight patients (14%) had incomplete resolution. A subsequent episode of ocular motor mononeuropathy occurred in 18 of 59 (31%) patients. The number of recurrences ranged from one (in 14 patients) to four (in one patient). There was no association between any risk factor and recurrence of ocular motor nerve palsy. Similarly, incomplete resolution of the vasculopathic 6NP was not associated with any risk factor.

Conclusions: Patients with a vasculopathic 6NP usually have complete resolution of their ophthalmoplegia, but nearly one third of patients in our study later experienced at least one episode of recurrent vasculopathic ocular motor nerve palsy.

Source: MEDLINE

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36. Recurrent sixth nerve palsy following measles mumps rubella vaccination.

Author(s): McCormick A, Dinakaran S, Bhola R, Rennie IG

Citation: Eye, June 2001, vol./is. 15/Pt 3(356-7), 0950-222X;0950-222X (2001 Jun)

Publication Date: June 2001

Source: MEDLINE

37. Sphenoid sinus mucocoele and cranial nerve palsies in a patient with a history of nasopharyngeal carcinoma: May mimic local recurrence

Author(s): Wong C.S.F., Luk S.H., Leung T.W., Yuen K.K., Sze W.K., Tung S.Y.

Citation: Clinical Oncology, 2001, vol./is. 13/5(353-355), 0936-6555 (2001)

Publication Date: 2001

Abstract: We report the case history of a patient with a sphenoid sinus mucocele detected by computed tomography and medical resonance imaging. The patient had a history of nasopharyngeal carcinoma, which was treated by radiotherapy more than 10 years previously. He presented with bilateral twelfth and sixth cranial nerve palsies. Local tumour recurrence was suspected. Further investigations showed that the cranial nerve palsies were caused by radiation damage and the sphenoid sinus mucocele was an incidental finding. Sphenoid sinus mucocele is a possible rare late complication of radiotherapy in patients with nasopharyngeal carcinoma.

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   ... We recommend adding this rare disease process to the list of causes of isolated **sixth nerve palsy** in children. ... Pediatric third, fourth, and **sixth nerve palsies**: a population- based study. ... Neurosurgery 1990;26:71–9. 9. Nguyen DQ, Perera L, Kyle G. **Recurrent** isolated **sixth nerve** ...
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45. **Ophthalmic segment aneurysmal subarachnoid hemorrhage presenting with contralateral abducens nerve palsy: A false localizing sign**
   SV Furtado, D Mohan… - Optometry-Journal of the American …, 2010 - Elsevier
   ... About 26% of sixth nerve palsies are considered idiopathic ... Sixth nerve palsy caused by SAH is known to recover spontaneously between 3 and 8 weeks after onset ... of dolichoectatic cavernous carotid artery are associated with a single episode or multiple recurrent episodes of ...

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   AG Lee… - MedLink Neurology, 2006 - medlink.com
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47. **Cranial nerve VI palsy as a rare initial presentation of systemic lupus erythematosus: case report and review of the literature**
   Z Saleh, J Menassa, O Abbas, S Atweh… - Lupus, 2010 - lup.sagepub.com
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51. **Diabetes and Hypertension in Isolated Sixth Nerve Palsy: A Population-Based Study**
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S Prasad, NJ Volpe - Neurologic clinics, 2010 - Elsevier
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