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In Neurology

Idiopathic intracranial hypertension (IIH) was formerly referred to as benign intracranial hypertension (BIH) and pseudotumor cerebri. When ineffectively treated, IIH can result in visual loss. Hence it is now no more considered “benign”. In the pre-CT, pre-MRI era when patients used to present with headache and papilledema, a possibility of intracranial tumor used to be considered. When such patients were taken for craniotomy and it was later realized that there was no tumor a diagnosis of pseudotumor cerebri was considered. The term IIH is now the accepted terminology for this disorder since no etiology for the same has been determined on imaging studies.

Patients with late-onset headache requires evaluation for giant cell arteritis (GCA). The headache of GCA is usually throbbing and is often accompanied by scalp tenderness, often noticed by patients while combing. Tenderness of the superficial temporal artery is not universal and is seen in only 2/3rd of the patients. Treatment of this condition is required urgently, most importantly to prevent visual loss which may initially present as amaurosis fugax. Steroid is the most important treatment modality for this condition.

Idiopathic intracranial hypertension (IIH)

The most common presenting symptoms of IIH are headache, transient visual obscurations, diplopia, and pulsatile tinnitus. The headache is usually worse on awakening and is worsened by activity. The headache is often severe, occurs daily, and described as throbbing. High CSF pressure must be documented during lumbar puncture using manometric studies. Values greater than 250 mm H2O recorded with the patient lying on a side with legs extended confirm elevated intracranial pressure.

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