Diabetic microvascular ischemic disease can affect both peripheral nerves and cranial nerves (CNs). Diabetes is a major risk factor for cranial ocular motor nerve palsies, and diabetics have been reported to have a 7.5-fold greater incidence of ischemic ocular motor nerve palsies. Ischemic palsies of CNs III, IV, and VI result in diplopia, ocular misalignment, and patient discomfort. Although diabetic ischemic disease is a recognized and common cause of each of these palsies, it is critical to rule out life-threatening etiologies such as aneurysm, tumor, and infection, particularly fungal infection.

Other CNs can also be affected by diabetes. CN II, the optic nerve, can be affected by nerve fiber dropout and papillitis, and optic neuropathy can occur in young diabetics. Dialysis-related optic neuropathy has also been described. Diabetic peripheral neuropathy can affect CN V, causing trigeminal neuralgia. Finally, CN VII can be affected, producing a scenario mimicking Bell’s palsy. Multiple studies have correlated lack of glycemic control to incidence of cranial neuropathies in diabetics, although some studies have failed to show any direct link.

**Palsies of Cranial Nerves III, IV, and VI**

Third, fourth, and sixth CN palsies are the most commonly found among diabetic patients. Most often, these palsies are found in isolation, but occasionally they may be found in conjunction. The cavernous sinus is a likely locale for pathology as multiple CNs pass through it and can be simultaneously affected by thrombosis; tumor; and infiltrative, vascular, or other lesions. Similarly, the brainstem can also be a location for pathology involving multiple CNs at their origins.

Apart from the usual concern of brainstem lesion or cavernous sinus tumor, infection is a serious concern in diabetics, especially in those with poor glycemic control. Single or multiple cranial motor nerve palsies can be the sentinel sign of an advancing infectious process in diabetics. Fungal infections such as aspergillosis and mucormycosis can originate in the sinus cavities and spread to surrounding tissues in diabetics, typically in those with poor glycemic control or other immunocompromising factors. These infections must be detected quickly and treated aggressively and often surgically if the patient is to survive.