Results of Coagulation Studies

	Fibrinogen (mg/100 ml)	Factor VIII (%)	Euglobulin Lysis Time (hours)
Normal range	Case 1 200-400	50-150	3-4
On admission	550	1,090	>24
On Varidase treatment (14 days)	480	—	2-3
Without treatment (for seven days)	450	1,000	>8
On Varidase treatment .. .	460	290	2-7
On admission	Case 2 580	780	>24
24 hours after treatment with intravenous streptokinase ..	202	375	0-5
On oral Varidase treatment ..	456	280	3-5

Comment

Few studies of the clotting mechanism in Behçet's disease have been reported. Cunliffe and Menon (1969) investigated a case with deep thrombophlebitis and repeated pulmonary emboli. They found that despite a normal coagulation and fibrinolytic mechanism the patient improved on treatment with phenformin and ethyloestrenol, which enhanced fibrinolysis. In the present two patients plasma fibrinolytic activity was strikingly

decreased and the levels of fibrinogen and factor VIII increased. We do not think these coagulation defects have been described in Behçet's disease before. In both cases giving streptokinase reduced the euglobulin lysis time to normal and greatly improved the thrombophlebitis. Phlebitis and decreased fibrinolysis recurred in the first case when treatment was discontinued.

The aetiology of Behçet's disease is still unknown, but vasculitis seems to be the underlying cause of most of its diverse manifestations (Dowling, 1961). The recurrent thrombophlebitis may be secondary to or enhanced by decreased fibrinolysis. Because of the successful treatment with streptokinase in the cases reported here we suggest that fibrinolytic agents may be indicated in cases of Behçet's disease with superficial or deep thrombophlebitis.

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Facial Palsy as the Sole Presenting Symptom of Parotid Carcinoma

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Facial palsy is by no means an unusual feature of an advanced carcinoma of the parotid salivary gland. The two most common presenting features of the disease are, however, the presence of a mass and pain. Facial palsy may be associated with these symptoms, and the significance of this palsy with regard to the diagnosis of malignancy is well recognized.

Facial palsy may, however, precede the appearance of other features by many months. Frazell (1954) stated "In a few patients seen by us, such palsy was the initial and only complaint for weeks or months prior to discovery of the tumour."

It is our experience, in the combined plastic surgery radiotherapy clinic, that this mode of presentation is more common than we had previously appreciated. From 1969 to 1971 three cases (see below) out of 21 (14%) of parotid carcinoma presented in this way.

Case Histories

Case 1.—An 80-year-old woman presented with a history of weakness of the left side of the face for one week, associated with some pain in the region of the left side of the mandible. An almost complete facial palsy was present but there was no evidence of causation. Bell's palsy was diagnosed. The palsy did not recover. Thirty-three months later she was referred for treatment of corneal exposure problems as a result of the complete palsy. At examination a small ulcer was found near the lobule of the left ear, with an underlying mass. Biopsy showed a poorly differentiated carcinoma of parotid gland origin. A cervical lymph node contained metastatic tumour. Lateral tarsorrhaphy was performed and radiotherapy started.

Case 2.—A woman aged 41 was under regular review after the treatment of basal cell carcinomata of the skin. A right-sided

facial palsy developed and was diagnosed as Bell's palsy. Sixteen months later a parotid mass was first apparent. Parotidectomy was performed and a parotid carcinoma of squamous cell type was found.

Case 3.—A 58-year-old woman presented with a left-sided facial palsy which was diagnosed as a Bell's palsy. It did not recover. Seven months later an ill-defined firm mass was found between the jaw and mastoid process. A biopsy specimen showed normal parotid gland tissue. Plain x-ray examination of the region and parotid sialography showed nothing abnormal. Ten months later a further mass became apparent and was then associated with pain in the left side of the face. Exploration showed a tumour of the parotid gland of the squamous cell type. Radiotherapy was given.

Comment

The first two cases are typical of the problem, the delay between diagnosis of facial palsy and eventual discovery of the parotid neoplasm being 33 months and 16 months respectively. The third case shows how difficult it may be to confirm the diagnosis even when suspicion has been aroused. It is our belief that at the time of biopsy the clinically apparent mass was normal parotid gland tissue displaced laterally by a more deeply lying neoplasm.

In case 1 pain was mentioned at the time of initial examination. Perhaps its significance should have been realized. It seems doubtful, however, if any more direct evidence of a neoplasm could have been found at that time.

When a patient presents with a facial palsy without other diagnostic features it is more than likely that the diagnosis of Bell's palsy will be made. In many cases this must be diagnosis by exclusion. If a parotid neoplasm is the underlying cause it will escape detection until other features become apparent.

The purpose of this report is to increase the awareness of the possibility of parotid neoplasm as a cause of the apparent Bell's palsy, and earlier diagnosis may well be achieved by critical follow-up of all cases diagnosed initially as Bell's palsy.

In cases where the palsy recovers, the label of Bell's palsy could be justified. When it does not recover, the label should be "facial palsy—cause not yet diagnosed."

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